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No. 45: Medical Recruits: the Temptation of South African Health Care Professionals

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Southern African Migration Programme

THE SOUTHERN AFRICAN MIGRATION PROJECT

MEDICAL RECRUITS: THE TEMPTATION OF SOUTH AFRICAN HEALTH CARE PROFESSIONALS

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Medical Recruits: The Temptation of South African Health Care Professionals

Christian M. Rogerson

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Southern African Migration Project
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EXECUTIVE SUMMARY

Health workers are one of the categories of skilled professionals most affected by globalization. Over the past decade, there has emerged a substantial body of research that tracks pattems of international migration of health personnel, assesses causes and consequences, and debates policy responses at global and national scales. Within this literature, the case of South Africa is attracting growing interest. For almost 15 years South Africa has been the target of a 'global raiding' of skilled professionals by several developed countries. How to deal with the consequences of the resultant outflow of health professionals is a core policy issue for the national government.

This paper aims to to examine policy debates and issues concerning the migration of skilled health professionals from the country and to furnish new insights on the recruitment patterns of skilled health personnel. The objectives of the paper are twofold:

- To provide an audit of the organization and patterns of recruitment of skilled professionals from South Africa in the health sector. The paper draws upon a detailed analysis of recruitment advertising appearing in the *South African Medical Journal* for the period 2000-2004 and of a series of interviews conducted with private recruiting enterprises.
- Based upon the above analysis and additional interviews with key stakeholders in the South African health sector, the paper offers a series of recommendations for addressing the problem of skilled health migration. These recommendations are grounded in both South African experience and an interrogation of international debates and 'good policy' practice for regulating recruitment.

The paper is organized into five sections. Section Two positions debates about the migration of skilled health professionals within a wider literature that discusses the intemational mobility of talent. Section Three reviews research on the global circulation of health professionals, focusing in particular upon debates relating to the experience of countries in the developing world. Section Four moves the focus from intemational to South African issues and provides new empirical material drawn from the survey of recruitment pattems and key interviews undertaken with health sector recruiters operating in South Africa. Section Five addresses the questions of changing policy interventions in South Africa towards the outflow of skilled health professionals and the recruitment of foreign health professionals to work in South Africa. The

final section provides a short conclusion and specific recommendations related to the recruitment industry.

The main policy issues at national and international levels in relation to the migration of skilled health professionals concern the monitoring, management, or regulation of such flows. Although several strategies have been put forward for national strategies and international co-operative measures to address the issue of skilled health migration, the realistic options available for most poor countries are limited. It has been argued, for example, that in order to manage migration effectively, it is necessary for governments and other agencies to develop a more strategic approach towards regulating the flow of health workers between countries. The international record shows that there are no 'off the shelf solutions' or universal panaceas and that each country has to develop its own strategy for dealing with the issue of migration in its own context. Nevertheless, the international policy consensus appears to be moving in the direction of national and global cooperation for the 'managed migration' of health professionals using bilateral agreements or international codes for recruitment.

The empirical research on recruitment points to the urgent need for such policy interventions in South Africa. Over the five-year period 2000-2004 a scan of recruitment advertisements appearing in the *South African Medical Journal* (SAMJ) records a total of 2522 recruitment initiatives for South African medical personnel. The numbers of advertisements appearing each year fluctuated from a low of 458 in 2004 to a peak of 646 in 2002; overall, the average number of advertisements was 504 per annum across the five-year study period. The advertisements varied from seeking applicants for specific positions available in particular countries to more general recruitment of personnel by international agencies for placement in either designated countries or for opportunities and placements across a range of international destinations. Moreover, the type of recruitment spanned the entire spectrum of medical personnel from general doctor to specialist.

The most critical set of findings relates to the international origins of the recruitment initiatives of South African medical personnel. In terms of individual countries, the analysis discloses that the greatest volume of recruiting across the study period was for appointments in the United Kingdom. Overall, a total of 35.5 percent of all advertising was for positions in the UK. The second and third most important recruiting countries were New Zealand and Australia, which represent 21.8 percent and 16.2 percent respectively of all recruitment. Canada occupies fourth position with a 12.4 percent share of all recruitment advertisement. As a whole, therefore, these four countries – the United Kingdom, New Zealand, Australia and Canada – account for 85.9 per-

cent of all recruitment advertising for South African medical personnel in the period 2000-2004.

Of significance is the changing ranking and share of countries in the total volume of recruitment advertising. In 2000, New Zealand was the leading source of recruitment advertising for South African medical personnel with 26 per cent of the total. By 2001, the United Kingdom had emerged as the most important destination for recruitment, a position it retained for the rest of the study period. In 2000 the United Kingdom was responsible for a 22.6 percent share of advertisements and by 2004 this had risen to 42.1 percent. By 2004 the numbers of recruitment advertisements for South African medical personnel to work in the United Kingdom matched the combined recruitment advertising from Australia, Canada and New Zealand.

