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**Kwadwo Mensah, Maureen Mackintosh
and Leroi Henry**

February 2005

This paper was commissioned by health charity Medact as part of its programme of work on health, poverty and development. It was funded by the British Medical Association (through its Strategic Grant Agreement with the Department for International Development) and Save the Children UK, to whom Medact is grateful. The views expressed in the paper are those of the authors and not necessarily those of Medact or its funders. For further information, please contact info@medact.org.



Medact
The Grayston Centre
28 Charles Square
London N1 6HT
United Kingdom

T: +44 (0)20 7324 4739
F: +44 (0)20 7324 4734
W: www.medact.org

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Registered Charity 1081097
Company Reg. No. 2267125

The ‘Skills Drain’ of Health Professionals from the Developing World: a Framework for Policy Formulation

Kwadwo Mensah*, **Maureen Mackintosh†** and **Leroi Henry‡**

February 2005

Summary[§]

This paper should be read in association with its companion paper on migration and human rights (Bueno de Mesquita and Gordon 2005). Human rights discussed there form part of the ethical and political premises of this paper. This paper in turn examines policy towards health professionals’ migration from economic and governance perspectives. Our aims are conceptual and agenda-setting. In essence, we argue that current policy responses to migration of health professionals from low income developing countries underestimate the pressures and mis-identify the reasons for rising migration, overestimate the impact of recruitment policies on migration flows while ignoring unintended side effects, and mis-specify the ethical dilemmas involved.

The paper employs as its central case study the migration of health professionals from Ghana, the home country of the lead author, to the UK. This case is typical neither of migration flows nor impact, and is not presented as such. Rather, Ghana-UK migration provides a good example of many of the worst problems and contradictions in the current situation and policy debate. We therefore employ it as a test case, a source of insight, and a ‘place to stand’ in constructing arguments that can be tested subsequently on a wider field.

The paper puts forward the following propositions, with evidence where available and with identification of gaps in evidence that research could usefully address.

* *Medical doctor and independent health management consultant, Kumasi, Ghana*

† *Professor of Economics, The Open University, UK.*

‡ *Research Fellow, The Open University, UK.*

§ *Thanks to Mike Rowson, Jude Bueno de Mesquita, and Matt Gordon for comments on earlier drafts. Assistance from David Hewitt also acknowledged with thanks.*

1. The employment in wealthy countries of health professionals trained in staff-short low income countries contributes to rising international inequity in health care. That effect should be central to the design of policy responses to health professional migration: the inequity ought to be tackled systematically and in a co-ordinated way. The objective of policy towards migration should be, not limitation of mobility, but equity in health care as soon as possible.
2. The migration of health service professionals is an aspect of rapid international integration and commercialisation of health service labour markets, in the context of high levels of international inequality. These processes are cumulative, self-reinforcing, and hard to reverse; policy must work with, not against their grain.
3. Coercive measures to prevent departure, taken in low income countries that are losing staff, work poorly; worse, they can intensify pressures to leave. Conversely, incentives to stay that redress the key violations of decent working and living conditions, and that value skills and commitment, do work, and lessen rather than worsen inequalities; the implication is that health service financing and governance needs to improve in countries that are losing staff.
4. The UK Department of Health's 'ethical recruitment' Code reflects a welcome recognition of the detrimental impact of international recruitment on the health systems of some developing countries. It is however generally ineffective; it may impose increased migration costs on staff from those countries; furthermore it is implicitly discriminatory along the lines of 'race', affecting as it does mainly African and Caribbean, hence predominantly black, staff. The Code is thus neither an ethically satisfactory nor an effective response to the detrimental impact of staff loss on low income, staff-short health systems; a better recruitment policy response would improve migration experiences and strengthen likelihood of return.
5. The benefits of migration to migrants' home countries are substantial, but do not compensate for the health service impacts; furthermore the problems suffered by migrants and by divided families can be substantial.
6. The net effect of some types of health professional migration such as that from Ghana is a perverse subsidy: a net flow of benefits from poor to rich country health services. That perverse subsidy is indefensible, contributing as it does to worsening the huge inequality in health services between the UK and developing countries, including Ghana. UK health service users benefit from the services of people who would otherwise be caring for African health needs, hence compensation should be paid to remove this perverse subsidy from poor to rich.

7. It is possible to design compensation in such a way that it overcomes most of the main objections usually presented, of which by far the most important is that it constitutes a tax on migration that undermines the right to migrate.

8. This would be best done within a political framework that accepted that health professional migration blurs the boundaries between countries' of origin and destination countries' health services. In the case of the UK and Ghana these boundaries are already permeable. The best way forward is therefore to build on current links between institutions, professional associations, trades unions and individuals so that, for example, Ghanaian and UK professionals increasingly accept that they are colleagues in a joint enterprise of health service development that can only be done ethically if it explicitly addresses, over time, inequalities of services and conditions.

This returns us to our initial point. *The objective of migration policy is not limitation of mobility but equity of health care as soon as possible.*

1. Introduction: policy as if people were equal

The employment in wealthy countries of health professionals trained in staff-short low income countries contributes to rising international inequity in health care. That effect should be central to the design of policy responses to health professional migration: the inequity ought to be tackled systematically and in a co-ordinated way. The objective of policy towards migration should be, not limitation of mobility, but equity in health care as soon as possible.

In the recent avalanche of writing on the topic of out-migration of skilled health professionals from developing countries, rather little has been written by and from the perspective of those professionals themselves. This paper aims to put forward analysis and policy recommendations that start explicitly from a developing country point of view. Our theme is 'policy as if people were equal', and we give the following meanings to that phrase.

A starting point in human rights

We root our arguments in the proposition that there are no differences in human rights between human beings; the human rights of each person must be treated on an equal basis regardless of accident of birth and therefore of nationality. The basic question addressed by the paper is: "*How would policy towards health service professional migration look if one starts from these principles?*" We know, of course, that profound

inequalities exist, and indeed document some of them here. We base our policy arguments on an analysis, but *not* an ethical acceptance, of those inequalities.

As the companion paper to this one shows, health worker migration has a bearing on the human rights of many individuals and groups. The migration of health workers can have serious implications for the right to health of those who rely on health systems for care and treatment in countries of origin, and the denial of health care in turn undermines the rights to life, work, education and adequate nutrition of those who need care, their families and communities.

Where health workers do not enjoy human rights freedoms and entitlements, including adequate remuneration, a safe and healthy working environment, an adequate standard of living, non-discrimination, vocational training and freedom from torture and violence, they may be more likely to migrate from underserved areas to better served areas in their countries or to a high-income country. Many countries of origin pay salaries that cannot provide health workers with a decent living for themselves and their families. Thus the salary of health workers is both a labour rights issue and an issue of the right to health. Health workers are also vulnerable to the violation of their human rights during the process of migration, as well as in countries of destination.

Many countries of origin have tried to restrict migration of health workers out of their countries, an approach supported by policies in destination countries that seek to restrict the hiring of people trained in specified countries. A coercive approach may however be in contradiction to the right to freedom of movement. The International Covenant on Civil and Political Rights recognises the right of everyone to leave any country, including his/her own (article 12.2). This right is also recognised in other human rights instruments including Universal Declaration on Human Rights (article 13) and the African Charter on Human and Peoples Rights (article 12(2)). Those from richer nations are often lucky enough to be able to take for granted their right, and ability, to leave their country.

In conditions of acute inequality and rising professional migration, the impact of migration on the right to health has two diametrically opposite dimensions. In the countries of origin, migration contributes to denying the population adequate health services, while in the destination countries migration improves health services. More generally, in these conditions the migration of health workers can pit the human rights of health workers against the human rights of communities in countries of origin, and the human rights of this latter group against the human rights of communities in countries of destination. Policy responses to these acute dilemmas imply explicit or implicit hierarchies between the human rights of different groups.

Yet as our companion paper points out, as well as having obligations to give effect to human rights in their own jurisdictions, states have an obligation of international assistance and co-operation towards the realisation of the right to health, rights in work and other human rights in other jurisdictions (ICESCR, article 2.1). We follow up the policy implications of this obligation below.

Health and inequality: ethical dilemmas, and the example of Ghana

Health inequality across the world is extreme. The populations of low income countries from which some health professionals are migrating to the UK, the USA and other high income countries, and especially those in Sub-Saharan Africa, suffer appallingly high levels of morbidity and mortality, associated with very severe under-funding of the health services (public and private) that should respond to those problems.

Table 1 shows just one snapshot of this intolerable inequity. The African countries shown are those in the ‘top 25’ countries of origin of overseas nurses registering in the UK in 2003/4. The number of new nurse registrations is shown alongside the total doctors on the UK register from those countries, and is compared with Asian countries from which many health professional migrants also come. A rich Commonwealth country of origin (Australia) and the UK are shown for comparison¹. The table also shows life expectancy and total (public and private) health expenditure. In Eastern and Southern Africa life expectancy has been cut dramatically by HIV/AIDS. The inequality in life expectancy – one indicator of health care need – is huge, dwarfed only by the extent of relative privilege in rich countries indicated by the comparison of African and Asian with Australian and UK health spending.

This is the economic and social context in which global labour markets for health professionals are increasingly integrating, as hiring of overseas-trained professionals by rich country health systems increases. The dependence of the UK health service on overseas-trained staff is nothing new. As Table 1 shows, over one third of registered doctors are not originally from the UK, and not far off half of newly registrant nurses are from overseas. The UK population relies for its standard of health care on health professionals trained elsewhere, and the consequences of this ‘skills drain’ for low income, staff-short health care systems and the populations who rely upon them, is now widely recognised by policy makers (House of Commons 2004, Department of Health 2004, Willetts and Martineau 2004). This paper argues that policy still has a substantial way to go – in the UK and even more elsewhere – in responding effectively to the ethical dilemmas and obligations this dependence creates.

Table 1 : New registrations of nurses in the UK, numbers of doctors on the UK register, and selected health indicators, for selected African and other countries

Country	Nurses: no. joining register 2003/4	Doctors: no. on register 1.1.04	Life expectancy at birth 2002	Total health expenditure /head (\$) 2002
Sub-Saharan Africa				
South Africa	1,689	6,208	50.7	222
Nigeria	511	1,661	48.8	15
Zimbabwe	391	117	37.9	45
Ghana	354	293	57.6	12
Zambia	169	76	39.7	19
Kenya	146	60	50.9	29
Botswana	90	0	40.4	190
Malawi	64	18	40.2	13
South and SE Asia				
Philippines	4,338	14	68.3	30
India	3,073	18,006	61.0	24
Pakistan	140	3,807	61.4	16
Sri Lanka	36	1,903	70.3	30
High income commonwealth				
Australia	1,326	2,648	80.4	1,182
Total overseas (non-EU)	14,122			
Total overseas (non-UK)	15,162	61,551		
UK	19,465	150,805	78.2	1,508
Total registrants	34,627			
Total on register	660,480	212,356		
<i>Sources: NMC 2004, GMC 2004, WHO (www.who.int/countries) accessed 3.2.05.</i>				

The paper employs the case of Ghana, and the migration of Ghanaian health service personnel from Ghana to the UK, as our central case study. From it, we generate arguments about the economic and governance policy issues surrounding health professional migration. We do not imply by our choice of case study that migration from Ghana is 'typical' statistically or culturally, nor that it forms a very large part of the total migration flow to the UK or the USA; neither assertion is true. Rather, the widely cited² Ghanaian case focuses on a number of the most serious stresses and contradictions generated by the current international labour market for health professionals.

