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Medical migration and inequity of health care

The 17% decline in UK government investment in research and development in real terms over the past two decades prompted fears that scientists would seek greener pastures abroad. Hence last week's announcement of a £1 billion capital boost from the government and the Wellcome Trust for the science budget was seen as a step towards stemming any brain drain.

At about the same time, the Republic of Ireland introduced regulations to cope with its shortage of doctors. The regulations were intended to enable more doctors trained outside the European Union to remain in the country to practise (*Lancet*, July 8, p 146). Of the 6000 people who graduated in medicine in the republic over the past 12–15 years, only about 1400 are still practising there below consultant grade. A contract to improve employment conditions is in the pipeline, and efforts are being made to recruit doctors from Germany, where the unlimited intake to medical school has led to a surplus.

The extent to which poor countries are losing doctors to more affluent ones is described by Peter Bundred and Cheryl Levitt in today's *Lancet* (p 245). As they point out, this migration of doctors is not new. A medical qualification is a portable possession. Why should doctors then not be free to go where they think they can get the quality of life they wish? The reason for concern becomes clear with accounts of how South Africa, for example, which 4 years ago had to start recruiting doctors from Cuba, has 600 of its medical graduates (trained at a cost of US\$37 million) registered in New Zealand.

The geographical movement of doctors is not restricted to emigration. The preference of doctors for working in urban areas has made health services in rural areas precarious in many countries. But at least the problem has been actively investigated and new ideas have been tried out. Thus new categories of health-care workers have been created, appropriate medical training and career structures for rural health-care staff have been developed, graduates have been bonded to serve a term in a rural area, and interested parties meet to share information.

At the 2nd World Rural Health Congress in Durban in 1997, participants affirmed their wish to

work together to overcome inequities facing rural areas. The declaration included a call to nations relying on doctors from poorer countries to consider how their policies might affect disadvantaged countries. Drawing attention to this item, Bundred and Levitt propose the establishment of an international code of ethics for recruiting doctors from less-developed countries, and that the countries that gain doctors should reimburse the losing countries for the cost of medical education.

The UK Government, which has been on an overseas drive for nurses, may already have set an example of responsible recruitment in its guidance on international recruitment. The guidance specifies the provisos under which NHS employers may actively recruit from a developing country with nursing shortages of its own.

The UK has agreed with Ghana, for example, to employ the nurses for only specified periods and to post them to only agreed specialties (that suit Ghana's needs). No arrangements for formal repatriation of some of the nurses' earnings were made, although in its examination of its loss of medical graduates, Ghana considered the possibility that such an arrangement might produce indirect returns from its investment in training.

The effect of medical migration on equity of health care ought to be tackled systematically and in a coordinated way. Getting together to collect and to work through ideas for possible solutions would be a start. What must be remembered is that the objective is not limitation of mobility but equity of health care as soon as possible. To achieve this aim, efforts must be led by a body with the flexibility and the power to effect change. However, there should be no illusion that the task will be straightforward. Prediction of human-resource needs probably requires more prescience than science, being influenced as it is by factors such as changing demographics and expectations, health-sector reforms, the balance between public and private health care, liberalisation of trade, and new laws such as the EU directive limiting overtime work.

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