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Background Paper
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Roundtable 1: Human Capital Development and Labour Mobility: Maximizing Opportunities and Minimizing Risks

Session 1.1: Highly skilled migration: balancing interests and responsibilities.

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Partners in the preparation of the session: Government of Malawi, Government of the Netherlands, WHO, OECD
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Executive summary

In a world of globalized labour markets, there has been an increase in mobility of qualified and educated persons, among developing and developed countries alike. The out-flow or “brain drain” of highly skilled from sectors key to development, such as health, education or agriculture is perceived in some cases to have a retarding effect on the achievement of development goals, particularly in smaller developing countries. But for some countries the brain drain has become a brain gain through migrant investments, networking for contacts and projects, knowledge transfer and other forms of émigré-home country collaboration.

Migration however is rarely the cause for a lack of development, even if it is often blamed for negative outcomes. Migration is part of a broader development picture, and is as much a consequence of a lack of development as it is a cause of that lack of development. General development policies to stimulate economic growth, improve the rule of law and good governance can have an impact on a migrant’s decision to migrate. However, a number of policies and initiatives are already in place in countries of origin and destination to specifically help to train, retain and regain skilled personnel for development. Joint approaches between governments and between public and private sectors can often ensure a better balance of interests and results.

This paper focuses on the health sector as a lens through which to examine the flows and impacts of skilled migration; and how effective policies have been to address these to the benefit of development: What incentives have been used to make these policies effective? What partnerships exist and how have they been made to work? How can development aid be used to support policy initiatives in this area? The paper identifies some good practices by governments and other agencies aimed at ensuring that skilled migration from developing countries, while meeting labour market needs in developed countries, does not negatively affect developmental efforts of the origin country.

Introduction

Highly skilled migration from developing to developed countries has increased in recent years, in part driven by the emerging global markets for certain skills and strong competition among developed countries to recruit those skills.¹ The developed economies of East Asia are the most recent to join the global race for skills; and their market is likely to expand rapidly with regional growth and increased net-immigration.²

But skilled emigration from developing countries is also in part driven by poor opportunities and work conditions in those countries; although this cannot automatically be equated with a decline in conditions at home. Migration is rarely the cause for lack of development, even if it is often blamed for negative outcomes. Migration can be as much a consequence as a cause of lack of development. While earlier studies pointed to the detrimental effects of skilled migration on communities left behind, today it is more widely understood that skilled migration can also bring returns to education and boost human capital development in poorer countries, also through remittance or knowledge transfers to the origin country (although as the World Bank points out, remittances of the skilled may not have as high an impact as those from lower skilled).³

The impacts of skilled migration vary from country to country; and are generally greater on smaller populations and fragile economies. For many countries in Sub Saharan Africa or the Caribbean region, if they cannot retain the skills generated by their education systems, or attract the skills they need, the loss of brains in critical sectors can diminish their ability to reduce

poverty and increase economic growth.⁴ At the same time, a growing number of developing countries are also increasingly competing with the developed world for highly skilled workers.

In the developed countries' race to attract the "best and the brightest" there arises a tension between migration policy and development policy. Immigration policy often aims to attract the highest quality migrants, which may conflict with development policy's aim to reduce poverty and raise levels of wellbeing in developing countries. Some of the "best and brightest" may need to stay at home for development policy to be effective. How to achieve a workable balance so that migration benefits both countries of origin and of destination is the theme of GFMD session 1.1. Education and training are critical policy issues at this interface of migration and development.

The purpose of this background paper is to inform the roundtable discussion by summarising the main findings of recent research on skilled migration and highlighting current policies and practices to manage the migration of skilled professionals. The movement of health professionals is used to illustrate the migration of highly skilled in general. It is not identical but can be a useful lens through which to view the migration of the skilled as a whole. The session will then discuss some programmes in operation, and draw from these the policies, incentives and conditions most likely to maximise the benefits and minimise the risks of highly skilled migration.