Ghana is a low income country with an absolute and rising shortage of health care professionals and high and rising out-migration. It has a growing economy and a government making substantial efforts to improve health care. However the country is spending far too little on health to achieve decent provision for its citizens. Ghanaian health spending was \$US12 per head in 2002 (Table 1), of which \$7 was public spending. The WHO's *Commission on Macroeconomics and Health* estimated the cost of a set of 'essential interventions' at US\$34 per capita per year, much of which would need to be public spending, or \$45 to include some additional hospital services (Commission on Macroeconomics and Health 2001)³.

Table 2: Selected indicators of health need, health service staffing and performance, Ghana and UK, last available year

Indicator	Ghana	UK
Need indicators		
Mortality < 5 / 1,000 boys	106	7
Mortality < 5 / 1,000 girls	99	6
TB cases notified/ 100,000 population	57	2
Staffing		
Nurses/ 100,000 population	64	497
Nurses and midwives/ 100,000 population	84	540
Physicians/ 100,000 population	9	166
Outputs		
Births with a skilled attendant (%)	44	100
Immunisation against polio (%)	80	91
Immunisation against diptheria ++ (%)	80	91
<i>Source WHO www.who.int accessed 3.2.05</i>		

As Table 2 illustrates, the gulf in indicators of need and in health professional staffing between the two countries is huge. Insufficient health personnel form one of the main constraints limiting health service capacity to deliver even basic services; in cross-country comparisons, health service staffing is associated with better health outcomes after allowing for the effects of higher income on health (WHO 2003, Chen et al 2004, Anand and Baernighausen 2003). It follows that in Ghana, as in many other low income countries, many people are denied the health care that is an essential component of the right to health, and the failure is worsened by out-migration. The Ghana Health Service (GHS) is still achieving substantial immunisation coverage (Table 1) but that is now under threat from declining staff numbers, and health

indicators such as infant mortality are showing signs of worsening; surveys show facilities are ‘grossly understaffed’ (Nyonator et al 2004). The extreme inequalities of income, working conditions and employment rights that are associated with struggling, underfunded health services, so well illustrated by the Ghanaian case, are the context of policy towards professional migration by health services staff, and should be its key concern.

The Ghanaian government and health care authorities, like others in comparable situations, face a dilemma. Ghana has ratified international human rights treaties which impose binding legal obligations to ensure that their people have decent health care and safe working conditions⁴. On the other hand, overworked and underpaid doctors and nurses are looking for alternatives, often helped by international recruiting agencies that the Ghana government, like many African governments, accuses of poaching their much-needed medical staff (Itano 2002, House of Commons 2004). The Ghana Health Service has close current and historical links with the UK NHS, and there has in the recent past been active recruitment in Ghana for the NHS.

Ghanaian health care professionals who migrate and who return, of whom the lead author is one, also face painful dilemmas and contradictory pressures that policy towards migration must confront. If the health care workers in developing countries seek to demand their rights, then going on strike, for example, removes the health care of other people. This is a dilemma of conflict between rights, rooted in poor conditions of the health system. Health service administrators in Ghana seek a working compromise after industrial action – then after a couple of years, this conflict re-emerges. Some health workers, to avoid this spiral of conflict, decide to leave.

Finally, policy makers in high income countries also face dilemmas. There are strong economic and political pressures at present in the OECD countries to recruit health workers from overseas (Forcier et al 2004, Stilwell et al 2004). Responding to these pressures is compatible with individuals’ wishes to migrate. Trades unions and professional associations including the Royal College of Nursing (RCN) in the UK for example support individual nurses’ rights to travel and work overseas to develop their practice and further their experiences (RCN 2002).

There is now a strong and welcome awareness not only among health policy makers and aid donors, but also in the broader policy and activist communities in the rich countries, and among health service trades unions, of the damage done in some developing countries by loss of large proportions of skilled health care staff. We discuss below the policy approach that has widespread support at present in the UK, which is often characterised as ‘ethical recruitment’, yet, we will argue, lacks a solid ethical base.

The current Department of Health Code of Practice for international recruitment of health care professionals in England and Wales (Department of Health 2004) includes Ghana as a country from which active recruitment is unacceptable because it will undermine local health care delivery. If the underlying intention to reduce recruitment were to be effective, the Code would amount to selective restriction of individuals' right to leave their country purely on the grounds of profession and nationality; if it is ineffectual, as it appears to be, then the underlying problems should be addressed in other ways. The Code causes unease precisely because it appears implicitly discriminatory along racial lines: it implies (given the selected countries of origin) that migrants from richer countries should be preferred to Caribbean and African health professional migrants, an implication that can risk playing into a racist agenda on immigration policy.

Finally, in considering the arguments for restitution payments, in response to the benefits health professional migrants from low income countries bring to rich country health services, Ghana provides a highly relevant test case, illustrating the scale of the subsidy from poor to rich involved. Ghana would provide, because of its very particular set of characteristics including relatively small size, a long political association with the UK and active participation by its governments in the recent political debates on health professional migration, an excellent setting for experimentation in the way in which such restitution processes might be designed and managed.

Ghana is thus, in this paper, a test case, a source of insight, a 'place to stand' in constructing the arguments that can be tested subsequently in a wider field. The purpose of this paper is to make a series of arguments about ways of understanding the migration process as a basis for policy, and the policy implications that emerge from these insights. We draw from, and reference, but do not attempt to summarise the voluminous relevant literature to which we hope to make a useful contribution.

2. Integration of international health care labour markets

The migration of health service professionals is an aspect of rapid international integration and commercialisation of health service labour markets, in the context of high levels of inequality. These processes are cumulative and self-reinforcing, and are hard to reverse; policy must work with, not against the grain of them.

Governments can influence the international integration of labour markets, but cannot determine it. Labour markets, like other markets, have dynamics of their own and are driven by technical change, by private investment and profitability, and by shifting macroeconomic pressures. A good example is provided by Thailand, where major influences on the ‘brain drain’ have been the liberalisation of private investment in health care (creating an internal ‘drain’ to the private sector) and the pattern of economic growth, crisis and recovery (Wibulprolprasert et al 2004). Much current policy towards migration over-estimates the impact of formal regulatory decisions on commercially driven migration flows.

The implication is that policy needs to take into account major step-changes in the level and nature of market integration and to find effective responses in that context. Otherwise market interventions may simply make the employment and migration experience of professional migrants more costly to them without materially affecting the rate of migration flow from targeted countries.

International labour market integration and commercialisation in health care

The activity and outcomes of international health care labour markets are strongly influenced by a number of factors. These include ‘demand’, that is, active recruitment and availability of jobs. The pressure of demand for health care staff on the international labour market has soared in recent years, as the result of a complex mix of rising expenditure on health care in many high income countries and a reluctance of high income countries’ nationals to go into nursing, in particular, in sufficient numbers (in part because of low pay and status, relative to other professions). The American Hospital Association estimates that in 2001 there was a shortage of 126,000 nurses in the USA⁵. This trend is likely to accelerate due to the imminent retirement of a large proportion of health care professionals, the ‘baby boomers’; for example in 2001 in the UK 15% of nurses were over 55 (Buchan and Seccombe 2003). Thus demand is set to rise significantly in the next decade with the US Bureau of Labor Statistics

(February 2004) projecting that more than one million new nurses will be needed by 2012.

A second major factor is availability of staff seeking work. This, like demand, is subject to a number of social determinants: not merely the numbers trained in lower income, lower paying health systems, but also the knowledge those staff possess of job opportunities, and their willingness and ability to migrate. The responsiveness of job seekers to overseas demand is thus a function in part of the infrastructure and level of integration of the labour market itself: the ease with which information is available, the cost of migration, the ease of availability of the relevant documents and processes, and the ability of the would-be migrants to raise the funds for these documents; the extent to which the intending migrant needs personal connections in order to migrate or can go to a commercial agency. The wage gap is also important: higher wages to be earned abroad must typically be believed to be sufficient to cover remittances and overseas living costs. Finally, the willingness to migrate may be influenced by professional ambitions: the aim of furthering careers and training; this may be particularly true of doctors, though nurses also seek further training overseas.

The international health care labour market has been both integrating and commercialising in recently years. Technological change, notably the Internet, has dramatically increased knowledge of jobs and conditions elsewhere. Active recruitment by governments, and the use by health care employers in particularly the USA and UK of commercial recruitment agencies and advertising, have added to this knowledge. Commercial investment in labour market intermediaries (such as agencies) also appears to have risen sharply in response to rising demand, formalising the process of visa obtaining, work permits and job search as a service available for market payment. Loans for migration costs are also increasingly available on an impersonal basis to professional migrants. The effect may have been to increase the cost of migration, but also to make those costs more affordable; to change the international job seeking process from one dependent on informal contacts to one that is more overt and impersonal⁶.

These processes of increased demand, integration and commercialisation have been associated with a sharp rise in the extent and complexity of activity in the international health care labour market in recent years⁷. First, there is increased movement between sectors and regions within individual countries. Second, there has been an increase in migration between developing countries; certain countries in sub-Saharan Africa, notably South Africa and Botswana, attract migrants from other African nations. Third, there has been an increased circulation of health care professionals between high income countries; the USA has recruited large numbers of nurses from other developed countries. In addition it is anticipated that the accession of 10 new countries to the EU in May 2004 may lead to a significant influx of health care

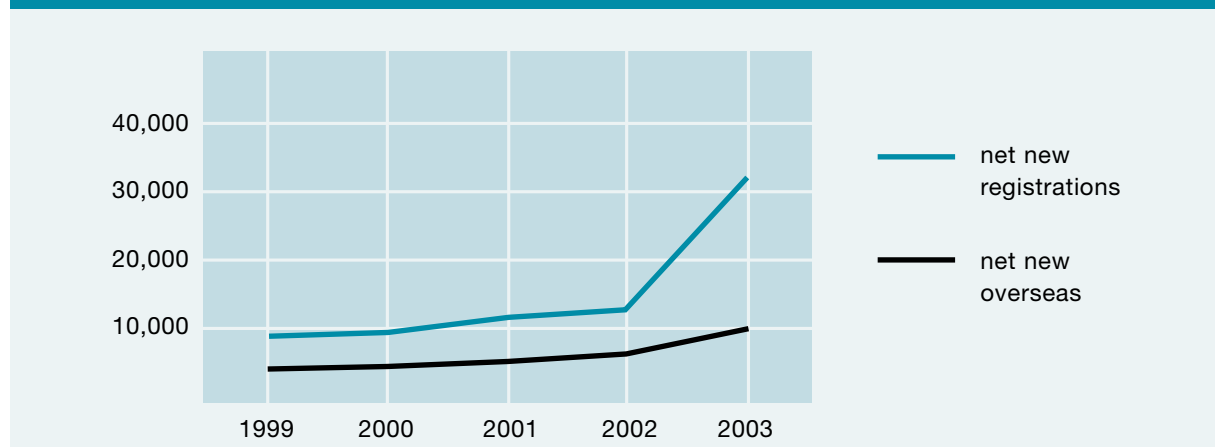
professionals from these states though the effect is not yet visible. Fourth, and of most concern for this paper, there has been an increase in health care professionals migrating from the developing to the high income world.