The business of recruitment is dominated by UK-based enterprises such as Global Medics, Medacs Healthcare Services, Corinth Health Care or NES Healthcare UK. Significant players recruiting in South Africa outside the UK include Auckland Medical Bureau for New Zealand, AMAQ Services for Australia, and Northern Medical Services in Canada. Many of the large UK recruitment agencies are long-established and have been in operation for 25 years or more. Most offer placements in both the private sector and the National Health Service of the United Kingdom. From the analysis of the contact details provided on recruitment advertisements, it is evident that the largest share of advertising in the SAMJ is placed by overseas recruiters. In year 2004, for example, only 15 percent of recruitment advertisements for South African medical personnel included any local contact details. For 85 percent of recruitment the channel of communication was through e-mail or web contacts outside South Africa and overseas telephone/fax communication. This finding is of considerable policy relevance for it points to the weak position and limited room for manoeuvre of the South African government in dealing with the activities of the international recruitment industry. Indeed, looked at from an international industry perspective, the operations of the cluster of recruitment agencies in South Africa are minor players. Enterprises are small in size, often branch operations of UK-based operations, or represent independent niche operators.

From interviews with recruiters, several key policy points emerged.

- South Africa lacks adequate knowledge and data on the numbers of medical personnel leaving the country.
- The core of the recruitment industry is based outside South Africa and local enterprises emerge as only minor players in the global context.
- Recruiters are responding to a demand fuelled by shortcomings

in the existing wage and working conditions in the South African health care system.

- At least two different recruitment channels may be differentiated. The largest channel is that of young South African medical graduates seeking short-term appointments as locums or RMOs in the UK health system. The majority of such recruits probably return to South Africa after the close of their temporary contract appointments. A subsidiary channel is that of a permanent movement of more experienced medical personnel to appointments in New Zealand, Canada or Australia.
- In recent years there is evidence that the trend towards the recruitment of South African medical personnel for permanent appointments abroad has slowed and been replaced by temporary appointments.
- The major catalyst for temporary recruitment is that of the 'wage gradient', which is attracting medical personnel to the UK, the Middle East and other destinations (including recently for Iraq and Iran). For permanent migrants issues of long-term working prospects and family considerations are of importance.
- South African recruiters have identified potential sources of medical skills in several Asian countries, but have not been permitted to tap these pools of medical talent.

Overall, the study argues that 'competing for talent' is now recognized as an essential element of international competitiveness in the current world economy. In this regard a central role is played by private and public sector recruitment agencies in shaping the intemational mobility of talented or skilled individuals. South Africa's re-integration into the global economy in 1994 exposed the new democracy to the full forces of this new international competition for talent. The initial ad hoc policy responses were weak and failed entirely to comprehend the organizational dynamics and structures that shape the new global movements of professionals. In terms of the health sector, the country hemorrhaged an important segment of its most experienced medical personnel. Moreover, without the enactment of countervailing replacement strategies and of a national strategy for managing the country's human health resources, South Africa was vulnerable to the activities of 'global raiders'. There has recently been an important and welcome policy shift away from the early reactive *ad hoc* policy responses to the development by 2006 of a more comprehensive strategic response that seeks to manage the mobility of health professionals.

INTRODUCTION

In the early twenty-first century the international migration of highly skilled personnel has increased significantly as a consequence of factors related to globalization.[1] The directions of circulation of skilled personnel are multiple: South-North, South-South, North-North and North-South. Nevertheless, substantial differences in levels of development between rich and poor countries mean that the predominant flow of intemational migration movements is from South to North.[2] The gains and losses from the international migration of skilled personnel for receiving and sending countries critically depend on whether the flow of personnel is temporary or more permanent.[3]

Health workers are one of the categories of skilled professionals that have been most affected by globalization. In recent years there have been "very significant changes in the scale and consequences of professional health worker mobility."[4] Some have styled this as 'a global conveyor belt' of health personnel or a 'medical carousel', which channels skilled professionals from poor to rich countries.[5] The conveyor belt of medical personnel sees the recruitment of Canadian doctors for the USA, of British doctors to North America, and of health professionals from developing countries into the United Kingdom, Ireland, the European Union, the USA and Canada.[6] The major consequence is a serious depletion of the health workforce of the Caribbean, the South Pacific and sub-Saharan Africa. The medical "brain drain" has catalysed research and energized new policy debates that place a high priority on managing migration.[7]

As Bach argues: "The higher profile attached to human resource issues within the health sector and the specific challenges of addressing staff shortages whilst not exacerbating problems of brain drain has ensured that the issue of health worker migration has rapidly climbed the health policy agenda."[8] Accordingly, over the past decade, there has emerged a substantial body of research which tracks patterns of international migration of health personnel and its causes and consequences and debates policy responses at global and national scales.[9] A swathe of opinions and debates have been generated by the popularly styled 'great brain robbery' and resultant crisis in health services across much of the developing world.[10]

Within this emerging body of research and debates on the recruitment of skilled health personnel the case of South Africa is attracting growing interest. For almost 15 years South Africa has been the target of the 'global raiding' of the country's talent pool of skilled professionals.[11] The exodus of South African health personnel in the post-apartheid period has been highlighted in several studies.[12] Dealing with

the consequences of this bleed of health professionals has recently become a core policy issue for national government.[13]

The aim of this policy series paper is to provide new insight on the recruitment patterns of skilled health personnel from South Africa and to examine policy debates and issues concerning the migration of skilled health professionals from the country. More specifically, the objectives are twofold:

- To provide an audit of the organization and pattems of recruitment of skilled professionals from South Africa in the health sector. This task draws upon a detailed analysis of recruitment advertising appearing in the *South African Medical Journal* and of a series of interviews conducted with private recruiting enterprises;
- Based upon the above analysis and additional interviews with key stakeholders in the South African health sector, to offer a series of recommendations for addressing the problem of skilled health migration. These recommendations are grounded in both South African experience and an interrogation of international debates and 'good policy' practice for regulating recruitment.