Definitions

There is no single agreed definition of "skilled" amongst states or scholars. In general terms, the highly skilled are those with tertiary-level qualifications who make up "human resources in science and technology".⁵ However, "the skilled" may be a much broader category and many lower-level skills are also required for development. This paper focuses primarily on those required in the health sector and uses the definitions of health workers given by the WHO.⁶ These definitions recognise that delivery of health services does not rest with doctors and nurses alone, but includes "*all people who are engaged in actions whose primary intent is to enhance health.*" Nevertheless, despite the importance of such workers, the categories of "doctor" or "nurse" tend to appear in the employment classifications of most countries and are therefore the focus of most existing work on the movement of health workers.

The discussion at the Global Forum will focus on a broad definition of highly skilled.

Context

Basic data

Adequate data through which to measure the migration of health professionals from one country to another are often lacking. Much of the information is anecdotal. Furthermore, the available data is rarely gender disaggregated, making it difficult to provide for accurate figures on the rate of female skilled migration movements. However, one trend is clear: there is an increasing proportion of foreign-trained health professionals in the developed countries of Europe, North America and Australasia. The proportion of foreign medical graduates practising in the United States, for example, rose from 18 percent in the 1970s to 25 percent in 2000 and over 30 percent of doctors in the UK and New Zealand around the same time were foreign-trained.⁷ Other estimates have been made that suggest that some 18,556 doctors from 10 sub-Saharan countries were working in eight OECD countries around 2005, or an average of 23 percent of the total number of doctors in the home country.⁸ The same source suggests that almost 30,000 nurses and midwives from 19 sub-Saharan countries, 5 per cent of the total, were working in seven OECD countries around the same time. And the needs are expected to grow: the United States is projected to have a shortfall of 800,000 nurses by 2020⁹. The OECD has recently conducted an

analysis of the main types of skilled migration to the most developed economies in the world (International Migration Outlook 2007). The World Bank has produced a new database on bilateral medical brain drain.

International patterns of migration

To divide the world into countries of origin in the south and countries of destination in the north is an oversimplification in a world where all countries today are both origins and destinations for migration. Recent research shows how difficult it is to confirm that so-called "staffing crises" or negative impacts on public health systems are the simple consequence of skilled emigration, even in sub-Saharan Africa.¹⁰ Not all foreign-born doctors and nurses in the developed countries were trained in developing countries; and health professionals, particularly doctors, are known to circulate within the developed world (e.g. UK doctors going to the US, Australian doctors going to the UK). Although a transition from net-emigration to net-immigration upon development was observed at the outset, rising levels of development do not imply a cessation of emigration. The UK, for example, remains one of the principal sources of skilled migrants at the global level: it is not just a destination country.¹¹

Internal patterns

Any assessment of the development impact of the exodus of health personnel needs to look at their distribution within the countries of origin. The majority of doctors and nurses in developing countries tend to be concentrated in the capital city or at least the main urban centres. Two-thirds of the doctors in Ghana, for example, are to be found in the two largest towns of Accra and Kumasi.¹² There is no reason to believe that if those doctors and nurses who migrated had remained home, they would have worked instead in the remoter or poorer parts of the country. Thus, any national exodus of doctors is unlikely to make a significant impact on the health status of the population in areas of greatest need, where an improvement in basic indicators would indeed be likely to have an impact on the MDGs.

Sectoral patterns

Skilled personnel also leave the sector rather than the country. Low wages, working conditions and career prospects cause professionals to move out of the public health sector into other jobs, including the private sector and into business. For example, although there were some 32,000 vacancies in the public health sector in South Africa for nurses in 2001, another 35,000 registered nurses were estimated to be either inactive or unemployed.¹³ This intersectoral rather than migration flow highlights the need for broad-based civil service reform and a shift of focus to the overall movement of talent from a country, not just doctors and nurses, if any crisis in the health sector is to be understood. Those who could play a leadership role in the civil service and in the political life of a country may also have left.