Sub-Saharan African migration to the UK and USA

In the UK since the inception of the NHS, both medicine and nursing have been dependent on migrant labour, a trend that has ebbed and flowed according to the demands of the labour market. Currently the UK is not training sufficient physicians, and over one third of doctors registered in the UK were trained overseas (Table 1), including 9152 trained in sub Saharan Africa (calculated from data in GMC 2004a). Of these African-trained doctors over a third are from South Africa, whilst 293 trained in Ghana, more than double the number in 1999 (GMC June 2004b). Numbers of both overseas and UK trained doctors registering are currently rising (Figure 1), and it is estimated that the UK will need by 2008 25,000 more doctors and 250,000 more nurses than it did in 1997 (Nullis-Kapp 2005).

A similar pattern is evident in the USA where 23 percent of practising non-federal doctors qualified overseas, of whom 64% trained in low or lower middle income countries (Hagopian et al 2004). Of the overseas doctors working in the USA, 5334 were from sub Saharan Africa including 478 trained in Ghana (Hagopian et al 2004). The numbers of Ghanaian migrant doctors are thus small relative to all overseas doctors in the UK and USA, but they constitute a significant proportion of the medical labour force trained in Ghana. Estimates from current research⁸ and recent publications (Nyonator et al 2004) suggest that around 2000 Ghanaian doctors are practising in all sectors in Ghana; a number of estimates including our own put the proportion of doctors trained in Ghana who have subsequently migrated at over 50%.

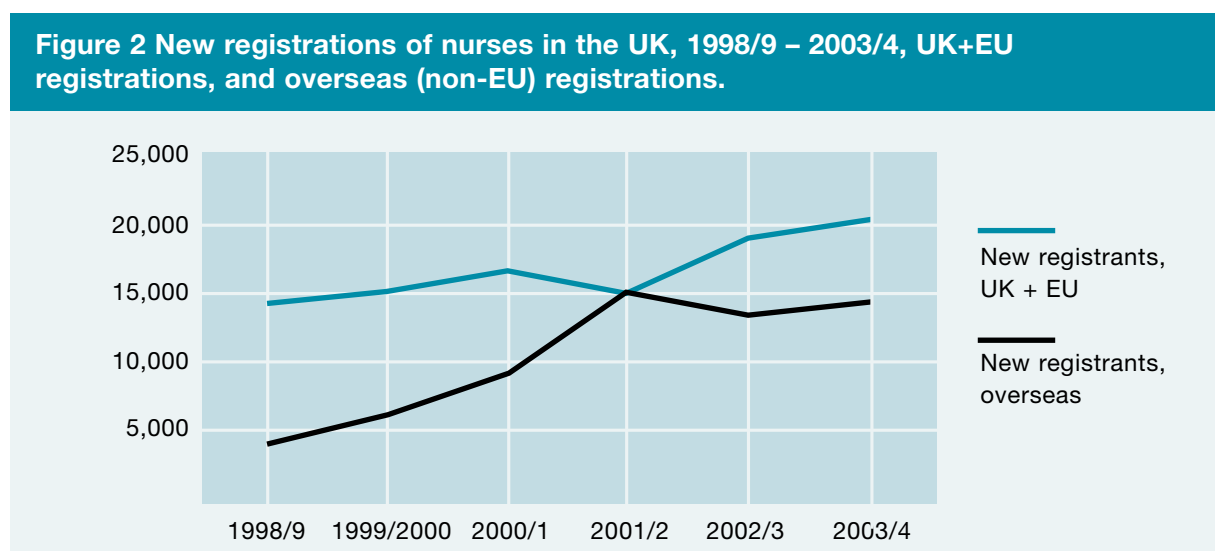
Figure 1: Net registrations of physicians in the UK, 1999 – 2003, UK and overseas (including EU)



Source: calculated from GMC 2004a

The UK nursing and midwifery labour market has seen an increase in all nurses on the register to its highest level ever (NMC Dec 2004). There have been significant increases in both overseas trained and UK trained nurses, reflecting an expansion of UK nurse education after 1998. In the year to March 2004, 40% of nurses registering for the first time were from overseas (Table 1). Over the last six years the annual number of overseas trained nurses registering in the UK has risen sharply and then levelled off (Figure 2). The majority of overseas registrants in 2003/4 were from developing countries, notably the Philippines, India and South Africa (Table 1). The number of Ghanaian nurses entering the register has risen sharply since 1998 (see Section 5 below), and seems likely to rise further. Between 1998 and 2003, over 3,000 Ghanaian trained nurses sought verification of their qualifications in order to migrate, more than two thirds aiming to go to the UK (Buchan and Dovlo 2004, Nyonator et al 2004).

UK-trained and other nurses in the UK also migrate to other high income countries. In 2003/4 7,610 requests to the NMC for verifications were made from abroad, including 2,708 from Australia and 2,082 from the USA (NMC December 2004). The balance between UK trained nurses migrating outwards, and those trained overseas using the UK as a 'stepping stone' to move on elsewhere, is unknown.



Source: calculated from NMC 2004

The impact on migration of labour market integration and commercialisation in Ghana

International labour market integration can be expected to put pressure on wages and salaries to converge. One would expect to find upward pressure on wages in countries from which migrants depart, if that departure causes a shortage of staff, and at least a lessening of upward pressure in employing countries' health systems. In health care, this convergence is severely constrained by financial and macroeconomic pressures, but it is nevertheless visible in individual countries of origin, and has been enabled by widespread commercialisation of lower income health care systems. As the private sector expands, it causes pay to diverge within countries, with the effect of also encouraging an internal brain drain to the cities and the private sector (Mensah 2002, Wilbulpoprasert 2002). In Ghana, there is immense pressure from Ghana Health Service staff, including managers trying to retain staff, for higher wages, salaries and allowances, and the wage gap with the UK and USA is repeatedly cited in interviews, as is the opportunity of migrating.

Increased information about the international labour market is thus evident in interviews in Ghana. Staff are well aware of differences in working conditions in low income and high income health care systems, and information on migration processes is widely available. The changing market infrastructure has created a step-change in the perceived scope for migration, and policy has to take this into account.

Commercialisation and formalisation of migration processes for professional employment can be illustrated from the experience of Ghanaian doctor and nurse migrants.

The rate of departure of doctors for the USA and UK and elsewhere has been extremely high from Ghana since the 1970s. Thirty years ago the formal processes of migration were relatively simple, and the real cost was lower than it is today. For example, comparing one of the authors, Dr Mensah, and his son, also a doctor:

- in the 1970s, an exam was required for the USA but not UK; the US exam could be taken in Ghana, paid by the Ghanaian university which used these exams to establish the standing of Ghanaian medical qualifications; after that, a visa was easily available, and could be applied for personally in Ghana;
- in 2004, the UK requires exams taken in UK, the USA requires three exams, two in Ghana and the third in the USA with an automatic visa issued in Ghana.

Therefore, doctors wishing to migrate did not and do not require an intermediary organisation, and the process was already formalised in the 1970s. As a result the rate of departure of Ghanaian doctors after qualification was already approaching 100% in the

1970s (although many have returned) and remains very high today, with the whole class that graduated in 2002 having left or currently planning to leave. In addition, doctors tend to have good contacts abroad, to assist the personal process of migration and settling in the USA, which is now very much the preferred destination. The hiring process thus still consists of professional qualification and job search processes and the level of commercialisation has not risen sharply.

Nurses' migration experience however is distinct. Nurses have generally required a personal or an organisational intermediary in order to migrate, and there has been a shift towards formalisation. Most Ghanaian nurses who leave at present head for the UK, at least initially, and generally go for a job, while doctors often present their objectives as specialisation. The entry into the nurses' labour market in the UK is experienced at present as highly structured by the private agencies.

The following are typical agency routes followed by nurses today, migrating from Ghana⁹. The first is an agency established in 2000. An American female nurse (originally from an African country) came from the USA to meet some Ghanaian nurses who could help her recruit Ghanaian professional nurses to feed her nursing agency in the USA. The agency had difficulties initially: their original intention was to support people to go to the USA, find temporary jobs, train to pass the US exams for registration, and then to find them jobs and recover the agency's investment in expenses, plus receipt of a recruitment fee of US\$2000. The Ghanaian recruitment agent would be paid US\$ 200 (10% of the recruitment fee). This did not work, as the first batch of five Ghanaian nurses were denied US visas at the US Embassy in Ghana on the grounds that they had not passed the requisite US exams.

The procedure was then changed to two options. The first option is that the Ghanaian nurse could study for the US exams in Ghana using books supplied by the US agent. When she passed the US exams, she would then be assisted to obtain a visa to the USA. Once in the USA, the agency would assist her to find a job and take care of her until she got a job as a nurse. When she gets the job she then pays back all expenses and the agency fee. The second option is that the Ghanaian nurse will manage through her own means to get into the US. Once in the USA, she would then contact the agency who would then accommodate her, find her a temporary job etc. as per the initial procedure. All Ghanaian nurses who have left through this agency took the second option.

The UK destination for nurses is however the most common. Before the 1980s, all that a Ghanaian nurse had to do was to register with UKCC (now NMC) as the professional qualification for nurses in Ghana was accepted for registration. The fee for

registration was minimal. From the 1980s the Ghanaian nurse qualification has still been accepted but they have to do supervised practice in the UK for 3 months (commonly known as ‘adaptation’) the successful completion of which then entitles the nurse for registration with the NMC (UK). The registration fee was increased to £70. From 2002 the fee was increased again to £117.

The standard procedure as described by Ghanaian nurses is that they first have to register with the NMC (UK). The nurse applies to the NMC (UK) and is given the package standard forms to complete. S/he completes some of the forms; other forms require transcripts from the Nursing Institution in Ghana and verification from the NMC (Ghana). When the various forms have been completed, the Ghanaian nurse sends them back to the UK with the appropriate registration fee. The NMC (UK) then sends to the Ghanaian nurse a ‘Decision Letter’ with a registration number for the Ghanaian nurse and information that she is required to do supervised practice in the UK. Until the ‘brain drain’ became a policy issue, the NMC (UK) then supplied the Ghanaian nurse with a list of hospitals in the UK that she could apply to for supervised practice. However, since the late 1990s the onus has been on the Ghanaian nurse to find the UK hospital willing to take her/him for the supervised practice. When s/he is lucky, the fee charged by the UK hospital ranges between £800 and £1800 depending on whether the hospital charges for accommodation and transportation.

