

Migration of healthcare professionals: practical and ethical considerations

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ABSTRACT – Recruitment of healthcare professionals from developing countries to the UK is escalating rapidly, and is severely damaging the fragile healthcare systems of the countries involved. This is happening in spite of the Code of Practice of the Department of Health, which, although voluntary, was supposed to restrict such migration; unfortunately it has not proved effective so far. Steps are now urgently required to reverse this trend, in order to prevent the total collapse of some overseas health services. The Department of Health is planning to implement the Code of Practice more rigorously, but while it remains voluntary it is unlikely to solve the problem, in view of the (relative) shortage of healthcare professionals in this country. Other measures, including promoting the retention of locally trained staff in the UK, are urgently required.

KEY WORDS: developing countries, healthcare professionals, migration

Migration of healthcare professionals has probably been going on for as long as medical services have existed. It is on the whole desirable: it enriches the professional and cultural lives of all concerned; it broadens horizons and promotes mutual understanding. Long distance travel is so easy nowadays that short- and long-term migration is becoming ever more common. This paper looks at the benefits, the disadvantages and ethical aspects of such migration.

Migration from developing countries

The economic and social advantages to those who migrate from developing countries to richer coun-

tries are obvious: better pay, working conditions and career prospects, good educational opportunities for the individual and the family, and money to send home, all make such migration very attractive. Some professionals are driven away from their homelands by political situations, the burden of AIDS, or the fear of violence. In the short term, everyone benefits from such migration, provided that the migrant workers meet the required local standards. In the long term, the shortage of healthcare professionals in the developing country worsens steadily, whilst the host country continues to benefit. However, even in developing countries, opinions may differ on the subject: for example, the ministry of health would oppose such migration, whilst the ministry of finance might welcome it, on account of remittances from overseas.¹

It is difficult to imagine the NHS without staff from overseas: the NHS has relied on healthcare professionals from developing countries since its inception. As the Chairman of the British Medical Association observed:

*as the fourth largest economy in the world we are still ... taking doctors and nurses from the Philippines who need them more than we do. It's a shameful record of exploitation. Surely after over half a century of the NHS we should be producing enough doctors to look after our patients.*²

There has been a gradual increase in NHS staff over decades, but in recent years there has been a rapid rise in the numbers of healthcare professionals coming from abroad, particularly from developing countries. Between 1993 and 2002, the number of non-EU graduates joining the UK Medical Register increased from 2,500 to 4,456 (78% increase), whilst the numbers of UK graduates rose from 3,675 to 4,288 (17% increase); currently, 32,118 of doctors on the UK Medical Register are from developing countries (21% of the total).³ Interestingly, the number of successful candidates in Part II of the Professional and Linguistic Assessment Board (PLAB) test has increased from 606 in 1998 to 5,207 in 2003³ and the Postgraduate Medical Education and Training Board (PMETB) will, in future, allow any combination of qualifications and/or training and experience gained anywhere in the world to be evaluated for direct entry to the General Medical Council (GMC) Specialist

Key Points

Migration of healthcare professionals from developing countries to the UK is escalating

This trend is damaging the health services in the source countries

The Government Code of Practice has been ineffective to date

New initiatives are required to reverse the migration trend

Register.⁴ These developments are bound to increase the numbers of overseas doctors applying for GMC registration.

In 2002, for the first time, over 50% of new nurses admitted to the Nurse Register were from overseas, many of them from needy developing countries.⁵ Some examples are seen in the numbers coming from Nigeria and Zimbabwe, which increased three-fold and nine-fold respectively between 1998 and 2002; similar trends are seen in the figures for physiotherapists.⁶

Meanwhile, the staffing levels in developing world hospitals continue to fall: for example, Lilongwe Central Hospital (Malawi) now has only one-third of its full complement of nurses,⁷ and 75% of medical graduates from the University of Ghana emigrated within 9.5 years of qualification, mostly to the USA or UK; very few have returned.⁸ In Ghana, the vacancy levels for doctors and nurses in 2002 were 47.3% and 57%, compared with 42.6% and 25.5% respectively in 1998.⁶