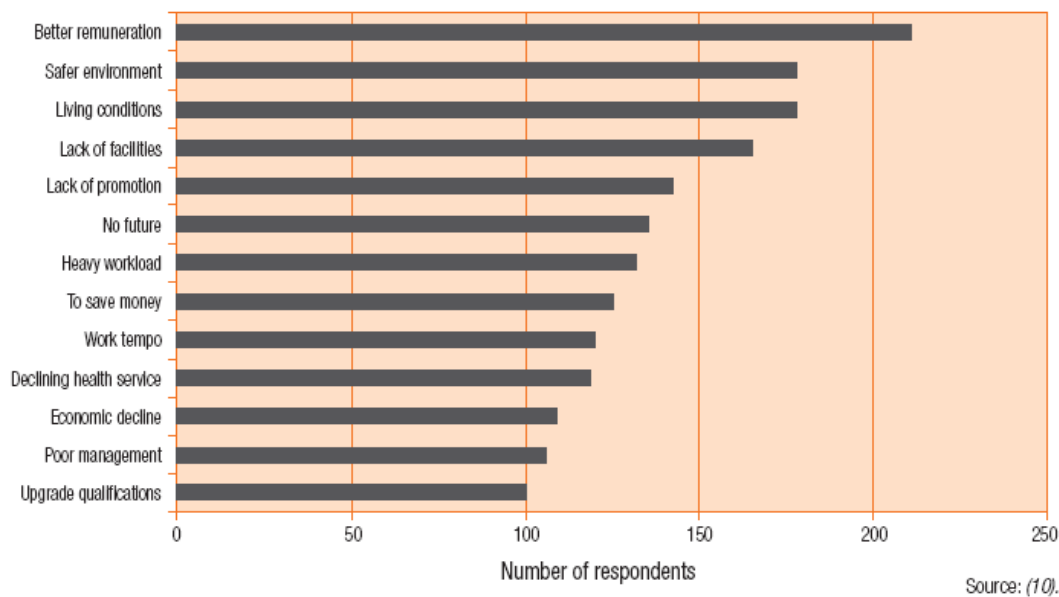
Impacts

Research findings on the impact of skilled migration on development are scanty and mixed. There is little specific consideration given to the migration of women and the consequential impacts on the delivery of development goals. But there is sufficient evidence to show the data are highly country-specific, determined by factors such as the strength of the economy and flexibility of the labour market. It is argued, for example, that countries like China, Mexico, India and the Philippines have been able to adapt to their brain "drain" through strategic shifts in production.¹⁴ But some smaller island economies, such as in the Caribbean or Pacific regions, are losing more doctors and nurses than they can retain for their own development support needs (e.g. Jamaica, Grenada).¹⁵ But the new literature on brain drain also points to the potential benefits to education and development generally that skilled migration can fuel. More people invest in education with a view to migrating, and returning skilled migrants reinvest resources in their countries of origin.

The newly industrialised economies are clearly better placed to maximise the benefits from the transfer of new technologies and skills by migrants (Katseli et al, 2006 (Policy Brief No. 30)). Some origin and destination countries are now working together on policies that aim at better balanced supply-demand outcomes for both the developing and developed country.

In general, although the emigration of health personnel may appear significant it is more likely to exacerbate an existing condition than to be the primary cause of it. The emigration of health professionals is as much a symptom as a cause of any failure in the health sector. The following table illustrates some of the factors which contribute to the migration of health workers.

Health workers’ reasons to migrate in four African countries (Cameroon, South Africa, Uganda and Zimbabwe)



Source: World Health Report 2006, p99

Current Policies and practices

Policies and practices to deal with the issue of the migration of the highly skilled fall into three broad categories: those that can be implemented in countries of origin of migration, those implemented in countries of destination and those that are implemented in partnership between and among countries.

Countries of origin

In countries of origin, policies are designed mainly around the supply of workers. Many types of policies and practices are in place, but it is too early in some cases to identify "best practices" or to know the conditions under which certain programmes are likely to succeed or fail. Training: Three broad categories of training programmes can be identified, although often countries might use a combination of these as part of an overall human resources strategy:

- a) **Expand existing training services.** Programmes in this category incorporate the continued training of doctors and nurses to the high standards in modern medicine. While this may be

the best approach, it is expensive and can still result in movement of trained staff to other countries. The graduates are able to enter global markets and may move to where remuneration and conditions are high. Some 60% of doctors trained in Ghana in the 1980s are estimated to have left the country, for example.¹⁶ Increasing the number of trained professionals in any developing country is likely to increase the pool within that country, despite leakages, as not all professionals will want or be able to migrate.¹⁷ The numbers of doctors in Ghana have more than kept pace with population growth despite the exodus even if the ratio of nurses to population has declined somewhat.¹⁸

Some expansion of training may be achieved through twinning between medical schools in developed and developing countries (see “Partnerships” below).¹⁹ Such training could involve short-term courses that improve the quality of the workforce in developing countries, while ensuring that they return home. Advanced training may also be carried out in developed rather than developing countries, with only some of the costs being borne by the country of origin.