The report is organized into five sections.

- Section Two positions the debates around the migration of skilled health professionals as a special case within a wider literature that discusses the international mobility of talent.
- Section Three reviews a body of international research specifically concerning the global circulation of health professionals, focusing in particular upon debates relating to the experience of countries in the developing world and policy interventions towards the migration of this category of talent.
- Section Four moves the focus from intemational to South African issues and provides new empirical material drawn from the survey of recruitment patterns and key interviews undertaken with health sector recruiters operating in South Africa.
- Section Five addresses the questions of changing policy interventions in South Africa towards the outflow of skilled health professionals and of the recruitment of foreign health professionals to work in South Africa.
- Section Six provides a short conclusion and specific recommendations related to the recruitment industry for health professionals.

THE INTERNATIONAL MOBILITY OF TALENT

During the last two decades, debates around skilled migration and human capital mobility have shifted from concerns about 'brain drain' to discussions about 'competing for global talent.'[14] Globalization and the advent of the 'knowledge economy' have radically shaped a new context for the migration of high skilled personnel.[15] Highly skilled migration thus represents an increasingly large share of contemporary global migration streams.

The expanded international circulation of talent is viewed as both a cause and product of greater economic independence and lower transportation costs.[16] Other key factors are the increasing globalization of firms and the internationalization of higher education. The emergence of international labour markets for well-educated and talented people is "an important part of the process of globalization and economic independence across countries and regions."[17]

Global talent has never been more mobile or in demand than at present. Many countries seek to compete for global talent, recognizing it as a key economic resource and source of creative power, and welcome foreign professionals in order to redress domestic skill shortages as well as to advance economic growth.[18] Overall, the international circulation of talent can have important development effects on source nations, on receiving countries and more generally on global economy and society.

The economic value of talent derives from its different uses. Talent can be variously a productive resource for current production, a source of wealth creation, a source of knowledge, or provider of a social service. Solimano develops a taxonomy of six different brands of talent according to occupational characteristics.[19]

- Technical talent in terms of people who are experts in information technology, telecommunications, engineering or computer science. This particular group of 'knowledge people' represents a human capital resource base for current production-related activities.
- Scientists and academics who constitute an important knowledge source for countries.
- Entrepreneurs and managers, an important group often overlooked in discussions of talent mobility. Migrant entrepreneurs and managers are significant agents for wealth creation.
- Qualified professionals, such as economists, engineers, heath or environmental specialists, who are recruited to assist multilateral and regional development banks, international organizations and development agencies at global, regional and national scales, constituting an 'international public sector.'

- Talented cultural workers, including musicians, artists and designers, who represent an important resource for the development of creative and cultural industries.
- Health professionals whose international circulation represents a specific form of talent outflow that is of considerable concern to developing countries.

A number of authors strongly maintain that there are distinctive features of the debates concerning the mobility of skilled health professionals, which set apart this category of 'knowledge people' as "a special case that requires different policy goals and interventions from the circulation of other professional occupations."[20] Akire and Chen make the case for 'medical exceptionalism' within the global circulation of talent.[21] Unlike many other services or production goods, health services usually require that health professionals be located in the same physical location as the patients. In other sectors, such as information technology (IT), more 'source' country employment has developed, the best example being that of business process outsourcing through call centres. Discussions of *brain circulation* (involving the return of talented people), or *brain exchange* (involving the exchange of highly skilled personnel between two countries), frequently draw on the experience of the IT industry. Unlike the mobility of health professionals, which negatively impacts upon the source country's capacity to provide essential health services, the migration of IT professionals does not undermine "an *existing* industry in the source country but reflects strong growth in demand for IT professionals overseas." The mobility of skilled health professionals is further distinctive "because it is influenced strongly by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals." Greater scope for policy intervention therefore exists for intervention in the migration of health professionals than in other sectors because of the centrality of government regulation in health sector work.[22]

THE INTERNATIONAL MIGRATION OF SKILLED HEALTH PROFESSIONALS

The migration of highly skilled health professionals from poor to rich countries is not a new phenomenon.[23] During the 1950s and 1960s many industrialized countries expanded their welfare states rapidly, triggering an increased intemational mobility of skilled health personnel. Colonial cultural ties, including language, were a core influence shaping the early international geography of flows of health professionals.[24]

Concerns about the international movement of health workers were expressed as far back as the mid-1960s at the Edinburgh Commonwealth Medical Conference. During the 1970s the WHO undertook the first pioneer research on the global stocks and flows of health professionals and identified India as the largest source country for doctors. Since the 1970s, the march of globalization and the development of free trade agreements have facilitated a new intensified wave of international migration of health personnel linked to reduced barriers to trade and mobility of services, products and people, including health professionals. Several developed countries – notably the UK, Australia, Canada and the USA – have become increasingly reliant on immigration and the international recruitment of personnel to cope with growing demands for health care services and domestic shortages of health personnel. The question of 'brain drain' of health professionals has re-emerged as an important issue for health research.[25] Across the international literature, common themes emerge relating to patterns and pathways of migration, causes, consequences and possible policy responses.

