The international migration of health professionals from developing to developed countries still remains a problem of increasing concern in many countries of the South-East Asia (SEA) Region.

Even though international migration of the health workforce is a complex and global phenomenon, several activities have been initiated in the SEA Region in the recent past to develop a better understanding of the problem with a view to address it.

The South East Asian Conference on Postgraduate Medical Education which was jointly organized by the Postgraduate Institute of Medicine, Sri Lanka, the Ministry of Healthcare and Nutrition, Sri Lanka and the World Health Organization from 1 – 3 August 2005, in Sri Lanka discussed the problem of ‘Brain Drain’ affecting four countries of the Region, namely Bangladesh, India, Nepal and Sri Lanka. Volume 10 of the World Health Forum too devoted a chapter on international migration of health workers.

At the twenty-fourth Health Ministers’ meeting held in Dhaka in September 2006, a declaration was made on health workforce development which reiterated the need to take further actions, in line with the World Health Assembly resolution 57.19 on international migration of health personnel in order to mitigate its impact on the effective functioning of health systems in Member countries.

During discussions held at the Joint Meeting of Health Secretaries and the Consultative Committee for Programme Development and Management (CCPDM), it was recommended that the item ‘International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries’ be included in the agenda of the Sixtieth session of the Regional Committee.

The paper is now submitted to the Sixtieth session of the Regional Committee for its consideration.
# Contents

Introduction .............................................................................................................................. 1  
Scope of the problem ................................................................................................................ 1  
Causes of international migration .......................................................................................... 2  
GATS and migration of health workers .................................................................................. 2  
Negative and positive aspects of migration ........................................................................... 3  
Global and regional action ....................................................................................................... 4  
Future challenges ...................................................................................................................... 5  
Actions required for future ........................................................................................................ 6  

References ................................................................................................................................ 6
Introduction

1. The international migration of health professionals from developing to developed countries has been a prominent concern in many developing countries since the 1960s. This concern has been echoed in many national and international meetings that have taken place in the past decade, but migration of health professionals remains a problem for many developing countries, some of which are in the South-East Asia (SEA) Region.

2. The objective of this paper is to generate discussion at the Sixtieth session of the Regional Committee for WHO South-East Asia to examine the advantages and disadvantages of international migration of health professionals-including the possible implications of the General Agreement on Trade in Services (GATS) of the World Trade Organization. As this subject will also be considered by the 122nd session of the Executive Board of WHO in January 2008, there is a need to represent the regional issues and concerns, and provide inputs to the Executive Board through the three countries of the Region which are members of the Board.

Scope of the problem

3. The sparse information that is reported from occasional studies from some countries of the Region is not adequate and robust to establish the magnitude of the problem. Within the SEA Region, there are Member countries which import and export health professionals into and out of the Region. However, they are indicative of the unresolved, persistent problem of health workers, migrating to foreign countries.

4. The movement of doctors began in the 1950s as a post-colonial phenomenon which was initially common to India, Pakistan and Sri-Lanka and later extended to Bangladesh and Nepal. The nursing professionals from SEAR countries began their journey mostly to the Middle East, but have currently shifted their attention to United Kingdom, USA and Australia.

5. The greatest exporter of doctors from the region has been India. For Indian doctors the United States, the United Kingdom, Canada, Australia and some Meddle Eastern countries are preferred destinations. It has been estimated that the number of Indian doctors in the United States exceeds 50,000 the largest group of doctors after the native-born American doctors.

6. Even though the data on international migration of health personnel is not readily available from Sri Lanka, a recently published report states that a significant number of post-graduate trainees who complete the nationally organized examinations for doctorate (MD/MS) and who leave country to complete the foreign training component of the board certification do not return to Sri Lanka once the period of foreign training is completed. During a four-year period from 1997 to 2000, out of 524 MD/MS qualified trainees, 146 (28%) have either not reported back for work in the government medical institutions or have left immediately after reporting.
Statistics from Bangladesh show that around 65% of the newly qualified doctors attempt to seek employment abroad. On average 200 doctors from the government sector leave for employment abroad every year. Nurse migration also has been seen as an increasing problem in many of the Member countries. Some countries in the region also serve as a source of nurses for Members of the Organization for Economic Co-operation and Development (OECD) as well as Middle Eastern countries such as Saudi Arabia and the United Arab Emirates. The main source country in the SEA Region is India but migration of nurses is also observed from Bangladesh, Nepal and Sri Lanka. There is evidence that the number of Indian nurses being registered in the United Kingdom has increased from 30 in 1998/1999 to 3,690 in 2004/2005. Although many other paramedical categories also migrate in relatively smaller numbers, this too creates a disruption of smooth delivery of health services in the source countries. Unfortunately, the data on numbers of these paramedical categories are scarce.

