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Physician migration: Views from professionals in Colombia, Nigeria, India, Pakistan and the Philippines ☆

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Abstract

There has been much debate recently about several issues related to the migration of physicians from developing to developed countries. However, few studies have been conducted to address these issues in a systematic fashion. In an attempt to begin the process of generating systematic data, we designed and distributed a questionnaire addressing several core issues surrounding physician migration to respondents selected on the basis of their special expertise or experience in India, Nigeria, Pakistan, Colombia, and the Philippines. The issues addressed relate to the reasons physicians migrate to developed countries, how migration is related to the structure of medical education, the effect that migration has on the health care infrastructure of developing countries, and various policy options for dealing with physician migration. Though responses varied somewhat by country, a desire for increased income, greater access to enhanced technology, an atmosphere of general security and stability, and improved prospects for one's children were the primary motivating factors for physician migration. A majority of respondents believed that physicians in developing counties are provided with highly specialized skills that they can better utilize in developed countries, but respondents were ambivalent with respect to the utility of educational reform. Responses varied significantly by country with regard to whether physician migration results in physician shortages, but there was widespread agreement that it exacerbates shortages in rural and public settings. With respect to policy options, increasing physician income, improving working conditions, requiring physicians to work in their home countries for a period following graduation from medical school, and creating increased collaboration between health ministries in developed and developing countries found the most favor with respondents.

Keywords: Physician migration; Health policy; Developing countries; India; Pakistan; Nigeria; Columbia; The Philippines

Introduction

Over the last half-century, there has been a significant increase in the number of physicians who have migrated between countries, especially from developing to developed countries. In Canada, 23% of practicing

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physicians are trained abroad, while in the US, international medical graduates account for 23.5% of all physicians and 24% of all medical residents (American Medical Association; Buske, 2002). Several events have contributed to this phenomenon. During the 1960s and 1970s, governments in developing countries used subsidies to promote the expansion of physician training in order to meet the primary health care needs of their populations. The health care systems in many of these countries could not absorb the trainees, leading a large number of physicians to seek employment elsewhere (World Bank, 1993). In addition, the increasing conformity of medical curricula with international standards for medical training, the internationalization of the English language, and the willingness of physicians educated in developing countries to work in rural and other undesirable locations in developed countries have made them a prime target for recruitment (Gish & Godrey, 1979).

Concern about the negative effects of physician migration on the health care infrastructure of developing countries was a focal point of both the 2002 and 2004 World Health Assemblies. The National Health Service in the United Kingdom has enacted a Code of Practice that forbids recruitment of health professionals from developing countries, unless the Department of Health in the sending country has specifically agreed to allow such recruitment (Department of Health, 2001). Recently, this has been expanded to prevent any hospital from recruiting nurses and physicians from developing countries (Nullis-Kapp, 2005). Nevertheless, pressure to ensure an adequate supply of physicians, especially in underserved areas, has led other developed countries to promote the active recruitment of foreign physicians. In the US, for instance, Congress recently approved bills extending a J-1 visa waiver program facilitating the placement of foreign physicians in underserved communities by 2 years (Croasdale, 2004).

The difficulty with regard to structuring policy related to physician migration in both developing and developed countries is that there is no clear understanding of the extent of the phenomenon, the reasons why physicians migrate, the benefits and burdens associated with physician migration, and the effect of policies aimed at dealing with the situation. Most systematic studies and in-depth analyses related to physician migration were conducted before 1980 (Barnett, 1988; Dublin, 1972; Horn, 1977; Mejia, Pizurki, & Royston, 1979; Oslak & Caputo, 1973; Portes & Ross, 1976). Recent articles addressing this issue are almost exclusively editorials or viewpoints that base their conclusions on a scattered array of unconnected data, anecdotal evidence, or basic intuitions (Bateman, 2001; Bundred & Levitt, 2000; Hilary, 2002; Laurence, 2003; Pang, Lansang, & Haines, 2002; Patel, 2003; Stein, 2002). This is largely due to the limitations of current data sources, especially in sending countries, which tend to be poorer and have less reliable information on physician inflow and outflow (Stilwell et al., 2003). Until more systematic studies are conducted, discussions will continue to reflect ideology rather than evidence.

On a more positive note, there have been efforts of late to conduct more rigorous studies of physician migration and its consequences for sending and recipient countries. Recently, the World Medical Association created a committee to examine implications of physician recruitment from developing countries, and it is expected that the 2005 World Health Assembly will follow up the 2004 resolution by beginning to develop a code of practice (Nullis-Kapp, 2005) In the last few years, WHO has sponsored the creation of an online journal, *Human Resources for Health*, which has begun to publish articles that are helping to fill in the empirical and conceptual void surrounding this important issue.

This study complements the efforts of WHO in striving to broaden the base of systematically collected data on physician migration. It focuses on five countries: India, Pakistan, Nigeria, the Philippines, and Colombia, selected both for the high quantity of physicians they send to the US and elsewhere, as well as for their geographic diversity. Of the roughly 210,952 international medical graduates employed as physicians in the US, 19.5% were trained in India, by far the largest sender of physicians to the US. 19,449 Filipino-trained physicians currently work in the US, making the Philippines the second largest source of US foreign-trained physicians (American Medical Association). Roughly 40% of all sub-Saharan African physicians employed in the US were trained in Nigeria (Hagopian, Thompson, Fordyce, Johnson, & Hart, 2004). According to a database kept by the National Residency Matching Program (NRMP) of incoming residents in 2002, India, Pakistan and the Philippines exported the highest number of medical graduates to the US that year. Colombia was the largest sender from South America, and Nigeria sent more medical graduates to the US for residency than any other African country (NRMP, 2002).

Methods

We designed a questionnaire survey consisting of four parts dealing with: (1) the reasons why physicians choose to migrate abroad; (2) the characteristics of medical education that influence physician migration; (3) the impact of physician migration on the respondents' respective countries; and (4) policy options for dealing with physician migration. In the first section, respondents rated a series of potential motivating factors for physician migration on a five-point scale