DATA SHORTCOMINGS

Many analysts bemoan the dearth of reliable quantitative and qualitative data upon which to base detailed analysis. Stilwell and colleagues at the WHO point out that despite growing concern about migration and its impacts upon the health systems of poor countries "there is no single source of data that can reflect the growing complexity of internal and international migration of health workers, taking into account trajectories/itineraries."[26] In addition, "data from countries that recruit or accept health professionals (destination countries) appear to be more reliable than data from the home countries of professionals who travel to work abroad (the source countries)."[27] This viewpoint is supported by Saravia and Miranda who argue that "countries that contribute human capital to the brain drain rarely record the characteristics of migrants", while receiving destinations often "maintain statistics on foreign-born nationals and immigrants through census data and national data bases on education and scientific and technological capacity."[28] The problem of inaccurate or unavailable information to monitor the migration of health professionals is particularly acute in sub-Saharan Africa.

A key policy conclusion is that the collection and establishment of reliable information on stocks and flows of health professionals remains a core challenge that inhibits effective migration management. Of particular concern is that little is known about whether intemational migrants return to their home countries. Indeed, "there is little systematic analysis or agreement about the degree to which health professional mobility represents a temporary or permanent phenomenon."[29]

SPATIAL FLOWS

Notwithstanding the weaknesses of data for tracking the international flows of health personnel, the broad contemporary spatial patterns and key source/destination countries of migrants are relatively clear. Since the WHO research conducted during the 1970s, several new regions and countries have appeared as sources for health professional recruiting. Among the most significant are the Caribbean, Egypt, sub-Saharan Africa, Cuba and the former Soviet Union. Further, in terms of the 'medical carousel', a number of developed countries are sources as well as key destinations for skilled health professional, in particular, Canada and the United Kingdom. The most important individual source is the Philippines, a country that has actively promoted labour migration through deliberate government policy. Overall, the Philippines has played a central role "in the political economy of migration and has figured prominently as a source country for nurses and to a lesser degree, physicians."[30] Although the volume of flows of health professionals out of sub-Saharan Africa is not as great as that from other parts of the world, the effects of this loss in particular countries have exacerbated a deepening health care crisis. This situation has focused international attention on the exodus of skilled health professionals from Africa, including South Africa.[31]

In terms of the key destinations, the USA is "the favoured destination for nurses and physicians seeking employment abroad and the US, with a rapidly growing and ageing population, a history of migration, and unrivalled levels of health expenditure, has proved to be a major destination for overseas trained health professionals."[32] The United Kingdom has maintained its historical role as a major destination country of doctors and nurses, including from within the European Union. Overall, global migration flows of health workers are "primarily demand led, with workforce shortages in some destination countries (such as the United States and United Kingdom in particular) triggering active overseas recruitment strategies."[33] An important new suite of destinations with rising demand for skilled health workers is the Gulf States, which recruit health professionals from all parts of the world, including Europe.

CAUSES OF HEALTH PROFESSIONAL MIGRATION

At one level, "the reason for the 'conveyor belt' is breathtaking in its simplicity. Richer countries and health systems pay better salaries."[34] The significance of wage differentials in accounting for the South-North movement of health care professionals cannot be over-emphasized. Nevertheless, complex forces shape the international mobility of health professionals.

A range of different factors have been aired in international research, much of which analyses flows in terms of 'push' and 'pull' forces. Push factors focus on issues of pay, working conditions, and broad management and governance factors that galvanize health professionals to exit their own health systems and migrate from their country. By contrast pull factors that tend to catalyse movement relate to shortages and active recruitment from high-income countries. In the case of Africa, Dovlo and Martineau view the migration decision as linked to the emergence between source and destination of "gradients" of six sets of factors.

- Income or remuneration gradient: the differential in salaries and living conditions between home and the destination country.
- Job satisfaction gradient: perceptions of good working conditions or environment and utilization of one's skills to the best technical and professional ability.
- Organizational environment/career opportunity gradient: differences in opportunities for career advancement and specialization and a well-managed health system.
- Governance gradient: differences in administrative bureaucracy, efficiency and faimess with which broader governmental services are managed.
- Protection and risk gradient: differences in the perception of risk (especially from HIV/AIDS in Africa and the lack of protective equipment) compared to that in recipient countries.
- Social security and benefits gradient: health professionals are concerned about their security after retirement.[35]

The significance of social networks as an influence upon migration flows also cannot be overlooked. These networks are drawn upon by newly-arrived migrants in destination countries and reduce the costs and risks associated with migration. Thus, "once migration pathways are established this will stimulate further migration" of skilled health professionals.[36]

With the growth in significance of demand-led migration in recent years, the dominant dynamic has been the 'pull' of targeted international recruitment, a factor that some researchers describe more strongly as 'predatory' or 'grab factors.'[37] Richards goes so far as to argue that the problem of medical migration "is not so much a drain as a positive suction on the part of many developed countries."[38] The WHO differentiates four models of recruitment agency involvement in relation to the international movement of nurses:

- An agency-provided recruitment model in which the agency actively recruits nurses on their own behalf for placement in other countries.