Causes of international migration

Migration of health personnel can be attributed to both external pull factors and internal push factors. Pull factors include globalization, free-market economy and attractive living standards which lead to a steady flow of international migration of health personnel. As a parallel trend, advanced countries which are facing acute shortages of health staff, especially nursing staff are attempting to attract deficient health workers by providing many incentives, which include, high salaries and better living conditions, etc. Many developed countries have revised their emigration criteria to accommodate an influx of some of these health professionals. All these act as pull factors for health personnel to seek greener pastures.

Many countries in the SEA Region have push factors which motivate health professionals to seek work opportunities in developed countries. Surplus production of health professionals which leads to unemployment, lack of infrastructure and attractive working conditions, unattractive salaries and inadequate career development opportunities, act as push factors for migration. Health sectors in many countries of the Region are faced with budgetary constraints which prevent health systems to remunerate health personnel in terms which are comparable to developed countries.

GATS and migration of health workers

The General Agreement on Trade in Services seeks to progressively liberalize international trade in services including health. Even before GATS was introduced there were natural movements of services and human resources in the health sector. Such movements in trade and services in health sector can now be classified under modes 1-4 of GATS. For example, under mode 2, when a specific health service is not available in a country, patients tend to seek it in the private health sector of another country. Such movements result in fast development of the private health sector in these countries which in turn causes internal migration of health workers.
from the public to the private sector. As a result, the public sector becomes impoverished in terms of qualified health workforce which is detrimental to the delivery of health services.

13. Movements under mode 3 relating to foreign direct investment of capital for establishing new private hospitals, also have a direct impact on the movement of employees from the existing public sector to newly-established private facilities which result in staff shortages in health institutions of the public sector. Under mode 4, movement of doctors and nurses from one country to another, mostly developed, takes place causing negative effects on host countries.

14. However, GATS affects migration of health workers only if and when such migration is explicitly included in the list of services that a country has agreed to liberalize; only few countries have done so. Although most countries in the SEA Region have not included health services in their GATS negotiations, trade in health services continues to take place, mainly under mode 2 and to a lesser degree under mode 3. Therefore, it is believed that GATS is not the major cause of migration. However, ongoing and future GATS negotiations may be used as a tool to increase opportunities for migrant health professionals in recipient countries.

15. Meanwhile, regulations that are being developed under the framework of GATS may affect national regulations dealing with temporary immigrant health professionals. The GATS agreement, however, does not pertain to permanent migration, nor does it set rules for dealing with departing workers.

16. The regional trade and bilateral trade agreements also facilitate movement of health personnel. The ASEAN Framework Agreement of Service is the umbrella for several mutually recognized arrangements for health professionals like nurses, physicians and dentists.

**Negative and positive aspects of migration**

17. The South-East Asia Region reports the highest disease burden in the world when compared to other regions. Many of the SEA countries are yet to develop their health systems to achieve universal coverage. Among the factors that limit rapid expansion of health systems in these countries, the shortage of competent, motivated health workers is an important bottleneck. Many of the SEAR countries do not meet the minimum threshold density of 2.28 doctors, nurses and midwives per 1000 population, below which coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals (MDGs), becomes very unlikely.

18. Development of health workforce is considered one of the key functions of an effective health system. In the SEA Region, many of the governments give considerable subsidies for health workforce training, while some countries provide training free of charge even up to the post-graduate level of medical doctors. Governments make this investment because they are very much aware of the need to have a competent health workforce as the backbone of their national health systems. Some governments even have expectations of a pay-back by these professionals by serving in their health systems. However, international migration of health workers makes this investment less cost-effective for health services.
19. Furthermore, many health personnel who migrate are treated unfairly by host countries in terms of remuneration, welfare, working conditions and continuing education. Thus there is a need for an international mechanism or tool to help alleviate the negative implications of migration and foster a positive environment instead.

20. For some countries, however, there are several positive aspects of international migration of health personnel. Since late some countries, including some in the SEA Region, have initiated a policy dialogue to promote migration of health personnel as a mean to improve foreign exchange to the country. The Government of Sri Lanka has initiated discussions to explore the possibility of scaling up training opportunities for selected categories of health personnel, which will promote migration while fulfilling the in-country health workforce needs.