The staff shortages in the UK are aggravated by the rapidly rising number of locally trained nurses emigrating, mainly to Australia, Canada and the USA. The USA is actively recruiting nurses from the UK and elsewhere, aiming for an extra million between now and 2012.⁹ In 2002–3, they recruited 2,224 nurses from the UK, compared with 1,089 in 2001–2, and 474 in 2000–1.^{9,10} They are also recruiting significant numbers from Canada, which itself has an increasing shortage.¹¹ Thus, the richest nations can import staff from both developed and developing countries, and the ultimate losers are always the poorest countries with the lowest staffing levels.

The politics of international recruitment

Those who work in the NHS or use its services are all too aware of the (relative) shortage of healthcare professionals. Part of the problem for nurses arises from low pay, unsocial hours, and the inflexibility of working conditions, which result in low recruitment and high losses of UK-trained staff. The implementation in August 2004 of the European Working Time Directive on junior doctors' hours has aggravated the shortage of doctors in the UK. The Government famously promised an increase of 88,000 nurses and 25,000 doctors between 1997 and 2008 (Budget 2003),¹² but gave no indication as to whence they would be recruited. The newly created medical schools will have only just started producing graduates by 2008, and increased output of graduates from the pre-existing schools will likewise only just be starting.

Thus, if this promise is to be fulfilled, the vast majority of new staff must come from overseas, and many of these will inevitably be from developing countries. Indeed, this is already happening, as the statistics above indicate.

An incentive offered by the British Government to attract highly qualified doctors to the UK consists of medical International Fellowships for up to two years, which are offered to English-speaking specialists overseas. The deal includes consultant salaries for two years, plus up to £62,000 to assist with relocation and housing, and a generous travel allowance. The invitation, including a letter from Prime Minister, Tony Blair, is addressed to anaesthetists, physicians, psychiatrists, clinical

oncologists, radiologists, pathologists and thoracic surgeons.¹³ The NHS claims not to recruit from countries 'where there are concerns about the effect on its workforce';¹⁴ however, these specialties have shortages in every country, especially in developing countries, so they would surely be unhappy at losing highly trained and highly skilled specialists; these, after all, are not training posts. The head of the NHS employment policy described this scheme as 'ethical', stating that 'we are assisting [developing countries] in offering fixed-term placements in the NHS as part of career planning for healthcare professionals'¹⁴ However, career planning is not the same as training; doubtless the experience will be good for the doctors, but the loss of specialists for up to two years must be damaging to the health services of developing countries.

Ethical considerations

The Code of Practice for NHS employers involved in the international recruitment of healthcare professionals was originally produced in 1999 and updated in 2001.¹⁵ It stated that there should be no direct recruitment by the NHS from certain designated developing countries where there is a shortage of staff, without specific permission. However, this is advisory, not mandatory, and there are many ways round the arrangement. Indeed, recruitment to medical International Fellowships, as described above, contravenes the spirit of the Code of Practice. Locum and temporary posts, as well as the independent sector, are not covered by the Code, and it is accepted that agencies and/or the independent sector may apply on their own initiative: staff recruited in this way can and do move on to the NHS.

Another problem is that many healthcare professionals who come quite legally on holiday or on short-term training visits to the UK fail to return home at the end of the agreed training period.¹⁶ These healthcare workers are then able to work in the UK: the NHS is allowed to employ doctors and nurses who have already arrived from Africa or elsewhere, and if they were not *directly* recruited by the NHS from their home country, this, curiously, does not contravene the Code of Practice. These 'escape clauses' are among the reasons why, in spite of the Code of Practice, there are so many healthcare professionals being recruited to the NHS from countries which *do* have severe staff shortages and which are on the list of countries proscribed by the Code of Practice. Thus, it is not surprising to find that since 1999, when the guidelines were originally established, the outflow of healthcare professionals from sub-Saharan Africa to the United Kingdom has increased substantially: one-quarter of overseas nurses entering the UK nursing register come from developing countries on the DH 'proscribed' list.⁶ The ethical principle of beneficence requires one's actions to promote welfare, and to cause no harm. In spite of certain obvious benefits, the migration of healthcare professionals harms the medical services (and therefore the patients) in developing countries. Furthermore, such recruitment fails also to respect the ethic of distributive justice, which is so often ignored by employers.