- An agency-led recruitment model in which the employer appoints an agency to identify a source country and in which the agency takes the lead on recruitment, selection and placement with some input from the employer.
- An agency-facilitated recruitment model in which the employer works in active partnership with the agency to identify a source country and the employer is directly involved in selection processes facilitated by the agency.
- An employer-led recruitment model in which the employer uses its own resources to identify a source country, select, recruit and place health personnel as well as deal with registration or permit issues.[39]

In general, "the opportunity for health professionals to be more mobile has been facilitated by the growth of more formalized channels of recruitment, with increased awareness of the role of commercial recruitment agencies and an increasingly important role for the internet."[40] The importance of the internet in facilitating recruitment also cannot be under-estimated. Schrecker and Labonte point to "the simple awareness of opportunities that comes from routine interaction with professional colleagues, in a world where information is often just a mouse-click away."[41]

POLICY RESPONSES

The main policy issues at national and international levels in relation to the migration of skilled health professionals relate to issues of monitoring, intervention, management and regulation of flows. Although several strategies have been suggested for national strategies and international co-operative measures to address the issue of skilled health migration, the real options available for most poor countries are more limited. The WHO is still optimistic that appropriate and concerted government strategies "can influence a country's ability to retain health workers."[42] As a starting-point "it is necessary for governments and other agencies to develop a more strategic approach towards regulating the flow of health workers between countries."[43] Moreover, "each country has to develop its own strategy for dealing with the issue of migration in its own context."[44]

Good human resource planning is a first step in the establishment and maintenance of appropriate information systems, including a data base on migration.[45] The WHO recommends that source countries should "establish and maintain appropriate information systems on human resources, including a database on migration in order to provide evidence for policy, planning and day-to-day decision-making and to monitor the effect of any intervention programme implemented."[46]

Issues of financial and non-financial incentives are high on the agenda of retention strategies. Bach emphasizes the legacy of under-investment in health services in many source countries in terms of low wages, poor working conditions, low job satisfaction, a lack of leadership and few incentives for health workers.[47] However, many source countries have limited scope to manoeuvre because of severe fiscal constraints. In some countries, "targeted incentives may be a more realistic possibility, particularly if traditional donor rules (that do not support recurrent health sector costs, such as wages) can be relaxed in the face of the crisis in human resources."[48]

The lessons of a group of newly-industrialized countries, including Korea, Singapore and India, that have been successful in retaining their health professionals or encouraging them to return has been that "domestic innovation and research and development programmes have been a common denominator." These examples underscore the finding that "when real opportunity exists within the context of coherent internal policies and investment in science and technology, returning to the home country becomes an attractive option for emigrants."[49] Policies of return have been most effective in economies that are experiencing a period of high growth and expansion of innovation in medical systems.

Retention strategies for several less affluent countries have moved beyond positive incentives in a different direction to include the introduction of financial penalties designed to deter health professionals from leaving. Bonding schemes for health professionals to work for set periods after training or South Africa's community service requirement are an example. These schemes have been the subject of much criticism. In the case of South Africa's community service programme, Ncayiyana argues that: "Young doctors doing their obligatory community service in far-flung rural hospitals under highly stressful conditions, with poor infrastructure and without proper supervision, are likely to be forever immunized against working in such hospitals in the future, and therefore choose to practice in the private sector or emigrate overseas."[50] Overall, in the absence of widespread legitimacy, they encourage evasion strategies as well as often being difficult to enforce.

Other proposed interventions include altering the curriculum to make Africa-trained doctors less attractive to industrialized countries and reducing the length of training period required for medical personnel with the dual objective of speeding entry into the workforce and deterring out-migration.[51] By reducing the attractiveness of health professionals from source countries to international recruiters, limits are theoretically placed on the transferability of skills, an option that has met with considerable hostility from health professionals.

The international policy consensus appears to be moving in the

direction of national and global cooperation for the 'managed migration' of health professionals:[52]

> *With increased recognition that international mobility of health professionals is an inescapable feature of the health sector, policy responses have shifted from a reactive approach that focuses on stemming migration, towards a more ambitious and active agenda of managed migration. The aim is to regulate the flows of health professionals to benefit source and destination countries.*[53]

At the heart of managed migration is the establishment of ethical codes of practice and recruitment guidelines that aim to influence and shape the international recruitment of health professionals. Another variant is the negotiation of bilateral agreements between particular countries.

Ethical codes of conduct and recruitment, such as the 2002 Melbourne Manifesto, are currently being developed and advocated.[54] The most prominent international example is still the Commonwealth Code of Practice.[55] In addition, at the national level, the UK government has moved to regulate international recruitment for the National Health Service in a series of measures. In 1999 the UK Department of Health issued guidelines that required NHS employers not to actively recruit from South Africa or the Caribbean. In 2001 the code of practice was extended with the mandate that NHS Trusts should not target recruitment at developing countries unless the Department of Health had a formal agreement with that country.[56] In 2004 a further strengthening of the Code of Practice was issued.[57]

The experience with these voluntary codes of practice is that their impact has been transitory at best. As the WHO observes, "it is difficult to know how they can be implemented when they have no legal status."[58] The code of practice issued by the UK Department of Health, for example, had a number of loopholes that could be readily exploited; the code did not apply to the private sector, to recruitment agencies or to the engagement of temporary staff. Moreover, the code applied only to the active recruitment by NHS Trusts and did not encompass individual health professionals who on an individual basis might be "considered for employment."[59] As a whole, a major limitation on the effectiveness of these codes relates to the lack of regulation or application to the private sector. In seeking to move from a situation of 'voluntary compliance' by recruitment agencies the 2004 Code went further by requiring that NHS Trusts use only recruitment agencies that fully complied with the code.