21. Some argue that migration provides opportunities for technology transfer which is true if time-limited migration is encouraged and the migrants will return to the source country once the period is completed. While there are exchange programmes arranged by many countries in the SEA Region with developed countries, evidence of effectiveness of technology transfer through time-limited migration is yet to be documented.

22. Two countries of the Region with relatively smaller populations do not have medical schools. Governments of Bhutan and Maldives depend totally on medical schools of neighbouring countries for training of their medical graduates. Further, at present many doctors and nurses from neighbouring countries are also employed in health institutions of Bhutan and Maldives. Timor-Leste is faced with the same health workforce problems and has taken steps to establish a medical school which is still in the initial stage of development. Therefore, these countries have benefited from international migration of health personnel and will continue to benefit for many more years.

**Global and regional action**

23. International migration of health workforce is a global phenomenon and is not a problem that can be solved only at the SEA Region level. Therefore, it is important to examine what action has already taken place in this regard in the recent past.

24. The fifty-seventh World Health Assembly passed a resolution (WHA 57.19) on international migration of health personnel which emphasized WHO’s stand on this issue. While stating the WHO’s stand on international migration of health personnel, the resolution urged Member countries:

- to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems;
- to frame and implement policies and strategies that could enhance effective retention of health personnel including, but not limited to, strengthening of human resources for health planning and management, and review of salaries and implementation of incentive schemes;
- to use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration;
• to establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin.

25. The Regional Office has been involved with few activities related to international migration of health workers during the recent past. The South East Asian Conference on Postgraduate Medical Education which was held from 1-3 August 2005 in Sri Lanka discussed ‘Brain Drain’ in four countries of the Region, namely Bangladesh, India, Nepal and Sri Lanka. The discussions that took place at this conference which was jointly organized by the Postgraduate Institute of Medicine, Sri Lanka, Ministry of Healthcare and Nutrition, Sri Lanka and the World Health Organization was a clear eye-opener to the regional crisis.

26. Volume 10 of the World Health Forum, which was published as a special edition to mark the celebrations of World Health Day 2006, discussed the international migration of health workers in detail. Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka are presented in this publication with emphasis on the problem of migration.

27. At the 24th Health Ministers’ meeting held in Dhaka in September 2006, a declaration was made on health workforce development. By this declaration, the governments of all Member countries of the Region showed their commitment to address health workforce-related issues and challenges, including the challenge of mitigating international migration of health personnel. They reiterated the need to take further actions, in line with resolution WHA 57.19 on international migration of health personnel, in order to mitigate its impact on the effective functioning of the health systems in the regional countries.

**Future challenges**

28. International migration of health personnel is an inevitable reality for many more years to come. The emphasis on respecting human rights has become more and more strong over the past decade. From a rights-based perspective it can be argued that a person, whether in the health sector or in any other sector has a fundamental right to select where he or she wants to live, work and what work to perform. Therefore a question arises as to what extent governments can limit the freedom of people to select a country of residence and place of work.

29. However, the right for free employment should neither limit the global nor the regional effort to find solutions to the problem of international migration of health personnel. Critics argue that developed countries should comply with the ethical practice of not attracting health personnel from countries that are already having disrupted health systems due to shortages of health workforce.

30. There are no straight-forward solutions to this problem as long as the distinction between developing and developed countries remains. It is opportune to examine the international migration of health workforce in detail, especially in the light of today’s context with the General Agreement on Trade in Services coming into enforcement.
31. Where do we draw the line in international migration? What are ethical and what are unethical practices? What will be the implications of curtailing international migration on the Member countries? How would this be seen in human rights terms? What are the possible implications of GATS on migration of health workers? To what extent would the absence of valid, timely data and information affect informed decision-making in this regard? In the light of resolution WHA 57.19 these are some of the questions that need discussion and careful consideration.

Actions required for future

32. In the context of the World Health Assembly resolution 57.19 and the Dhaka Declaration, the Regional Office has a role to play in mitigating the negative impacts of international migration of health workforce. Member countries need support to intensify their individual efforts to identify the magnitude of impact of such migration. Therefore, WHO needs to identify and provide the support required by Member countries to frame and implement policies and strategies that would mitigate the adverse effects of international migration of health personnel while enhance effective retention of health personnel and at the same time enhance measures to effectively retain health personnel. WHO would carryout this work in cooperation with global and regional networks of health workforce development within their respective mandates.

References

9. Proceedings of the South Asian Conference of Post-Graduate Medical Education. 2005