The loss of professionals in key areas has led some developing countries to call for compensation for effectively subsidizing the developed world. But implementing such a policy would be problematic: not all training is government-funded, some is funded by private foundations or by the migrants or their families themselves. The administrative burden of assessing loss and collecting compensation may also be very large, and not all losses are from developing country to developed country. It has therefore been suggested instead that developed countries could contribute to a voluntary educational reinvestment fund to expand training in the developing world.²⁰ Rather than compensate directly for migration losses, this would help expand the pool of skills in the home country.

- b) **Expand training for the local market.** This raises the issue of what training is most appropriate for local needs. Highly trained medical professionals, who can only use their skills productively in advanced hospitals, may not be the best health personnel for areas with few modern amenities. Programmes to train large numbers of people in basic skills may prove a better way to achieve the MDGs than just to focus on expensive training that can only be used in urban areas. Even in areas with high concentrations of people with HIV/AIDS, health workers with basic medical skills can make a significant difference. Training centres to teach basic skills are likely to achieve greater success if they are located in small towns in more marginal areas of a country, and they recruit trainees locally. Graduates from such centres are unlikely to be marketable internationally, hence less likely to go overseas. However, the opportunity must always exist to allow such trained people to upgrade their skills and avoid being permanently locked into a lower-tier health delivery system.
- c) **Expand training for global markets.** In the Philippines and India, health personnel are being specifically trained for overseas markets, so that the countries benefit from their remittances. In these cases the "export" of health workers, particularly of nurses but also doctors, is part of a broader strategy to send workers overseas. For example, about 934,000 workers left the Philippines in 2004 and 3.6 million foreign workers were estimated to be abroad temporarily at the end of that year in addition to 3.2 million overseas migrants.²¹ Currently, between 8,000 and 9,000 nurses leave the Philippines every year, but the country as a whole is still generating more nurses than it needs.²² About 85% of the training occurs in private institutions, which more than doubled in number to meet foreign demand between 2000 and 2005. However, monitoring the quality of this training has becoming an important issue.