It is this difficulty in getting a place for supervised practice that has led to the setting up of private recruitment agencies in Ghana to assist nurses to move to the UK. The agents arrange for a work permit for about 18 months which includes the period of supervised practice and an extra year or more of free practice. This makes the application for a visa at the UK High Commission in Ghana more of a formality. The agents charge between £2500 and £3500 which excludes accommodation, visa fees, and air fare. Once the nurse successfully completes the supervised practice in the UK, s/he is able to practise in the UK. If the Ghanaian nurse is able to pay 60% of the fee, s/he is accepted by the agency but must pay the difference before the work permit will be handed over.

The effect of the restrictions on hiring has thus generally been greater cost of migration, and a shift to commercial intermediaries. In some ways this has simplified the procedure by depersonalising it. What it has not done is to slow out-migration. There has been a huge acceleration of nurses leaving, and there is considerable local debate about reasons. Undoubtedly the failure of local working conditions to improve is a factor, as is the failure to address particular issues such as housing (see Section 3).

But the acceleration also appears to have taken on something of a cumulative momentum. Not only are nurses increasingly informed about the wage and conditions gaps and the scope for migration; there are also local labour market changes in response to increasing nurse recruitment overseas. Better qualified women are going into nursing than before, as an investment in leaving the country. As a result the required entry qualification into nursing has risen to the equivalent of university entrance, and some who could have gone to university are going into nursing.

Total applications for nursing training are also rising in Ghana, and there is a rising proportion of men among the applicants. In Winneba Community Health Nurses' Training School, for example, the number of qualified applicants rose from 400 in 2003 to 2000 in 2004 but lack of capacity means that less than 200 of these qualified applicants can obtain admission. Even this modest admission figure is made possible by the Government of Ghana's efforts to double the intake into nursing schools. The shift in the social composition of nurse trainees that this reflects appears to be associated with a higher capacity to pay, and there appears to have been a sharp rise in willingness to pay and also ability to pay. Not only are some applicants from better off backgrounds; loans are also now more easily available, and it is becoming easier also to raise money from extra income activities – there are now more opportunities to work for private practitioners in formalised locum systems and via local agencies for nurses. Relatives and partners abroad also support nurses to train and to join them¹⁰. Finally, there are some early initiatives to set up private nurse training schools, to respond to the rising demand for training.

The Ghanaian case study illustrates the major influence on rate of migration exerted by the extent to which the labour market for health service personnel in a lower income country is integrated into the broader labour market. There are a number of qualitative indicators of market integration: the extent to which people make informed comparisons of wages and conditions across countries, the extent of private investment in employment agencies for international recruitment, and the feedback in terms of upward pressure on wages in countries of origin. The Ghanaian labour market appears to have seen a sharp upward shift in integration associated with a major acceleration in departure specifically of nurses. Once integration is established, prohibitions on migration from either governments in countries of origin or those employing migrants serve chiefly to raise migrants' costs, and may undermine their human and employment rights (Section 4). Thus ultimately, unless governments in developing countries such as Ghana use innovative strategies to reverse the drain, the health systems in these countries could collapse from lack of human resources.

3. Coercion and incentives in countries of origin: policy implications of international labour market integration

Coercive measures to prevent departure, taken in low income countries that are losing staff, work poorly; worse, they can intensify pressures to leave. Conversely, incentives to stay that redress the key violations of decent working and living conditions, and that value skills and commitment, do work, and lessen rather than worsen inequalities; the implication is that health service financing and governance needs to improve in countries that are losing staff.

In spite of the damaging effects of migration of health service staff from developing countries, governments in these countries do not seem to be doing enough to manage with the brain drain. We concur with Martineau et al. (2002) who argue that while it is reasonable to complain about poaching of health workers by richer countries, low income countries of origin must accept that they are not doing enough to attract and retain health workers. We argue furthermore that much of what they are doing is counterproductive, and that more effective policy involves a more focused response to staff needs, which in turn requires changes in health service governance (this section) and funding (Sections 5 and 6).

There is widespread agreement on some of the reasons why health workers migrate from low income countries. Researchers in a variety of countries have identified poor remuneration, bad working conditions, an oppressive political climate, persecution of intellectuals, discrimination, lack of funding, poor facilities, limited career structures, poor intellectual stimulation, lack of security and the wish to provide a good education for children (Pang et al. 2002; Hardill and Macdonald 2000).

In Ghana, the major concerns expressed by a group of doctors interviewed in 2003 who were intending to migrate were unrealistic salaries (100%), poor working conditions (89%), unpredictable and time consuming local postgraduate training (50%) and difficulties in owning a home (33%) (Mensah 2004). Conversations with nurses planning to leave frequently identify the importance of a higher salary and the chance to save and invest.

The search for better pay and conditions is therefore the key reason why health professionals migrate. The wage differentials, well known to staff, are very large indeed. For example, a hospital doctor with consultant status, running a busy urban general

hospital in Accra, was last year earning about £7500 a year at current exchange rates, while a senior nurse was earning about £2000 a year. Both can expect to multiply those salaries by 10 if they migrate to the UK. While living costs are higher in the UK, and estimates of 'purchasing power parity' between the currencies (allowing for lower living costs in Ghana) would substantially reduce the real salary benefits of moving, especially for nurses moving to the very expensive context of London, salary gaps remain substantial especially for doctors. Furthermore the Ghanaian salaries quoted are urban health service salaries. In rural areas, and in all areas for more junior doctors and nurses, remuneration is substantially lower. In the USA, doctors and nurses can both expect to earn more than in the UK.

In circumstances where opportunities to move abroad are widely available, coercive measures taken in countries of origin to prevent departure appear to have been largely ineffective, and, unless they are widely accepted as legitimate, may increase pressures to leave. Compulsory public service schemes ('bonding') are widely used to try to manage the exodus of health care professionals, and some have had some success, especially in increasing the numbers of doctors serving temporarily in deprived areas. Compulsory rural service appears to work best however in conditions of economic recession and few opportunities for private practice (Wilbulpoprasert 1999).

It follows that when opportunities open up, bonding will cease to retain staff. Students may prefer to pay the fines and break their community service obligations. This reaction will be reinforced in countries where high inflation reduces the real cost of paying the fine, as occurred in Thailand and Mexico (Dussault and Franceschini 2003). A similar effect has occurred in Ghana, where doctors are bonded to serve for five years or in default to pay back their training fees. However high inflation and currency depreciation have made this bonding scheme ineffective, undermining its deterrent effect. At the time of graduation, the lead author of the paper had a bond of 3,300 Ghanaian cedis, then worth 13 months' salary; five years later it was worth five months' salary. Furthermore, many doctors left without paying their bond since the policing of the bond was poor. What these coercive measures do ensure however is that *return* of migrants who have avoided this obligation is made more difficult.

Smaller scale restrictions, imposed to make migration more difficult, may backfire, as have some restrictions imposed in Ghana. A large percentage of medical school graduates in Ghana travel abroad for periods between six months and one year to earn extra income to buy some basic necessities before starting their housemanship. These doctors cannot afford to miss their housemanship as it is a statutory requirement for registration in the Medical and Dental Council register of Ghana, which is a

requirement for finding a job as a doctor abroad. However in a measure widely regarded as high handed, the Medical and Dental Council of Ghana decided in 2001 that doctors starting their housemanship more than six months after graduation had to re-sit their final exams before being allowed to start. This certainly reduced the number of doctors staying abroad beyond six months before housemanship, but by annoying those who wished to stay longer appears to have encouraged rapid departure after housemanship. A second example related to graduates' academic transcript, which they are entitled to for an approved fee of US\$6. In the late 1990s the University of Ghana Medical School decided that doctors requiring academic transcripts for use outside Ghana (not for a government scholarship opportunity) should pay a fee of US\$500 in the first year following graduation, reducing to US\$120 after four years of service in Ghana. This measure, however, has not deterred those wishing to leave.

In an integrated international health professional labour market, coercive responses of this type do not appear to work (WHO, 2000). If implemented in an arbitrary and high handed way, they antagonise health care professionals already working in difficult circumstances, are experienced as blame, and can add to their desire to migrate (Dussault and Franceschini, 2003). Coercive practices involving bonding and sanctions tend furthermore to infringe on the human rights of health workers (Bueno de Mesquita and Gordon 2005).

Finally, a coercive approach is likely to be associated with a policy mind-set and management practices that do not encourage return, because skills and experience gained abroad are not valued and welcomed. Some employers in developing countries, especially in the civil service, make it difficult for people returning from abroad to rejoin the service at the appropriate level for their experience (Martineau et al. 2002). Sometimes returning doctors in Ghana have faced frustrations of placement leading to redeparture or relocation to other countries (Dovlo and Nyonator 1999). Returning healthcare professionals in Ghana relate a range of other difficulties. For example, nurses are promoted in Ghana on the basis of years served; however overseas work experience is not taken into consideration therefore a nurse with many years of experience will be re-employed at the same grade as when s/he migrated. And staff who have broken a bond may find difficulty and delay in being re-employed despite the staff shortages.

Conversely, incentives based on addressing the reasons for migration can be more successful (WHO 2004b), so long as they address the *perceived needs* of health care professionals. Many of these needs relate to issues of management and health service governance, in addition to salary levels and working conditions. In various developing

countries, incentive schemes have included increases in salary, pension schemes, insurance schemes, clothing allowance, travel allowance, child care allowance, subsidised meals and accommodation, and training. In Thailand, financial incentives started with special allowances for physicians working in remote district hospitals in 1983, and in 1995, those who agreed not to engage in private practice received an extra US\$400 per month (Wilbulpoprasert 2002). In Indonesia, graduates who work in very remote areas receive a higher salary and the guarantee of a civil service career, with free access to specialist training, after the completion of the three-year compulsory contract (Setiadi 1999).

It is sometimes argued that wage differentials are so large between low income and high income countries that no wage increases in, say, sub-Saharan Africa can reduce migration (Vujicic et al 2004). We do not believe this to be the case. In Ghana a very popular incentive scheme lauded by all health workers at its inception was the Additional Duty Hours Allowance (ADHA), instituted in 1999, which literally doubled or in some cases trebled take-home money overnight. This greatly improved living standards of health care workers, and had a marked effect in reducing strikes and other agitation for increased compensation for some time. However, as an allowance-based scheme, it has been open to arbitrary local decision-making, and later came to be perceived to have been abused by denying allowances to some deserving health workers; in September 2004 these grievances led to a 10-day countrywide nurses' strike demanding a 70% increase in the ADHA for nurses.

The examples of the ADHA and other incentive schemes illustrate that potentially effective incentive based policies can become ineffective or counterproductive if they are undermined by poor governance, where for example benefits are based on discretion rather than rights. Unless applied in a manner regarded as fair they can be divisive.