Source countries have increasingly called for reparations to be built into agreements. The strengthened Commonwealth Code of Practice

incorporates claims for the compensation of source countries for the costs of training emigrant health personnel. This measure alienated key stakeholders. Indeed, the proposal for compensation "proved a step too far for Australia, Canada and the UK", who declined to sign up to this Code of Practice.[60]

Bilateral agreements between countries often focus on creating short-term opportunities for health workers to work overseas for limited periods.[61] Sometimes these bilateral agreements extend into co-operation frameworks for the strengthening of national health care systems. Compared to ethical codes of practice and recruitment there are two key advantages of bilateral agreements. First, they reduce the need for and power of commercial recruitment agencies and ensure a more predictable and transparent process for both parties. Second, the bilateral agreement is a flexible tool that can incorporate a variety of provisions including best practice guidelines for training.

Finally, in terms of re-shaping the international migration of health personnel, attention is drawn to the impact of the General Agreement on Trade in Services, which represents a set of legally enforceable rules that govern trade in services.[62] The GATS is an agreement of the World Trade Organisation (WTO), emerging in 1994 out of eight years of negotiations as part of the Uruguay Round trade negotiations that transformed the General Agreement on Trade and Tariffs (GATT) into the WTO. Under GATS, government measures affecting international commerce in services, including health services, are regulated and restricted.[63] Mode 4 of GATS affects the movement of health professionals and focuses in particular on reducing barriers to the temporary movement of "natural persons" or the provision of health services by individuals from another country on a temporary basis. The impact of GATS on health care and migration is uncertain and potentially controversial. Some observers anticipate that it will facilitate further "emigration of health workers from the poorest countries who can not afford remuneration levels likely to retain them."[64]

THE RECRUITMENT OF SOUTH AFRICAN HEALTH PROFESSIONALS

South Africa is "bleeding skilled personnel at an accelerating rate."[65] Since the emergence of South Africa's new democracy, issues of 'brain drain' have been a focus of SAMP research.[66] Official data undercount the rate of skills migration by up to two-thirds. In particular, the migration of skilled professionals from South Africa to the "big five" of the USA, UK, Australia, Canada and New Zealand has been seriously under-estimated.

AN EMERGING POLICY ISSUE

The migration of skilled health professionals from South Africa is emerging as a matter of particular policy concern. Research on the international migration of skilled health professionals continues to highlight South Africa as a leading source country for medical personnel for the USA, Canada, the UK, Australia and New Zealand.[67] Nevertheless, accurate information on the extent of migration is admitted officially to be "hard to come by and invariably controversial."[68] In a recent speech the editor of the *SAMJ* stated that on the question of the numbers of doctors that leave South Africa "no one knows exactly how many do so."[69]

Table 1: Numbers of South African Born Workers Practicing a Medical Profession in select OECD countries, 2001

	Practitioners	Nurses/Midwives	Other Health Professionals	TOTAL
Australia	1114	1085	1297	3496
Canada	1345	330	685	2360
New Zealand	555	423	618	1596
United Kingdom	3625	2923	2451	8999
United States	2282	2083	2591	6956
TOTAL	8921	6844	7642	23 407

Source: Department of Health RSA, 2006, p. 48 based upon OECD.

Table 1 shows that in 2001 the largest number of South African-born health professionals were in the United Kingdom followed by the United States. This ranking holds for practitioners, which includes doctors, dentists, veterinarians, pharmacists and other diagnostic practitioners, and the category of nurses/midwives. Under the category of 'other health professionals', which includes assistants, the United States is the leading destination followed by the United Kingdom. The South African government observes that 11 332 doctors and 41 617 nurses were working in the public sector in South Africa in 2001 and concludes that "the above figures are very considerable and worrying, all the more since indications are that the trend is escalating."[70] Overall, the data used in the Department of Health Report appear to be 'best current estimates' of the extent of the medical health exodus.

In addition to the flow of permanent skilled migration of health personnel, there is mounting evidence of temporary losses as South African health personnel are recruited for work overseas on fixed contracts. As Stern argues, "conditions in the South African private sector support

exports of health services."[71] In respect of the export of health services and the temporary loss of health professionals, South African hospital groups have recently won major tenders to provide staff and services to the UK National Health Service (NHS). In particular, the Netcare Group, South Africa's largest hospital group listed on the Johannesburg Stock Exchange, aspires to become "a global integrated healthcare organization."[72] Since 2003 this company has been involved as a preferred bidder in a number of partnerships with the UK Department of Health.

This partnership has involved a five-year contract to perform 44 500 cataract operations for the NHS via mobile services and the opening in Manchester in May 2005 of a 45 bed, three theatre facility for performing 44 800 orthopaedic and general surgical procedures. Other contracts have been secured with the Southport and Ormskirk NHS Trust for performing 300 hip and knee replacement operations and with the Portsmouth Hospital NHS Trust for 1000 surgical procedures on hands, shoulders, hips, knees and feet. As Stern emphasizes, "In terms of these contracts Netcare sends teams of medical personnel from South Africa for fixed and short-term periods in the United Kingdom" and in terms of retaining skilled staff in South Africa "these personnel are then prohibited from employment with the NHS for a period of two years."[73]

In accounting for the permanent exodus of health personnel, the South African Department of Health focuses upon the 'push' and 'pull' factors that affect brain drain. Pull factors that are highlighted include "better wages, easier working conditions and opportunities for professional advancement in foreign countries." Push factors, seen as driving personnel out of the country, encompass "lack of management and support, work overload, poor working conditions, lack of appropriate skills and emotional burnout." In addition, the report mentions "high crime rates and uncertainties about the future."[74]

What has been ignored so far in official analyses and interpretations of the causes of the migration of skilled health professionals from the country is the role played by organized recruiters as part of wider international recruitment operations that "target the skill base of developing countries like South Africa".[75] Nevertheless, the new global marketplace for talent "facilitates aggressive transnational recruiting by both governments and the private sector."[76] In order to seek to probe this neglected aspect of the loss of skilled health professionals from South Africa, research was conducted during 2005-2006 on the activities of recruitment agencies involved in encouraging or facilitating local health professionals to step on the 'global conveyor belt.'