- d) Policies to have an impact on internal distribution.** A serious challenge for sending countries is how to bring health providers to the areas most in need: rural areas and marginal urban settlements. As suggested above, the recruitment and training of personnel within marginalised regions may be one way of improving the situation: skilled practitioners from affluent urban areas are unlikely to want to move to areas unknown to them with few facilities. Thus, the decentralization of recruitment needs to be a priority. Various programmes have been tried to encourage urban-trained health workers to move to rural areas. A system of salary supplements provided to doctors going to rural areas through Netherlands aid in Western Province in Zambia was so successful that, for a time at least, a shortage of young doctors was created in the capital, Lusaka.²³ The sustainability of such programmes is an important consideration.
- e) Policies to improve pay and conditions.** One of the principal reasons that health professionals leave their developing countries of origin is dissatisfaction over pay and conditions (see above chart). How can countries retain the health workers they have trained? The simple response is to increase pay and improve those conditions, but countries with limited budgets or undergoing structural adjustment, may have little room for manoeuvre. Nevertheless, countries such as Ghana have attempted partial schemes such as providing doctors with an advantageous car hire-purchase scheme and preferential access to housing loans for all health personnel. Such measures may lead to resentment among those not entitled to participate in the schemes. Improvements in pay and conditions for public sector health workers are more likely to succeed if they are part of wider reform in the civil service rather than a "go it alone" strategy. An alternative solution would be to allow public sector health workers to augment their salaries by participating in private sector provision. Public and private sectors could be mutually supporting, although careful monitoring and drafting of contracts are required to prevent the latter from undermining the former.
- f) Policies to limit the movement of potential migrants.** Countries of origin could attempt to stop the emigration of health professionals directly, although few do this. Barriers to migration can tend to push potential migrants into irregular channels and lead to skill wastage and exploitation. Such policies also infringe the rights of individuals to move, although that right does have to be counterbalanced against the rights of less privileged members of the same society to receive basic health care. More indirect measures such as "*bonding*", by which recent graduates have to give several years of service in return for their training, have been widely used throughout the developing world. In Ghana, doctors have to give five years of service to their country to defray the costs of training or pay a fine if they do not comply. However, inflation and currency depreciation reduce the real cost of the fine and consequently its deterrent effect. Developed countries such as Singapore also maintain bonds as a prerequisite for medical graduates going overseas on government grants for further training.²⁴ In certain situations, careful application of bonding may help to facilitate services from recent graduates in rural areas and be part of a broader training expansion strategy to help retain, at least over the short term, a greater proportion of those trained.
- g) Policies to promote return and diaspora involvement.** Policies can be designed to encourage return of those who have left for short or longer periods of time, and they can be promoted bilaterally or multilaterally. An example of the latter is the Migration for Development in Africa (MIDA) programme of IOM.²⁵ Such programmes can tend to be expensive and affect a relatively small number of people, e.g. only 40 Ghanaian doctors, nurses, public health workers and one ICT professional conducted return missions from the UK and the Netherlands to Ghana during the 2.5 years of the project. These programmes

may also not yet have had sufficient time to realise their full potential.²⁶ The experience of health practitioners working in developed countries may not be relevant to the special needs of a developing country. Issues of remuneration and terms of service would also need to be considered alongside legal status and tax status. But these can be expensive and generate resentment among those who stayed home, or even serve as a push factor for further out-migration.

Countries of destination

Policies in countries of destination are mostly designed to affect the demand for foreign workers. These tend to fall into two general categories: training and managing the importation of skilled; but there is also increasing attention being given to targeted sectoral capacity building

- a) **Training.** The demand for skilled migrants in general, and health professionals in particular, is set to grow, given the ageing of societies of the developed world. One policy response is to increase the number of trainees in sectors likely to experience a shortfall, and to improve the pay and conditions to attract more into such training, including returnees from other sectors. Increasing domestic supply can ease the reliance on external sources. However, news of any improvement in pay and working conditions is likely to be quickly transmitted back to countries of origin, further emphasizing income differences between origin and destination and potentially stimulating more migration. Thus policies to improve conditions for local workers and reduce dependence on migrants might have the opposite effect of encouraging more migration. Nevertheless, increasing the supply of health professionals being trained in developed countries should help to reduce the intake from overseas.
- b) **Direct migration policy interventions.** Ethical recruitment practices by which developed countries discourage direct hiring of health professionals in developing countries are one way of erecting barriers to the movement of nurses and doctors. The National Health Service in the UK, for example, has restricted itself from actively recruiting from over 150 developing countries. The Commonwealth have developed a similar recruitment code. The effectiveness of this policy is still under review, but several concerns have been raised.²⁷ Most importantly, the restrictions are for the most part non-binding for the private sector. The Netherlands Foreign Employment Act also restricts recruitment of nurses from developing countries. If similar codes of practice are not implemented by all major developed countries, the result may simply be a shift from one destination to another. Of greater practical concern, erecting barriers to mobility or free choice of health professionals may encourage potential migrants to resort to irregular channels to gain access to richer labour markets. On the positive side, codes of practice draw international attention to the impact of brain drain on the provision of health services in developing countries. Thus they may indirectly lead to the implementation of other measures at source and destination to ensure that more of the skills required are retained or replaced in the country of origin.