Nevertheless, salary levels are key to staff retention, alongside working and living conditions that make it possible to do a good job in reasonable safety (WHO 2003). Families of Ghanaian migrants report that migrants remit funds for family support and to invest in accommodation.¹¹ Many migrants express plans to return and finally settle back in Ghana, even if it is after retirement abroad. This suggests strongly that support to health workers to allow them to invest, especially in owning a home, and saving for basic personal and family commitments, is more likely to be effective in reversing the spiral of migration than providing free duty accommodation and free transport which do not belong to them. Policy is responding slowly to such evidence, though a new home ownership scheme – initially for critical staff and eventually for all staff, shows

that policy is becoming more responsive. One district director of health services in Ghana remarked, 'Just give me enough money and I will decide what to do with it. I want to own a home and have enough money to live on. Is it too much to ask?'

This need for assets, a decent living standard, and a means to live in retirement recur repeatedly in discussions with health workers. Alongside them concerns are expressed that can be summarised as career- related and stemming from management and governance problems in the health service. In Ghana, many well documented anomalies in health sector employment practices are still not adequately addressed. For example, staff who acquire higher academic qualifications are not rewarded through promotion or compensation and sometimes made to remain behind colleagues (Ministry of Health 2002). It can take 12 months or more between appointment and the first salary payment. And Ghana's pay system does not recognise workload variations or reward unfavourable work locations (Dovlo and Nyonator 1999).

There is thus a disparity between expressed needs of health workers and the response of government in Ghana, as in other developing countries. It appears that incentive policies are still frequently designed at high levels without any input from those they are expected to benefit, despite the known importance of involving key actors in policy formulation and implementation (Dussault and Dubois 2003). Incentive schemes must be based on evidence and an analysis of the expectations of staff, who are likely to express economic, professional, personal and family-related motivations (Dussault and Franceschini 2003), and need to be transparent during implementation. The policy process is key because *motivation* is key. In an integrated international labour market, health professionals from low income countries need to feel motivated to contribute to their home country health services; this puts increasing importance on incentives to return which in turn relate to the extent to which people feel welcome and feel their talents are well used.

Developing countries need to recognise that migration cannot be simply prevented, as it is influenced by a variety of factors such as living conditions, access to education, the political situation, wages and working conditions, and knowledge of opportunities. Countries of origin therefore have no choice but to focus on developing better management of migration and return, recognising that this can be an integral part of increasing their human resources for health capacity. Incentive schemes are essential, and need to integrate better financial support for staff and the health system as a whole with reforms that address other concerns of health care professionals such as arbitrary decision making, incompetent management and the failure to recognise and reward merit. We argue below for greater funding for these efforts from countries of

destination of migrants, through a process of restitution. Such support will only achieve health system strengthening in association with effective domestic policy, which in some countries implies major changes. Nigeria, for example, has claimed it can afford to pay its professors only \$50 a month while spending \$1million *a day* to fight in Sierra Leone (Emeagwali 2003). Restitution and health system strengthening, we argue in Sections 5 and 6, should and can be a collaborative process where countries of origin and destination of migrants share objectives, priorities and mutual working relationships – as to a substantial extent is the case for the Ghanaian and the UK governments and health services.

4. ‘Receiving’ country policies towards health professional migrants

The UK Department of Health’s ‘ethical recruitment’ Code reflects a welcome recognition of the detrimental impact of international recruitment on the health systems of some developing countries. It is however generally ineffective; it may impose increased migration costs on staff from those countries; furthermore it is implicitly discriminatory along the lines of ‘race’, affecting as it does mainly African and Caribbean, hence predominantly black, staff. The Code is thus neither an ethically satisfactory nor an effective response to the detrimental impact of staff loss on low income, staff-short health systems; a better recruitment policy response would improve migration experiences and strengthen likelihood of return.

‘Ethical recruitment’ codes

The UK Department of health has since 1999 developed and gradually strengthened a Code of Practice for the International Recruitment of Healthcare professionals (Department of Health 2004) which currently applies in England and Wales. The Code is an explicit and welcome recognition of the impact of the active recruitment, by the NHS and the UK private sector, of professional staff trained in, and working in, staff-short low income countries. The Code states that:

‘No active recruitment will be undertaken in developing countries by UK commercial recruitment agencies, or by any overseas agency sub-contracted to that agency, or any healthcare organisation unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for employment.’ Department of Health 2004 p.10
<http://www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf>

We welcome the recognition of the scale of this problem, and the consultation between the UK government and governments of countries of origin of staff that has created the agreed list of countries in which such active recruitment is proscribed. Codes of this kind are now widely advocated, and international versions, such as the Commonwealth Code of Practice for the International Recruitment of Health Workers, are being developed.

The UK Code, which has been the subject of widespread consultation and support within the country, has been the main response of the UK government to protests from African governments, and non-governmental organisations, about the impact of health professionals' recruitment from, in particular, sub-Saharan Africa. However, as the primary response to this problem, the Code is both ineffectual and misdirected: it mis-specifies the problem at issue.

The Code can be understood in two ways: as seeking to avoid UK health employers' direct encouragement of the hiring of health care professionals from countries of concern, or as seeking actually to reduce the flow of international migrants from those countries into the UK health services. The first definition of the objective constitutes a desire to avoid direct further stimulation of the international hiring process, and as such the Code has achieved some of its desired effect. The second definition of the objective would imply that the Code would be a success if flows of migrant professionals from countries such as Ghana were declining. Many discussions of the Code imply that that is the objective.

In the latter terms, the Code must be understood to have failed. Health care professionals in Ghanaian cities can and do purchase publications such as the UK 'Nursing Times', and make direct applications. As section 2 showed, the provisions of the Code that seek to prevent private recruitment agency activity in this field are ineffectual, and in this increasingly commercialised international labour market, are likely to remain so. Any attempt to drive out agencies would be more likely to undermine the protections and rights of those who use them. Registrations of Ghanaian professionals in the UK have risen since 1999, steadily in the case of doctors, and very sharply indeed in the case of nurses (Section 5). Other staff-short African countries, such as Zambia, Kenya and Malawi, have seen similarly rapid increases in out-migration of nurses to the UK (NMC 2004). While we do not know, of course, how much larger the numbers might have been had active recruitment campaigns continued, this experience demonstrates that the Code is not preventing an acceleration of health professionals' migration to Britain from sub-Saharan Africa, with particular reference to the skilled nursing staff who are the 'backbone' of health services such as that of Ghana (Mensah 2002, forthcoming).

There are two possible responses to this ineffectiveness. One would be to strengthen efforts to reduce migration through more coercive measures. We believe that this would be the wrong direction for policy to take. It is already the case that the Code creates two categories of migrants with, implicitly, different rights; and those categories are structured by income level of home country and by ‘race’: that is, the implied restrictions fall predominantly upon health professionals who are black. For this reason, the guidelines are not universally perceived as truly ‘ethical’, rather their ethical claims are contested, since they implicitly privilege the migration rights of the better off, notably those (predominantly white) migrants from rich commonwealth countries and from other parts of Europe.

Rather than proposing a strengthening of the Code in a coercive direction, we therefore welcome the fact that the Code does not proscribe unsolicited applications for employment from all countries; we believe that its non-coercive and inclusive approach allowing equal response by employers to all individual job seekers is the right one, and is in accordance with the rights to freedom of movement of all individuals. Given this principle of equality, we share the view of the WHO (2004b) that Codes such as this may have ‘at best ... a transitory effect’ on the rate of migration. What the Code may do is to help to ensure equal employment rights of international recruits in the UK, since it includes a commitment to ethical recruitment practices and full protection under employment law for all staff, including full information and appropriate support and induction. We would like to see these commitments further strengthened, as the next sub-section explains.

We do not take the view that the Code should be repealed – we are not in favour of a return to active recruitment in Ghana. Rather, we believe that the Code should cease to be seen as the key policy response to the problem that rising health inequality is being worsened by out-migration of staff from many developing countries, and other policies should be devised instead to address that problem (Section 5).

Strengthening the rights and experiences of migrants: ethical employment policies

An ethical international recruitment policy for health professionals should concentrate on strengthening the rights and career experiences of all international migrants in the country of destination, including strengthening the ability of professional migrants to both leave and return. In-migration of health professionals to the UK and other rich countries generates benefits for individual migrants, their dependents and their home country, but there are also negative effects for migrants and their families in addition to the well documented impacts on home country health care systems. Concern about

the impact of the migration of health care professionals must not be allowed to undermine the employment rights of migrant health care workers in the developed world.

Remitting money and investing in property in Ghana were the primary goals for most nurses interviewed by two of the authors¹² in 2004, prior to migration; for doctors interviewed in 2004, these were of secondary stated importance after career development and training. All the Ghanaian nurses and some of the doctors interviewed in the UK¹³ experienced however difficulties in balancing the high cost of living relative to salary with demands to remit to relatives and their desire to invest in property in Ghana. However, all were able to remit to relatives and have invested in property in Ghana, albeit to a lesser extent than they had originally intended.

Furthermore two important social and economic aspects of health workers' migration are often overlooked in discussion of the positive aspects of migration, namely the strain placed on family relationships and the often negative experiences in the workplace. For many migrants, working overseas entails separation from families which could be very traumatic for migrants and family alike with numerous problems with the upbringing of children and relations between the couple. These family relationships also influence remittances: anecdotal evidence from Ghana suggests that married migrants remit regularly so long as spouses and children remain in Ghana but remittances often reduce in both frequency and magnitude when these family members join the migrant in the host country.

The workplace experiences of migrant health care professionals in the developed world often include exploitation and relative disadvantage. In France, many of the 4,400 doctors trained outside Europe are on night call in children's and maternity wards, and X-ray departments of state-run hospitals and do not qualify for the same conditions or salaries as their French colleagues (Frommel 2002). The situation for health care professionals in Anglophone countries whilst less acute also involves hardship, discrimination and the under-utilisation of skills. For example, in the USA many inner-city hospitals rely almost exclusively on graduates of foreign medical schools to provide services to the poor (Mullan 1997). Similarly in the UK, overseas trained doctors frequently work in areas British doctors avoid, and engage in work below their professional qualifications (Williams, 1998). In the UK health care labour market overseas doctors are concentrated in low status specialisms or 'special' grades with little opportunity for career progression or work as single handed GPs in socially marginalised practices. The BMA has found that that a disproportionate number of overseas doctors are employed at Associate Specialist and Staff Grades (BMA 2004),

which provide no access to training and little scope for career progression. In addition to the inability to use existing skills and the lack of scope for developing new skills, many migrant doctors experience long periods of unemployment. In one case study, the 800 applicants for three vacant PRHO posts, the vast majority from overseas, had spent an average of 11 months unemployed and applied for an average of 260 posts each (Trewby 2004).

In addition to discrimination in career progression, many overseas trained doctors also complain of racism from patients which ranges from disrespect, for example refusal to be treated by non-white doctors, to abuse and violence. This is a situation which unless addressed by managers can make professional life intolerable.

