

This section looks back to some ground-breaking contributions to public health, reproducing them in their original form and adding a commentary on their significance from a modern-day perspective. To complement the theme of this month's *Bulletin*, Stephen Bach comments on Alfonso Mejía's presentation of findings from WHO's global study on health manpower migration in the 1970s. The original paper is reproduced by permission of the *International Journal of Epidemiology*.

# Migration patterns of physicians and nurses: still the same story?

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The publication of Alfonso Mejía's landmark study of physician and nurse migration in the late 1970s remains the most detailed analysis of the flows and stocks of the physician and nurse workforce, incorporating data from more than 40 countries (1). The study was undertaken by WHO because, as Mejía notes, "anxiety evoked by migration had reached a peak in both major donor and recipient countries". In the post-colonial period, developing countries were starting to expand their health services and to train their own nationals to fill the posts, but were confronted by a "brain drain". These developments coincided with the rapid expansion of health systems in industrialized countries and a shortage of professional staff to meet requirements, fostering the movement of health professionals between developing and developed countries.

Although Mejía's study is remembered mainly because of its attempt to quantify the stocks and flows of physicians and nurses between donor and recipient countries, its remit was more ambitious. It developed a number of propositions that explored the relationship between GDP, the production of physicians and the likelihood that physicians would emigrate. In view of his position in WHO as Chief Medical Officer of Health Manpower Systems, Mejía was concerned to move beyond documenting trends, and his study was centrally concerned with the policy implications of migration (2).

In 1972, about 6% of the world's physicians (140 000) were located elsewhere than in their countries of origin. Over three-quarters of them were found in only three countries: in order of magnitude, the United States of America, the United Kingdom and Canada. The then Federal Republic of Germany and Australia were the next most important recipient countries. The main donor countries reflected colonial and linguistic ties, with a dominance of Asian countries: India, Pakistan and Sri Lanka. At the same time, some countries — Canada, Germany and the UK — were both key recipient and donor countries. For nurses, it was estimated that about 135 000 (4% of the world's stock) were outside their country of birth or training.

The Mejía study has aged well, and many of the insights remain as relevant today as when they appeared 25 years ago.

Mejía highlights the lack of reliable data and the difficulties of defining whether a migrant is "permanent" or "temporary". Data limitations were exacerbated by the complexities of the migration pathways followed by physicians and nurses. In some cases labour migration took place directly from country to country, while in others it occurred in stages, with intermediate destinations complicating the interpretation of migration patterns. Mejía notes that government information on migrant inflows is more reliable than that on outflows, and this difference continues to the present day. The establishment of accurate data on stocks and flows of health workers remains a challenge that continues to inhibit effective migration management. Despite these difficulties, as the WHO study pointed out, data limitations should not be used to justify government inaction. The failure of workforce planning within donor and recipient countries, which Mejía attributed in part to a lack of political will to deal with underlying problems, continues to resonate with current concerns about imbalances in the health workforce (3).

The Mejía study provides an important benchmark against which to consider current trends in health worker migration. A number of trends are discernible. Most importantly, the health sector has been a major component of the increased number of international migrants that has more than doubled since 1975 to an estimated 175 million people (2.9% of the world's population), of which an increasing proportion are women (48%) (4). Whereas cultural ties were a key determinant in explaining migration pathways in the 1970s, an important facet of the globalization of health labour markets is that these historical ties are loosening as recipient countries become more utilitarian in encouraging migration primarily on the basis of economic requirements. The reverse side of this process, as far as the donor country is concerned, is that a number of Asian countries, notably the Philippines, are encouraging overseas employment on a global scale. In contrast to Mejía's findings, the employment of nurses and other health professionals has become a more important component of health worker migration.

The distinction between "push" and "pull" factors that encourage migration has been a central component of the analysis of health-worker migration. Push factors were a key

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element of Mejía's analysis and, by linking the number of physicians per 10 000 population to GDP per capita, he identified countries that produced more physicians than they had the capacity to absorb. These countries — which included Egypt, India, Pakistan, the Philippines and the Republic of Korea — suffered a net outflow of physicians. Mejía did not neglect pull factors and he concluded that governments had been more successful in fostering rather than hindering health worker migration, with restrictive measures merely postponing or diverting movements.

Commentators continue to highlight the importance of push and pull factors, but more attention is now focused on the pull side than in the 1970s. In particular, the role of governments and recruitment agencies in systematically encouraging the migration of health professionals has become more prominent (5). Increased awareness of the scale of health worker migration and a belief that migrant health worker flows will continue have shifted attention towards “managed migration”. This term signals attempts to link international migration to the health policy goals of individual states and to regulate the flows of health workers in a way that is beneficial to both source and destination countries. It implies a broad range of policy interventions that include international recruitment to incorporate the management of retention, training, deployment and return of health workers. Most attention has focused on bilateral agreements between countries including policies on return, the incorporation of ethical codes of practice into national practice,

and measures to cap the numbers of internationally recruited health workers entering countries (6).

Mejía anticipated these developments with his appeal for a more mutually beneficial approach to health migration in which developed countries would no longer unilaterally set the terms of health migration. This hope was formulated at a time of growing political and economic power of developing countries in the mid-1970s, in the expectation that they would force recipient countries to pay more attention to the needs of donor countries. This expectation has, at best, been only partially realized.

The WHO study was intended to be the first part of a more detailed analysis that would focus on the specific patterns of migration within key donor and recipient countries and the workforce planning measures required to redress these imbalances. The study was shelved, however, as concern about the level and consequences of health worker migration dissipated in the altered economic and political climate of the 1980s. Can we expect history to repeat itself and the current level of policy interest about health worker migration to evaporate as rapidly as it did then? The answer is almost certainly not. Although health worker migration has a cyclical component, the global trend towards increased migration and the heightened awareness of the importance of managing the health workforce effectively indicate that analysis of such movements will continue to form a central component of health policy analysis for the foreseeable future. ■

## References

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