Partnerships

It appears unlikely that policies and programmes implemented in either country of origin or destination alone will be sufficient. Joint approaches are needed if the movement of skills is to be managed to mutual benefit

- (a) **Joint support programmes:** An example of such collaboration are the government-to-government agreements between African countries and Cuba to supply doctors and nurses to rural areas or with private foundations such as the Clinton Foundation to fund nurses to go from Kenya to Namibia. Cuba, for example, has sent more than 67,000 health professionals to 94 countries since 1960, although these “medical brigades” illustrate a special form of South-South technical cooperation, based on the Cuban Government’s high investment in quality health education and production of surplus for overseas work as aid support.²⁸ In addition, developed-to-developing-country movements are facilitated by non-governmental organizations such as Médecins sans Frontières, which currently supplies more than 3,400 medical missions every year to almost 70 countries. These movements of health personnel are usually short-term or circular. Their frameworks may be bilateral or multilateral, and they may be funded by both public and private donors such as the Gates Foundation or the Clinton Foundation.

Among these programmes is the one mentioned above between the Netherlands and Zambia to supplement the income of doctors in rural areas. The UK Government has also been working with the Government of Malawi to establish a six-year program of reform in the Malawian health sector, in cooperation with other actors such as the Global Fund to Fight AIDS, TB and Malaria, to increase the remuneration for health workers, create incentives to work in rural areas, return professionals from abroad and strengthen local training capacity. Other support programmes to health and education sectors are ongoing including in Ghana, DRC and Caribbean countries funded by the Netherlands, Canada, the US, Belgium and others.

- (b) **Twinning arrangements:** Twinning arrangements between institutions in the developed and developing world can help promote centres of excellence in countries of origin through the secondment of staff and short training courses. For example, several country governments (e.g. Australia/Norway) offer scholarship opportunities for students in the health sector, but also in other key skills areas. Sometimes these schemes oblige students to return to their country of origin to practise after training.
- (c) **Multilateral Approaches:** At the multilateral level, the Global Health Workforce Alliance (GHWA), a partnership hosted and administered by the World Health Organization, provides a forum for governments, NGOs, international organizations, donors, academic institutions, professional associations and workers to search for solutions to the current “crisis” in the health workforce.²⁸ This partnership not only provides a forum for dialogue among the various actors to give the issues a higher profile, but also works towards establishing common definitions, standards and gathering and sharing of data, all fundamental to achieving better solutions. The EU has also developed a Programme for action to tackle the critical shortages of health workers which acknowledges the need for greater coordination and alignment between donors and civil society to support country level responses. While global partnerships are welcome, regional collaboration, as well, is more likely to provide initial areas of agreement where groups of countries face common problems. More realistically, however, bilateral groupings of actors, as seen in Malawi, will be most likely to offer examples of “best practice” through responding to specific problems in specific places.

Lessons learned

Three clear lessons have emerged from recent research on the migration of health professionals from the developing to the developed world:

- 1) Migration is not the primary cause, but only one of several factors, of any disintegration of basic health services or deterioration in health in the developing world. Hence, focusing on migration alone is likely to produce a distorted view.
- 2) Movement of health professionals will not slow with increasing levels of development: developed countries, too, experience circulation of doctors and nurses.
- 3) Policies and programmes to improve human resources in the developing world need to be multi-pronged, and include managing the movement of health professionals as an integral part. That management should ensure that enough personnel are deployed where they are needed most, rather than restricting the migration of health personnel.

To achieve the last objective, more emphasis is needed on training to increase both the number and quality of personnel available, but also on the appropriateness of training. This emphasis reintroduces the importance of skills in more than just the health sector. Education and teachers are fundamental to improvements in training, and some centres of excellence are emerging in areas outside the traditional developed world, a trend that can be expected to continue. Regional centres in Africa, Asia and Latin America can be expected to create the skills needed not just within their own regions but also globally; in other words, training to international standards.

Policies and programmes that go beyond training have been tried and tested to achieve these objectives, some clearly more effective than others. Creating obstacles to movement, for example, has tended to be ineffective and counterproductive. Attempts to improve pay and conditions for staff moving to rural areas appear to have achieved some success over the short term, but their sustainability in the longer term remains to be tested. Partnerships among diverse actors in both developed and developing worlds seem to provide a productive way forward towards implementing programmes that will achieve positive results.

Looking ahead and possible outcomes of the Roundtable discussion

Drawing from the evidence and case studies, several outcomes may be possible as a result of the discussion at the roundtable.