The racism experienced by black nurses in the UK is well documented (Baxter 1988; Beishon S. et al 1995; Iganski and Mason 2002). These accounts detail a long history of black and overseas nurses suffering discrimination in promotion; and humiliation and abuse from managers and patients. A number of contemporary reports in the UK cite abuse of migrant nurses by private sector employers such as bullying, poor accommodation, undervaluing of skills in terms of pay rates and employing qualified nurses as care assistants, misleading information about employment contracts and payment of commissions to recruitment agencies – which have raised concerns at the NMC (Buchan 2002; RCN 2002; Allan and Larsen 2003, PSI 2004). Many overseas nurses are concerned about the manipulative and dishonest activities of agencies (Allan and Larsen 2003). These negative experiences are not confined to the private sector, as overseas nurses working in the NHS are often prevented from using to the full their nursing qualifications and skills developed in source countries and are subject to unfavourable treatment by managers, for example disproportionate numbers being obliged to work difficult shifts (Allan and Larsen 2003).

Current research¹⁴ suggests that the career trajectories of Ghanaian trained nurses vary considerably. A few have been successful and have achieved promotion up to grade G, albeit slowly, whilst others have worked in the UK for over a decade without gaining promotion. However, the majority interviewed so far feel that their qualifications and experiences are undervalued by managers and patients and that their career development has been hindered by overt but more usually subtle and/or institutionalised forms of discrimination at the level of the ward, the hospital and the Trust. Often these issues only became apparent after nurses were alleged to have made mistakes which were often racialised or attributed to ‘inferior foreign training’. Furthermore compared to incidents involving white and UK-trained nurses, these incidents were perceived to be treated more harshly by managers often focusing on punishment rather than problem solving.

In addition to discriminatory practices and structures, all Ghanaian trained nurses so far interviewed in the UK, and to a lesser extent the doctors, have experienced difficulties adapting to working in the UK. Many nurses take years to adapt to an environment where, in comparison with Ghana, promotion and access to training are more competitive. Many initially experienced difficulties in operating in organisational cultures which are less overtly hierarchical than in Ghana and therefore found it difficult to establish relationships with managers. Most Ghanaian nurses interviewed by the authors found adapting to working in the UK involved periods of career stagnation. They have often received little formal support in updating these skills from managers and colleagues.

In addition to those whose skills gained overseas are not fully utilised by the UK health care labour market there is anecdotal evidence that a considerable proportion of migrant Ghanaian trained health care professionals are unable to enter this market and are working in non-health related fields. While some migrants gain additional qualifications and experience others might remain abroad for years with little financial benefit, minimal career development whilst seriously damaging their family relationships.

An ethical employment policy, one that ensures effective and equal access to training and promotion by overseas staff, is essential to addressing the inequities involved in health professional migration. It needs to be associated with effective policies to facilitate the circulation and return of trained staff, and better reception and conditions of work in countries of origin. In those circumstances, ethical employment can contribute to the rebuilding of health care systems in sub-Saharan Africa. This is an approach which also requires, however, more finance for low income countries' health systems. Section 5 proposes an approach.

5. Restitution

The net effect of some types of health professional migration such as that from Ghana is a perverse subsidy: a net flow of benefits from poor to rich country health services. That perverse subsidy is indefensible, contributing as it does to worsening the huge inequality in health services between the UK and developing countries, including Ghana. UK health service users benefit from the services of people who would otherwise be caring for African health needs, hence compensation should be paid to remove this perverse subsidy from poor to rich.

It is possible to design compensation in such a way that it overcomes most of the main objections usually presented, of which by far the most important is that it constitutes a tax on migration that undermines the right to migrate.

A ‘perverse’ subsidy is a flow of resources from the poor to the rich. The hiring of health care staff from low income countries by high income countries creates a perverse subsidy in this sense: that is, there is a flow of resources from *users* of poor country health care systems – whom those staff would otherwise have been treating – to *users* of rich country systems who would otherwise face staff shortages. We start in this section by defending the concept that a perverse subsidy exists and discussing estimates of its extent, using the case of Ghana as our core example; we then examine arguments for and against payment of restitution for the costs imposed on low income health care users by the benefits enjoyed in rich countries; and finally we discuss how such restitution could be managed in practice in a manner that would address some of the core problems raised by those for and against the practice and principle.

Is there a perverse subsidy, and to whom?

The UK government and many activists and commentators broadly accept, as the commitment to ‘ethical recruitment’ has shown, that the hiring in the UK of health service staff trained in low income countries suffering from acute home shortages of health care staff constitutes an ethical problem. We agree, though we believe that the problem has been mis-specified and that the current predominant policy response is therefore not the appropriate one.

The core of the problem is that international recruitment by the UK of health professionals from countries such as Ghana worsens an already ethically intolerable inequality in health care between the two countries (Section 1). The hiring of, for example, Ghanaian health care staff improves health services in the UK at the expense of worsening them in the much more disadvantaged context of Ghana. It does this because:

- both health systems are experiencing staff shortages, in the sense of vacant posts;
- however in relation to needs of health care users, the staff shortage in Ghana is vastly greater, and is a blockage on even basic health care for all (Section 1);
- the health care professionals who have migrated to work in the UK were trained in Ghana at Ghanaian public and private expense; the benefits of that training are being experienced however in the UK, and lost to Ghana;
- the UK has not had to expend resources for training of the overseas staff it recruits.

Health professional migration from low income staff-short countries thus imposes severe economic costs and social costs in source countries, while saving the employing health service substantial training costs. The economic name for this process is ‘subsidy’: the NHS is using resources it has not created through investment, to the benefit of its users. The subsidy is perverse, and unjust, because it worsens the existing inequity in access to health care at a global level. This is the problem that needs to be addressed.

How large is this perverse subsidy? We use the example of Ghana to explore this question. Ghana trains doctors and nurses at public and private expense. The social return on that investment in training is then the cumulative year on year health service benefits received by patients in the Ghana Health Service, in other health facilities, and by those ‘insured’ by rights of access to a competent health care system in time of need.

There are no reliable estimates as yet of the training costs of those who have migrated from Ghana nor of the full health service costs to users, though a project to measure these costs is nearing completion¹⁵. But the scale of the problem of missing staff in Ghana is well documented. Vacancy rates for doctors and professional nurses are high and rising, reaching around 50% of ‘workable’ numbers needed for the Ghana health service in 2002, and around 65% of ‘ideal’ numbers (Nyonator et al 2004). (Note that these are not ‘ideal’ from the point of view of needs, nor by international standards.) In a survey of 25 randomly selected Ghanaian health districts (from a total of 110), we found that over 40% had two Ghanaian doctors or fewer to serve the entire district population; two districts had none. Of those, six were relying upon a small number of Cuban volunteer doctors to assist. The vacancy rates for nurses are rising fast, with experienced professional nurses the most likely to leave¹⁶.

That there are substantial costs to the Ghanaian population – and especially to its poorer members – from out-migration of skilled staff is not in doubt. It is sometimes argued, however, that these costs are substantially mitigated or matched by the benefits of out-migration, notably the remittances sent by migrating professionals. These remittances, though poorly documented, are known to be substantial, and recent economic literature concentrates strongly on these benefits (Kangasniemi et al 2004, Commander et al 2003, Doquier and Rapoport 2004). Potential benefits identified in this literature include: remittances from migrants, largely to their own families, which in some countries outweigh inflows of foreign exchange from all donor sources; and the incentives for investment in education and training represented by the higher earnings trainees can expect as a result of opportunities to migrate. The second effect

only constitutes a benefit to the low income country, of course, if some of the additional trained labour remains in the country. As explained in Section 2, there is evidence that some of these latter effects are emerging in Ghana, alongside related questioning of the extent to which the additional doctors and nurses will indeed remain.

Many migrants benefit from migration in the form of better working conditions and higher incomes, which facilitate remittances. These remittances do represent an important part of the financial inflows of many developing countries (IOM 2002). Remittances wired by migrant workers through the banking system have been estimated at US\$ 90 billion in 2003; at least as much again is thought to be remitted outside the banking system. However, the extent of transfers back home depends on the circumstances of the migrant and his/her family. There is some evidence that higher education and income of migrants are associated with lower remittances (IOM 2002).

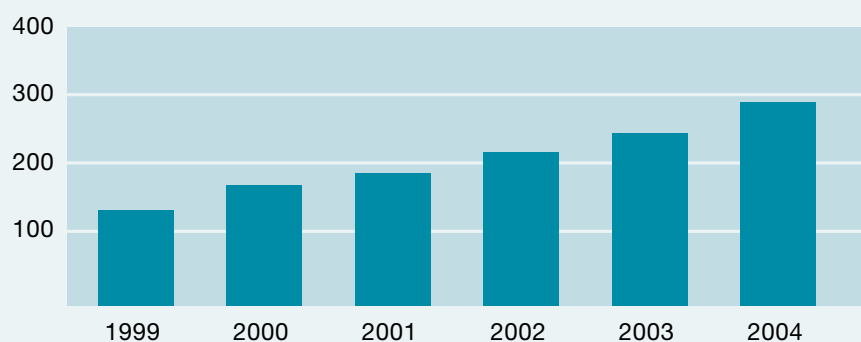
Should remittances from migrant staff be *subtracted* from the health service costs created by their departure, in assessing the net costs to, say, Ghana? The difficulty with this proposal lies in the nature of health services – a point also recognised in the ‘beneficial migration’ literature. Health services are ‘non-tradeables’ in economic jargon, that is, they are services that need largely to be delivered face to face within a locality, and cannot be sold across international borders. The health services are also ‘basic needs’: a priority for human well being. Funds remitted to families certainly support the economic development and incomes of the country; they are of substantial benefit. *But they do not go into the health service* except for the difficult-to-track use for individual medical care.

It is therefore, we propose, appropriate to examine only *health* services – public and private and charitable – when examining the subsidy effects. Since health care access is a human right (Section 1, Bueno de Mesquita and Gordon 2005), it follows that health service costs cannot be simply ‘traded off’ against other benefits elsewhere in the economy. We should rather look at the economic relationship between the health services, in human and resource terms. The operation of the UK NHS is being subsidised by the provision of services by people who would otherwise be providing services in Ghana. This is the subsidy flow that policy should address.

While we cannot yet put a reliable monetary figure on the costs to the Ghana health service of this loss of staff¹⁷, we can make an initial monetary estimate of the benefits to the UK health care system of Ghanaian-trained staff. This exercise gives some useful orders of magnitude for informing the design of ethical policy in the UK towards this problem.

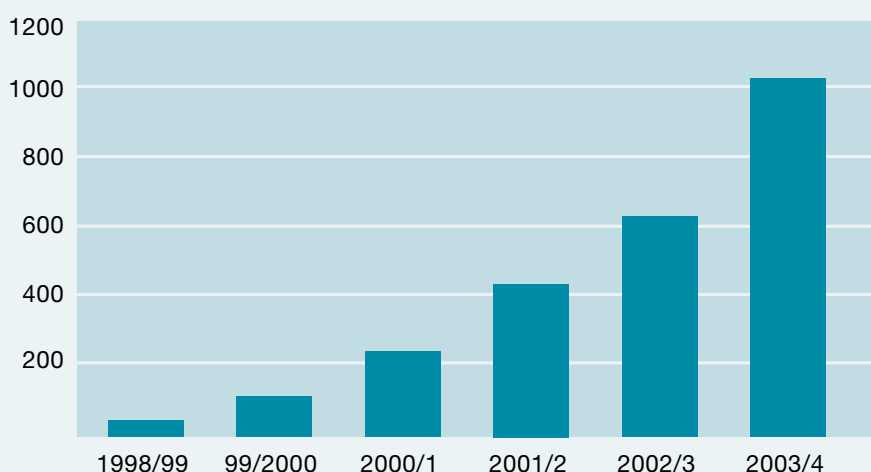
Figure 3 shows the total number of Ghanaian-trained doctors registered to practise in the UK in each year from 1999. The numbers have been rising steadily. Figure 4 shows an estimate of the same total for nurses, calculated from figures for new registrations since 1998/9, the year when numbers of overseas nurses registering started to rise rapidly. It allows for a wastage rate which is the calculated annual rate of loss of nurses from the register as a whole. The number of nurses from Ghana registering in the UK has shown a rapid increase, confirming impressions within Ghana that the rate of departure of nurses has been accelerating. In 2004, there were 293 Ghanaian-trained doctors on the register and an estimated 1021 nurses. These figures do not of course include the doctors and nurses from Ghana still seeking registration.