RESEARCH METHODOLOGY

The research on recruitment of South African health personnel involved two major components.

- The first, and largest, component of the investigation involved a five-year audit, covering the period 2000-2004, of all advertisements placed in the South African Medical Journal (SAMJ) for the international recruitment of medical personnel. As the SAMJ is a critical channel for recruitment activities of medical practitioners, the core focus of the investigation was narrowed to exclude the recruitment of nurses. The SAMJ is published on a monthly basis and the study involved analysis of a total of 60 issues of the joumal over the five-year study period. For each recruitment advertisement, information was extracted, inter alia, about the recruitment agency, positions advertised, where available, contact details and the nature of the advertising. The five-year data base allowed an analysis of the changing pattems of international recruiting initiatives for South African medical personnel.
- The second component of the research involved a set of focused key informant interviews concerning the organization of medical recruitment in South Africa. Interviews were sought initially with recruitment agencies with active operations in South Africa. Many recruiters of medical personnel were reluctant to speak openly of their activities and refused to be interviewed. Nevertheless, focused interviews on recruitment were secured with representatives of five different recruiters. The rich information obtained through these interviews was supplemented by a search of corporate websites. Finally, two additional focused interviews were conducted with the editor of the SAMJ and the Deputy Director General for Human Resources in South Africa's Department of Health. Issues of the impact and policy response to recruitment activities formed the focus of these interviews.

RECRUITING SOUTH AFRICAN MEDICAL PERSONNEL

Over the five-year period 2000-2004, the scan of the SAMJ yielded a total of 2522 recruitment advertisements for South African medical personnel. The numbers of advertisements appearing each year was relatively consistent, except for 2002 when 646 advertisements appeared (Table 2). Many of the advertisements were repeated for a period of several months and, in the case of the global recruiters, appeared on an almost monthly basis.

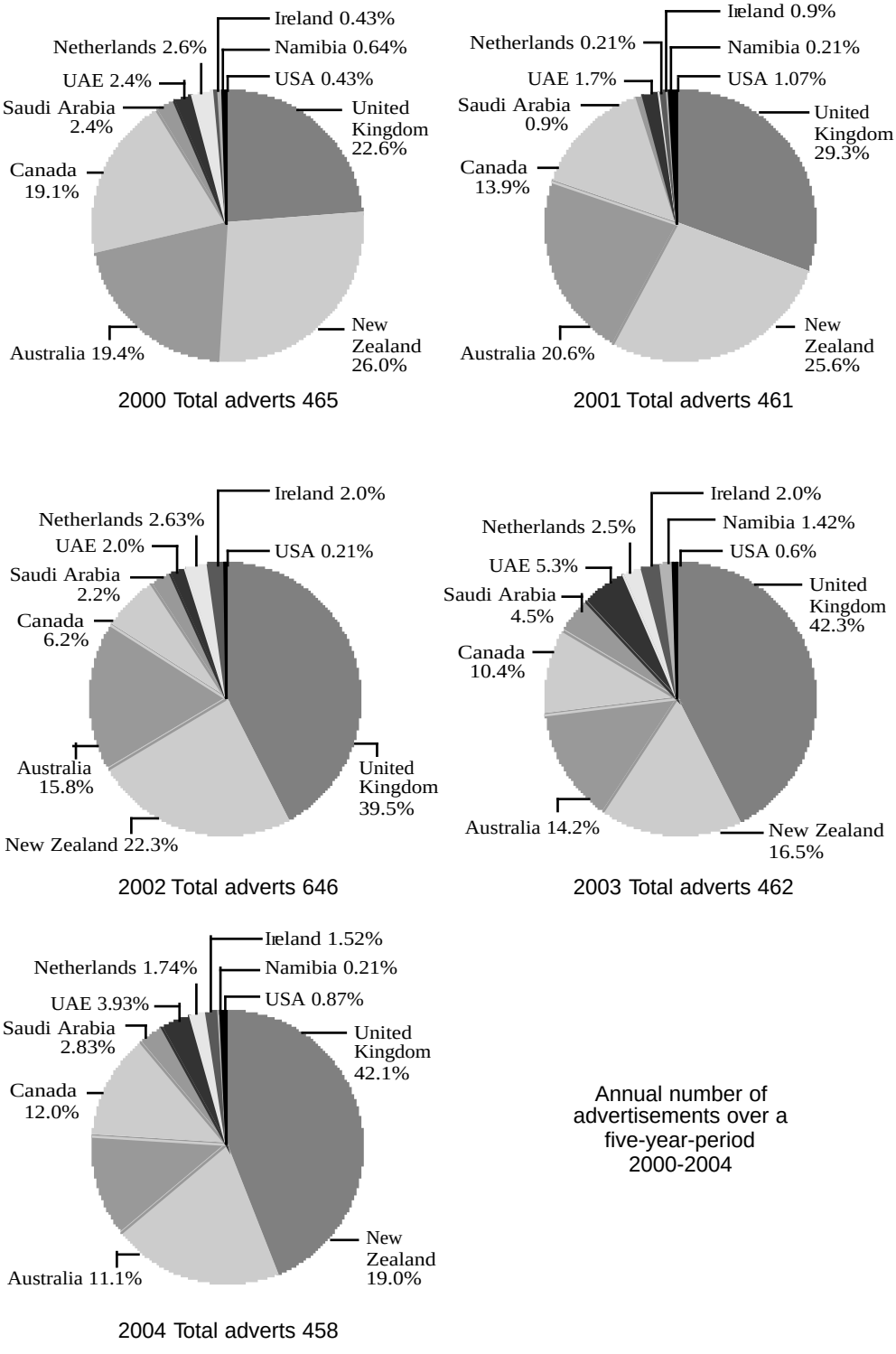
Table 2: Recruitment Advertisements by Year, 2000-2004			
	No. of Advertisements	% of Total	Monthly Average
2000	465	18.2	39
2001	461	18.3	38
2002	646	25.6	54
2003	492	19.5	41
2004	458	18.2	42
Total	2522	100.0	42