Furthermore, there have unfortunately been some reports of immigrant nurses being exploited in the private sector.⁶ The

fundamental ethical principle of respect for individuals is violated when people are used as a means to an end, without benefit to themselves.

Possible solutions

How can these conflicts be resolved? There are no quick fixes. The recruitment of staff from overseas, fuelled by politically motivated promises to produce a rapid increase in the numbers of healthcare professionals in the NHS, is bound to continue. Developing countries could try to reduce emigration by training 'unexportable' professional staff. Professor Levy, Professor of Neurosurgery in Zimbabwe, speaking of a new medical school in a developing country, suggested that 'it would be better for that country to produce graduates whose qualifications are not recognised abroad, then although they might be functioning at a lower standard than elsewhere, at least they would be there and of some help to that country': understandably, this concept was unacceptable to the university concerned, which 'did not want to be seen to be producing a substandard (by first world estimations, at least) product'.¹⁷ Another approach is to train clinical officers, who are not qualified in medicine (or nursing or pharmacy), but are trained to undertake many procedures traditionally done by doctors (or nurses or pharmacists). This system is working well in many African countries¹⁸ and elsewhere, and as there are no jobs for these excellent health workers in the developed world, they will continue to fulfil a very important role in their own countries.

The large-scale migration of healthcare professionals to the UK from developing countries could be reduced significantly by the rigorous enforcement, and some modification, of the existing Code of Practice.¹⁹ The Code supposedly 'prevents agencies targeting developing nations, stripping those countries of qualified health professionals',¹⁵ but this clearly has not worked. This is not surprising, as the recommendations are advisory rather than mandatory, and there are no sanctions against employers who disregard the Code. The Government is now trying to strengthen the Code,²⁰ and is targeting active recruitment from developing countries (excepting recruitment under the terms of government-to-government agreements). Healthcare organisations are 'strongly commended to adhere to the Code of Practice'; and the Government would like the private sector to 'follow the NHS's example'. However, there are still no sanctions (other than removing a non-compliant agency from the list of complying agencies). Furthermore, the many other routes into UK healthcare employment (both legal and 'by the back door') are not being addressed fully, so it may be a long time before this unethical recruitment ceases.

If the loss of professionals from developing countries continues, then a recipient country cannot remain morally inert. The support of healthcare training in developing countries is vital. Such schemes are being supported by the Tropical Health and Education Trust, working with the Royal College of Physicians.

Other solutions are needed at both ends of the migration balance. Theoretically, it would help to some extent if there were

improvement in pay and working conditions, or compensation (financial, educational or personnel) from the recruiting country to the source country.²¹ However, even if such measures were financially possible, they would be unlikely to have a significant impact on migration of professionals. Serious efforts are being made in the UK to recruit and retain UK-trained nurses, and to persuade those who have left nursing to return to work; more postgraduate medical training is now flexible. These changes should reduce the necessity to recruit staff from overseas to some extent.

The recruitment of healthcare professionals from developing countries is not going to stop,²² even though it is severely damaging the fragile health systems of many of those countries. However, a clearer understanding by institutions (including the NHS and government departments), politicians and the British public of the complex medical, social and ethical issues involved, might pave the way towards improving some of these inequalities. The Government may have to recognise that the unrealistic targets on staff recruitment it has set itself will not be fulfilled by 2008, if ever. Any significant improvement in staffing levels will probably take several years longer, by which time the increased output of British-trained nurses and doctors will have ameliorated the problems of staff recruitment, thereby reducing the need to recruit from overseas. In the meantime, the suggestion made in a report for the charity Save the Children that this country should compensate African countries for poaching trained medical staff is both timely and compelling.²³

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