Figure 3 Ghanaian-trained physicians in the UK (number)



Source, General Medical Council June 2004

Figure 4 Estimated numbers of Ghanaian trained nurses registered in the UK



Source: calculated from NMC 2004

The employment of these staff represents a direct subsidy to UK health service users, since the training costs have not been borne in Britain. It is estimated that it costs approximately £220,000 to train a doctor in the UK¹⁸ and £37,500¹⁹ to train a nurse. This would imply a saving in current training cost terms of about £65 million from the employment of 293 Ghanaian doctors, and about £38 million from the employment of 1021 Ghanaian nurses. The calculations are crude: but these are the orders of magnitude of the savings involved for the UK.

A better way to look at investment in training however is to value it as economists (and markets) value investments more generally: in terms of the stream of benefits they are expected to produce. How would we value the benefits UK health service users – public or private – derive from the services of these staff? One way – a maximum estimate – would be to assess the full value of the services they provide, that would not otherwise be provided to patients. A lower, but useful valuation, would be provided by asking, what do we pay them? The salaries the Ghanaian-trained staff earn in UK employment can be understood to represent one measure of their worth to the UK health services – and therefore, to those they care for in Britain.

We do not have data on the location of the Ghanaian health care staff within the UK health system. Some of the doctors will be hospital doctors at different grades, some (probably quite a small number) GPs, some may have failed to find employment. We know from individual stories that some Ghanaian trained doctors have found it hard to find posts (Section 4). Similarly, some of the nurses will be in hospital posts, perhaps most; some may be working in primary care; some in nursing homes and care homes; some may have found it hard to find or retain a post despite successful registration.

We therefore need to make some assumptions, to provide an order of magnitude for the valuation we are putting on the benefits of the services these staff provide in the UK. Here is one such calculation.

(a) Doctors

Of the 293 registered doctors who were trained in Ghana, 156 have arrived in the last three years (2002–2004 inclusive). Let us assume that they are all at the early stages of their career. Let us further assume that of the total, 10% (29) are hospital consultants (we know from our interviews²⁰ that some Ghanaian-trained doctors have reached the consultant grades). If we then make reasonable assumptions²¹ about salaries, Table 3 shows one valuation of the doctors' services, assuming all the Ghanaian doctors registered are practising.

Table 3 Valuation of Ghanaian doctors' services at NHS rates

Assumed grade / situation of doctors	Number	Salary (£)	Total valuation
Arrived in last three years	156	50,000	7,800,000
Consultant	29	90,000	2,610,000
Mid career	108	70,000	7,560,000
Totals	293		17,970,000

Different assumptions will of course produce different estimates. If we assume 10% of the doctors are not practising, for example, this would reduce the estimate to about £16 million.

(b) Nurses

Of the Ghanaian-trained nurses, 800 have arrived in the last three years for which we have data (2001/2–2003/4 inclusive). Let us assume that these are all on Grade D, as recently qualified nurses. Many nurses arriving will not be newly qualified, so this amounts to assuming that they are initially working below the grade their experience would make appropriate, which may be a reasonable assumption (Section 4). We know that London is particularly dependent on overseas-trained nurses (RCN 2003), so let us assume half of the new arrivals are working in Inner London, and half elsewhere. Let us assume the rest of the Ghanaian nursing staff are working at Grade E, also evenly split between Inner London and elsewhere. Table 4 shows a valuation assuming that all the Ghanaian nurses registered are working at NHS grades.

Table 4 Valuation of Ghanaian nurses' services at NHS rates

Assumed grade and location of nurse	Number	Salary (midpoint)	Total
Grade D	400	17,945	7,178,000
Grade D London	400	22,104	8,841,400
Grade E	111	20,123	2,223,536
Grade E London	111	24,369	2,692,719
Total	1021		20,935,656

Note: some figures do not add to totals because of rounding

This figure would be increased if we allowed for some Ghanaian nurses working – as we know they do – at higher grades. It would be reduced if we allowed for, say, 10% without work, to £18.8 million. If some nurses are working, as they are likely to be, in care homes and nursing homes, this will reduce the totals.

These calculations thus employ explicit assumptions to illustrate the order of magnitude of the value to UK health service users of the services of Ghanaian-trained staff. The total of Tables 3 and 4 is £38,905,656. In other words, on these calculations, we value Ghanaian health professionals' services in 2004 at about £39 million; if these numbers of staff remain this is a valuation of their services *per year*. If the numbers rise, so does the value of the services they provide.

This figure is thus one possible measure of the year on year perverse subsidy to UK health service users arising from the hiring of Ghanaian-trained health professionals. We could raise the figure substantially by assessing the value (at cost of production) of the services the staff offer. We could lower it by altering the assumptions. The purpose of the calculation however is to make the point that these annual benefits are substantial. And they are matched by losses in Ghana of these professionals' services there.

Let us reflect further on that last sentence. Clearly, if we did the equivalent calculation in Ghana to the calculation just undertaken here, the total would be smaller, because salaries are lower. But that gap in salaries is part of the problem – along with the lack of supplies and equipment and infrastructure and career progression, it *is* the problem (Sections 1-3). So the appropriate figure for policy reference in the UK is surely the benefits to UK citizens of the work of Ghanaian trained professionals. There is a substantial perverse flow of implicit subsidy from the Ghanaian health care users – who have lost services – to the population dependent upon the NHS and the UK private sector – who have gained. This is unjust, and ethically unacceptable. It is this that policy needs to tackle, and in a manner that treats equally the human rights of all those involved.

What is the link between policy and subsidy? The UK NHS receives a subsidy from the employment of staff not trained in the UK wherever they were trained, including staff from high income countries such as Australia. However, the subsidy flow in the case of staff from high income countries is not *perverse* – it does not flow from poor to rich countries. For the purpose of this paper we can therefore ignore it. The perverse subsidies are all those which worsen existing health care inequality between rich and poor countries. This will include flows from all low income countries of origin that suffer from an absolute shortage of health care staff.

Restitution: why and how?

The perverse subsidy just described is ethically indefensible, and should be reversed by the payment of restitution by countries of destination to low income countries of origin. The UK population dependent on the NHS and private UK health care, who

are richer than the Ghanaian population, should be – in all justice – cross-subsidising the Ghanaians rather than vice versa. That the UK health care investment effort is inadequate, and that that gap is currently being filled at the expense of health service provision in poor countries, is indefensible, and the subsidy flow should be reversed. We agree with the WHO (2004b) that it is essential that mechanisms of compensation be designed and agreed, a proposal reinforced by last year's World Health Assembly which argued that countries of destination should 'support the strengthening of health systems ...in the countries of origin.' (WHA 2004) The rest of this paper aims to contribute to debate about how such restitution might effectively be achieved.

We have argued in Section 3 that while coercive measures are ethically unacceptable and simply do not work, responses to the 'skills drain' that focus on rebuilding the terms and conditions on which people work in health services in the countries of origin do potentially work over time: rebuilding health services, encouraging circular migration and return, supporting people to stay, improving infrastructure and appreciation of those who work in difficult situations, ensuring that people do not end up destitute and homeless after a lifetime of service: these approaches can work.

The proper approach to restitution therefore is one which involves *redistribution* aimed specifically at health service reconstruction. Our proposal is for a form of international redistribution which has a good *domestic* track record: health services are a highly successful and stable site for economic redistribution in all wealthy countries (with the partial exception of the USA). The reasons for redistributive stability include the insurance function of health services ('it could be me'), their public health function ('it could infect me') and their ethical importance ('it's not right to let people suffer when at their most vulnerable').

For the same reasons, health service spending can also be an effective site for international redistribution through restitution. Yet this approach is widely rejected in international debate²². We consider here the main arguments against it.

The most commonly offered arguments include the following. First, practicality. It is sometimes argued that there is insufficient information, for example concerning people's training location, to know which countries need to be compensated. This seems in general not to be correct. The one piece of evidence that, certainly in Britain, is easily available is location of training, since this has to be established and certified on registration. So we know from which low income countries the UK health service is effectively being subsidised, and roughly to what extent, from the registration data.

The second common objection concerns motivation. It has been suggested that if people come of their own free will, or via third countries, rather than being actively

recruited, then there is no case for compensation. We believe this line of argument to be irrelevant to the ethical arguments for restitution. First, when people feel unable to work effectively in the circumstances in which they find themselves, then the extent to which movement implies free choice is debatable. And second, the ethical argument for compensation rests on the damage to health service users of the inequalities that drive migration, not upon the motivation of individual migrants.

The third common set of objections concerns the macroeconomic effects of the transfers that restitution would require. It is argued that these are either (a) destabilising or (b) will merely replace other health service spending (the fungibility argument). We take these in turn.

The basic macroeconomic concern is with the impact of deficits in the public accounts on monetary management. Externally grant-funded local public sector deficits need not be destabilising; in the health sector, they may if properly managed generate employment and local input purchase which can support incomes and growth. They are not necessarily inflationary (DFID 2002), and the experience of substantial inflows of funds to low income health systems e.g. from the Global Fund appears to support the conclusion that they can be managed sustainably.

The kick in that last paragraph was, 'if properly managed'. Within Ghana, doubts expressed to us about substantial restitution payments to the health service have focused on fears about the management of the funds, and the danger that they would be dissipated to other sectors or (which comes to the same thing) merely replace existing health expenditure. We consider below how those fears might be allayed.

Finally, we believe there is one very substantial argument against restitution, and this needs to be faced and is difficult to deal with effectively. This is the fear that an agreement to pay restitution for staff from low income countries will act as a tax on migration from those countries, disadvantaging migrant staff severely by creating an incentive to exclude them. To address that problem, we believe restitution efforts and agreements should be detached from links to individual migrant staff. Instead, the extent of reliance in the UK on staff from a particular low income country should inform and motivate government decisions to increase transfers of funds to rebuild those low income health systems in a manner that can tackle the causes of out-migration in the longer term.