1. In light of the lessons learned, agreement to develop a matrix of best practice policy interventions which can be drawn upon by states. In particular, evidence needs to be strengthened on deployment and retention policies.

The table below provides an illustration of some of the options which might be considered. Interventions would need to be selected according to the specific context in a country. Policy options should be considered and designed with a view to differential gender-specific needs.

Countries of Origin	Countries of destination	Partnerships
Aim: To address push factors and retain workers	Aim: To address pull factors	Aim: Support each other with mutually beneficial interventions
Policy Options 1. Training <ul style="list-style-type: none"> • Expand existing programmes • Expand training for local market only • Expand training for export 2. Provide incentives to	Policy Options 1. Increase domestic training capacity 2. Ethical codes of recruitment	Policy Options 1. Joint Support programmes e.g. strengthening health systems capacity, supplying temporary personnel 2. Twinning arrangements for training and circular migration

<p>redeploy to disadvantaged areas</p> <p>3. Improve pay and conditions</p> <p>4. Restrict the movement of potential migrants e.g. through bonding</p> <p>5. Promote return and diaspora involvement</p>		<p>3. Multi-lateral approaches - Global Health Workforce Alliance/WHO/EU</p>
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3. An assessment of the initial lessons learned from codes of practice on the recruitment of healthcare workers as a tool for managing migration.
4. Identification of the core elements of a human resources strategies for countries of origin, and donor best practice to support such strategies
5. An assessment of which lessons learned might be applicable to other sectors of highly skilled migration.

(June 2007)

¹ D. Kapur and J. McHale, *Give Us Your Best and Brightest: The Global Hunt for Talent and Its Impact on the Developing World*, Washington, Center for Global Development, 2005.

² See M. I. Abella (ed.), Turning points in labour migration, *Asian and Pacific Migration Journal*, 3(1), 1994, special issue.

³ The World Bank finds that often skilled migrants remit less than unskilled ones. They may also have a smaller impact on poverty alleviation because many come from better-off households, so it is the potential investment of skills and resources targeted at human capital development that can distinguish the benefits of skilled migration from unskilled migration. See Ozden, Caglar and Maurice Schiff, 2006, *International Migration, Remittances, and the Brain Drain*, World Bank, Washington DC.

⁴ The issue of the brain drain is not new, dating from the 1960s and the migration of scientists from the UK to the United States but it has recently become a major policy issue in the migration and development debate. See, for example, Ç. Özden and M. Schiff (eds.), *International Migration, Remittances and the Brain Drain*, Washington, World Bank, 2006; S. Commander, M. Kangasniemi and L. A. Winters, The brain drain: curse of boon? A survey of the literature, in R. Baldwin and L. A. Winters (eds.), *Challenges to Globalization*, Chicago, University of Chicago Press, 2004; and *Migration and Development: How to Make Migration Work for Poverty Reduction*, London, House of Commons International Development Committee, Sixth Report of Session 2003-04, 2004, pp. 27-29.

⁵ L. Auriol and J. Sexton, Human resources in science and technology: measurement issues and international mobility, in *International Mobility of the Highly Skilled*, Paris, OECD, 2002, pp. 13-38.

⁶ *Working Together for Health: The World Health Report 2006*, Geneva, World Health Organization, 2006, chapter 1.

⁷ Cited in S. Bach, International migration of health workers: labour and social issues, Geneva, International Labour Office, Sectoral Activities Programme, Working Paper 209, 2003. See also, J. Buchan, T. Parkin and J. Sochalski, *International Nurse Mobility: Trends and Policy Implications*, Geneva, World Health Organization, 2003.

⁸ *The World Health Report 2006*, Geneva, World Health Organization, 2006, p. 100.

⁹ Cited in S. Bach, International migration of health workers: labour and social issues, Geneva, International Labour Office, Sectoral Activities Programme, Working Paper 209, 2003.