How might such restitution be managed in such a way as to allay fears within countries such as Ghana that they would not be effectively applied to key health service needs? The requirements for effective restitution funding would seem to include: a commitment to strengthening of the Ghanaian health services (including

non-governmental services); a management process that is transparent to donors but under Ghanaian control; and an assurance that the fund would be responsive to Ghanaian priorities? Discussions in Ghana²³ have suggested that restitution payments might be particularly focused on supporting training including support for those teaching. Furthermore, Ghanaian officials suggest that a mechanism already exists in Ghana for ring fencing and effectively applying overseas funds to health services: the 'Donor Pooled Funds' (DPF) mechanism, which appear to be well managed and accounted for²⁴, and the mechanism could be extended to apply restitution funds appropriately and in ways that support and value staff remaining in or returning to the country, including recognition of overseas skills.

An alternative to government-to-government transfers, that would have a number of additional benefits discussed further in the next section, would be to set up a restitution fund: a fund, say, for the reconstruction and support of health care in Ghana. It could be managed in a number of ways; one would be an 'off-shore' management structure. For example it might be constituted as a trust, run by a Board with a majority of Ghanaians from *both* the Ghanaian health professional diaspora in the UK (whether of UK or Ghanaian passport or both, perhaps) *and* Ghanaian representation from government and NGO sectors. The two together would form a majority; representatives from the UK donors (government, and perhaps other) would form a minority. Agreement on how the money should be spent would require a substantial majority or consensus, and the Board would also publicly account for the spending.

We put forward these ideas as a basis for discussion, to illustrate the kind of innovation that might be developed, and the kind of debate it would be good to see emerging. This kind of structure would in principle allow: ring-fencing of the funds, setting up tracking methods to ensure a high degree of additionality; debate and consensus around different uses of the funds – discussed further in the final section – a level of transparency and the avoidance of the inefficiency and corruption associated with conditionalities imposed from outside. It could also be a focus for interaction between health professionals of Ghanaian origin, and between the UK NHS and the Ghana Health Service, in managing the restitution process for the benefit of Ghana over the longer term.

6. Positive collaboration

This [restitution] would be best done within a political framework that accepted that health professional migration blurs the boundaries between countries' of origin and destination countries' health services. In the case of the UK and Ghana these boundaries were already permeable. The best way forward is therefore to build on current links between institutions, professional associations, trades unions and individuals so that, for example, Ghanaian and UK professionals increasingly accept that they are colleagues in a joint enterprise of health service development that can only be done ethically if it explicitly addresses, over time, inequalities of services and conditions.

Two increasingly integrated health systems: the NHS and the GHS

Globalisation – in this case the international integration and commercialisation of labour markets – is a powerful force for change. The huge rise in migration of professional health care staff from Ghana to the UK can be understood as a further *blurring of the boundaries* between the two health services. In economic terms, what is happening is that the two health services, in Ghana and the UK, are becoming increasingly integrated. Both train staff – and the staff are then redistributed (towards the higher income country). Both have health systems where the bulk of the population rely on the public sector, but also have a substantial private sector on which both poor and rich (in each country's terms) also rely, and the migration also involves the private providers. The wage setting process in health care in Ghana *and* in the UK is influenced by the openness and integration of the labour markets: in Ghana, UK earnings serve as argument and reference point for salary demands, in the UK an absence of in-migration on the scale recently seen, especially of nurses, would have further pushed up staffing pressures that in turn push up staff costs (e.g. through rising use of agency staff and overtime). While Ghanaian migration alone forms a small part of UK health labour force expansion, the Ghanaian migrants are part of a broader set of labour market changes, discussed in Section 2, that are common to the two services. But the effects on users are profoundly unequal.

Recognition of this increasing economic integration makes the argument for redistribution within the two health services, taken together, ethically more insistent. (Mackinnon 2003 makes a similar argument about aid more broadly.) Restitution if well invested can both rebuild the health system that is in decline, and encourage the staff to stay or return.

The particular history of interconnections between the Ghanaian and UK health services would also be a rather good place to start. There is a substantial history of mutual knowledge and understanding, as well as active collaboration in the past. Training and teaching links persist in exchange of examiners and students; UK medical students spend time in Ghana as well as *vice versa*. There are numerous links between individual facilities and units in the two countries. Doctors do circulate between the two health services, and there are a number of collaborative institution-to-institution arrangements that might be built upon.

Ghanaian expatriate staff in the UK are also active in creating new connections. In January 2005, as part of the celebration of their 25th anniversary, the 1979 graduates of the University of Ghana Medical School renovated the medical school auditorium at a cost of 100 million Ghanaian cedis (US\$11,000) and provided an LCD projector and screen for the auditorium. Similarly Ghanaian associations in the UK, such as the Ghanaian Nurses Association and the Association of Ghanaians in Milton Keynes have sent medical equipment to hospitals in Ghana.

There are also implications for trades unions and NGOs. If the health services are increasingly integrated, then the UK unions could help to strengthen their Ghanaian counterparts' ability to defend and improve the terms and conditions of the Ghanaian workforce – in effect, improving the conditions that can encourage people to stay or return. This could include support for industrial action by Ghanaian colleagues – the Ghanaian unions have little capacity. Furthermore, union action in the UK is important too. By helping to ensure that the careers of Ghanaian-trained and other overseas staff in the UK are supported, as the BMA and RCN are already seeking to do, including improving training opportunities, and by supporting the sustaining of contacts between the two health systems, the unions can enhance opportunities for circular migration between the two systems.

The academic side of the UK and Ghanaian health services could get more involved too. There already exist many contacts. One of the most serious effects of the out-migration is the 'beheading' of the health service – the loss of leadership and high level skills. Encouraging researchers and specialists to stay is key to tackling this problem – it is not a diversion from a concern with poverty. The scope for research and development, and the capacity for local leadership, are central to the building up of a good Ghanaian health service, and international experience shows them to be relevant to bringing in funds, sustaining investment and creating conditions for others. Current research links could be strengthened, to support initiatives underway in Ghana to create better postgraduate specialisation opportunities for doctors who remain.

Integration and managing restitution

Effective use of restitution funds could be enormously enhanced – and thus the argument for their continuation strengthened – by an acceptance of the extent of *de facto* integration between the health services brought about by hiring Ghanaian-trained staff in the UK. This kind of integration brings with it ethical obligations, along with mutual knowledge. Not only does it create a political, economic and ethical basis for restitution, it is also the potential social and institutional basis for its success.

Restitution should be an expression of mutual valuing of each other by Ghanaian and UK health professionals, as colleagues in a joint enterprise of health service development. Campaigning for financial support of Ghanaian colleagues working in Ghana would be an excellent – and ethical – response to international health professional migration.

7. Conclusion: rethinking policy towards health professional migration: a place to start

Finally, we return to the explanation in Section 1 of why we have chosen Ghana-UK health services and health professional relationships as the focus of this paper. In rethinking ethical and effective responses to health professional migration from low income, staff-short economies, Ghana offers a good place to ‘think from’ and it would offer a good place to start developing revised policies. Ghana has a health service still succeeding in delivering health care, though its capacity is deteriorating as staff leave; it has a health management structure and health governance processes which – though we have argued that they require reform – are capable, and the Treasury and the Ghana Health Service have procedures well able to deal with higher levels of funding. The Ghana Health Service thus is able to benefit from the higher funding implied by restitution payments, and to apply it effectively.

We are arguing, therefore, not for a global solution to health professional migration, but for making a start in the direction of restitution, in the context of existing aid funding processes for health service strengthening in African countries. We are arguing for a major shift in perspective in this policy area, from employment Codes focused on the type of international recruitment undertaken, to well managed financial compensation that is rooted in collaboration between the advantaged and the disadvantaged health services, and is based on a recognition of the scale of perverse subsidy that has been created by the recent rise in recruitment in the UK of those

trained in developing countries, and especially in low income Africa. The benefits of international labour market integration in health care are currently accruing chiefly to the advantaged among health service users; it is time to accept the level of international labour market integration as non-reversible by any code of conduct, and therefore to respond more directly to the need for health service reconstruction in countries of origin of migrants. That, to revert to our theme in our introduction, is the only way to treat people as inherently having equal human and employment rights, while recognising and responding to the economic inequality that undermines the enjoyment of those rights in low income countries.

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Endnotes

¹ Not all those registered will be practising in the UK.

² References to the Ghanaian case include House of Commons 2004, Buchan and Dovlo 2004, Adams and Stilwell 2004, among many others.

³ All figures on an exchange rate basis (not purchasing power parity calculations).

⁴ The International Covenant on Economic, Social and Cultural Rights was ratified by Ghana in 2000 (Article 12); The Convention on the Elimination of all Form of Discrimination Against Women was ratified by Ghana in 1986 (Article 12); the Convention on the Rights of the Child was ratified by Ghana in 1990 (article 24); African Charter on Human and People's Rights (Article 16). The authors thank Jude Bueno de Mesquita for these details.

⁵ American Hospital Association cited in Joint Commission on Accreditation of Healthcare Organizations *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* <http://www.jcaho.org/about+us/public+policy+initiatives/health+care+at+the+crossroads.pdf>.

⁶ This paragraph draws on current research by K. Mensah.

⁷ This paragraph draws upon, among others, Meija 1978, Buchan and Seccombe 2004, Buchan and Calman 2004, Buchan and Sochalski 2004, Stilwell et al. 2004, Marchal and Kegels 2003, Liese, Blanchet and Dussault 2003, WHO 2004a, O'Dowd 2003, O'Dowd 2004.

- ⁸ Supported by the World Health Organisation and by the United Nations Research Institute for Social Development, this project, entitled ‘Measuring the costs of out-migration of health care personnel’, is based at the Department of Community Medicine, University of Ghana Medical School, Accra, and led by Prof. Richard Biritwum. It is due to report shortly.
- ⁹ Source, interviews by K. Mensah
- ¹⁰ Sources, continuing research by K. Mensah, and researchers for the project referenced in note 8.
- ¹¹ Evidence from continuing research by R. Biritwum and all authors; see notes 8 and 13.
- ¹² K. Mensah and L Henry
- ¹³ This continuing research is supported by the European Social Fund as part of the project entitled, ‘Improving equal opportunities in employment for internationally recruited health care staff’, a joint project between Surrey University and the Open University. The support of the ESF is acknowledged with thanks, the views expressed are solely those of the authors.
- ¹⁴ By L. Henry, see note 13
- ¹⁵ See note 8.
- ¹⁶ Early results of current research, see note 8.
- ¹⁷ Martineau et al. (2002) put at £35 million the training costs in Ghana of Ghanaian professionals who have migrated. While this estimate is not based on accurate costs of training, which are not yet available, the costs to the cash strapped Ghanaian state have been very substantial.
- ¹⁸ Source: British Medical Association estimate.
- ¹⁹ Source: Department of Health estimates.
- ²⁰ Continuing research by L. Henry see note 13.
- ²¹ Data from the NHS Careers website, accessed February 2005.
- ²² The objections listed here are culled from seminar reports and brief statements about reasons for rejection of the option in published reports. We have found no sustained discussion of restitution as an option.
- ²³ By K. Mensah, with Ghana Health Service and Department of Health officials.
- ²⁴ Research for the project identified in note 8 confirms this.