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- ¹⁰ See M. Clemens, Do visas kill? Health effects of African health professional emigration, Washington, Center for Global Development, Working paper No. 114, 2007. The soon-to-be released results of research of health workers moving to OECD countries will also show lower than anticipated impacts of the migration on countries of origin.
- ¹¹ F. Docquier and A. Marfouk, International migration by educational attainment, 1990-2000, in Ç. Özden and M. Schiff (eds.), *International Migration, Remittances and the Brain Drain*, Washington, World Bank, 2006, p. 175.
- ¹² F. Nyongator and D. Dovlo, The health of the nation and the brain drain in the health sector, in T. Manuh (ed.), *At Home in the World? International Migration and Development in Contemporary Ghana and West Africa*, Accra, Sub-Saharan Publishers, 2005, p. 229.
- ¹³ The international mobility of health professionals: an evaluation and analysis based on the case of South Africa, in *Trends in International Migration*, Paris, OECD, 2003, pp. 116-151.
- ¹⁴ Manolo Abella, 2006, "Global Competition for Skilled Workers and Consequences" in *Competing for Global Talent* (eds Kuptsch and Pang), International Institute for Labour Studies, ILO, Geneva).
- ¹⁵ See the World Bank's *Global Economic Prospects 2006* report.
- ¹⁶ Cited in A. Adepoju, Patterns of migration in West Africa, in T. Manuh (ed.), *At Home in the World? International Migration and Development in Contemporary Ghana and West Africa*, Accra, Sub-Saharan Publishers, 2005, p. 39.
- ¹⁷ This idea is the foundation for a reinterpretation of the brain drain. See O. Stark, "Rethinking the brain drain", *World Development*, 32(1), 2003: 15-22.
- ¹⁸ F. Nyongator and D. Dovlo, The health of the nation and the brain drain in the health sector, in T. Manuh (ed.), *At Home in the World? International Migration and Development in Contemporary Ghana and West Africa*, Accra, Sub-Saharan Publishers, 2005, p. 229.
- ¹⁹ See, for example, C. Farthing, H. Lu, W. Xu, D. Lui and Y. Cao, Training doctors in developing countries - a twinning project between AIDS Healthcare Foundation (ARF), Los Angeles, and the Shanghai Public Health Center (SPHC) yields results and provides a model, Amsterdam, AIDS Healthcare Foundation, 2006.
- ²⁰ *Human Resources for Health: Overcoming the Crisis*, Cambridge, Harvard University, Joint Learning Initiative, 2004.
- ²¹ S. Go, Recent trends in international movements and policies: the Philippines 2005, paper presented at the workshop on International Migration and the Labour Market in Asia, Tokyo, Japan Institute for Labour Policy and Training and the OECD, 17 February, 2006.
- ²² K. Acacio, Producing the "world-class" nurse: the Philippine system of nursing education and supply, presentation made at the workshop on Mobility, Training and the Global Supply of Health Workers, Development Research Centre on Globalisation, Migration and Poverty, University of Sussex, 16-17 May, 2007.
- ²³ S. Tyson, Human resources for health: ignorance-based policy trends, presentation made at the workshop on Mobility, Training and the Global Supply of Health Workers, Development Research Centre on Globalisation, Migration and Poverty, University of Sussex, 16-17 May, 2007.
- ²⁴ Medical Research Council of Singapore, see www.nmrc.gov.sg/homepage1/fellowship.htm
- ²⁵ MIDA, *Mobilizing the African Diasporas for the Development of Africa*, Geneva, International Organization for Migration, 2004.
- ²⁶ See L. D. Long and K. Mensah, MIDA Ghana health project evaluation: London, Netherlands and Accra, Accra, a report for the Royal Dutch Embassy, Accra, IOM and Ghana Ministry of Health, 2007.
- ²⁷ See, for example, K. Mensah, M. Mackintosh and L. Henry, *The "Skills Drain" of Health Professionals from the Developing World: A Framework for Policy Formulation*, London, MEDACT, 2005.
- ²⁷ See Médecins Sans Frontières, Malawi's emergency human resources plan: a ray of hope?, 2007, at www.msf.org/msfinternational
- ²⁸ See www.ghwa.org
- ²⁸ *Human Resources for Health: Overcoming the Crisis*, Cambridge, Harvard University, Joint Learning Initiative, 2004, p. 110.