The recruitment advertisements targeted (a) applicants for specific positions available in particular countries; (b) general recruitment of personnel by international agencies for placement in designated countries; and (c) general recruitment agencies listing for placements across a range of international destinations. The vast majority of advertisements are for specified individual country destinations; a small share of advertising (3%) is for multi-destinations or geographical regions, such as the Middle East or Europe. The type of recruitment spanned the entire spectrum of medical personnel from general doctor to specialist. For example, in 2004, recruiters were seeking South African personnel for positions including general practitioners, ward doctors, consultants, radiologists, plastic surgeons, anaesthetists, geriatric specialists, rehabilitation specialists, pathologists, dermatologists, cardiologists, oncologists, orthopaedic consultants, trauma specialists, hip specialists, anatomical pathologists, neurosurgeons and urologists. The largest number of individual advertisements is for general practitioners, RMOs (Resident Medical Officer) or "doctors of all grades."

Table 3: Numbers of Recruitment Advertisements by Size and Year			
	Full Page	Half Page	Small Insert
2000	21 (4.5 %)	77 (16.6 %)	367 (78.9 %)
2001	28 (6.0 %)	91 (19.7%)	342 (74.2%)
2002	80 (12.3 %)	130 (20.1%)	436 (67.5%)
2003	76 (15.4%)	67 (13.6%)	349 (70.9%)
2004	75 (16.4%)	70 (15.3%)	313 (68.3%)
TOTAL	280 (11.1%)	435 (17.2%)	1807 (71.6%)

Table 3 shows that the majority of advertisements are less than a half-page insert in size. From 2002, however, there has been a marked trend towards the placement of larger recruitment advertisements of half-page or full-page size. Overall, 28.3 percent of the recruitment advertisements were of a half-page or full-page size in the SAMJ across the study period.

Figure 1: The Geography of Recruiter Advertising 2000-2004



Annual number of advertisements over a five-year-period 2000-2004

The most critical findings relate to the advertised international destinations for South African medical personnel. Figure 1 shows the overall geographical pattern of recruitment. The greatest volume of recruiting was clearly for South African medical personnel to take up appointments in the United Kingdom. Overall, a total of 35.5% of all advertising was for positions in the United Kingdom. The second and third most important recruitment destinations were New Zealand (21.8%) and Australia (16.2%). Canada occupies fourth position with a 12.4% share. As a whole, therefore, these four countries – the United Kingdom, New Zealand, Australia and Canada – account for 85.9% of all recruitment advertising for South African medical personnel in the period 2000-2004.

In terms of the existing patterns of practice of South African-born medical personnel (Table 1), what is missing is any significant element of direct recruitment from the fifth member of the 'big five', namely the USA. Indeed, the USA, with a total of only 15 advertisements, ranks tenth on the listing of individual countries. The reasons for this are not altogether clear since the USA is one of the major destinations for South African physicians and specialists. Clearly, South African health professionals learn about job opportunities in the USA through other channels. Personal contacts with health professionals already in the USA are likely to play a significant role. Web advertising may also be important. Many African-trained physicians also enter the USA through residency programmes.[77] Information about residency opportunities in the USA is obtained from other sources.

More significant than the USA are Middle East destinations, in particular Saudi Arabia and the United Arab Emirates, the Netherlands and Ireland in Europe, and Namibia, the only African destination of any note. Minor recruiting destinations included Bahrain, Qatar, Oman, Belgium and Nigeria. Finally, isolated advertisements appeared for work in the following destinations: Bermuda, Botswana, China, India, Kuwait, Lesotho, Mozambique, Russia, Swaziland, Vietnam and Zambia.

Figure 2 shows the numbers of advertisements placed on an annual basis for the leading ten individual country destinations and Figure 3 indicates the share of advertising accounted for by particular countries for each of the years covered in the study. In any individual year the peak volume of advertising is that recorded for the UK. In common with the UK, the largest volume of recruitment advertising from both Australia and New Zealand appears in 2002. For Canada the peak year is 2000.

Figure 2: Number of Recruitment Advertisements By Leading Destination Countries 2000-2004

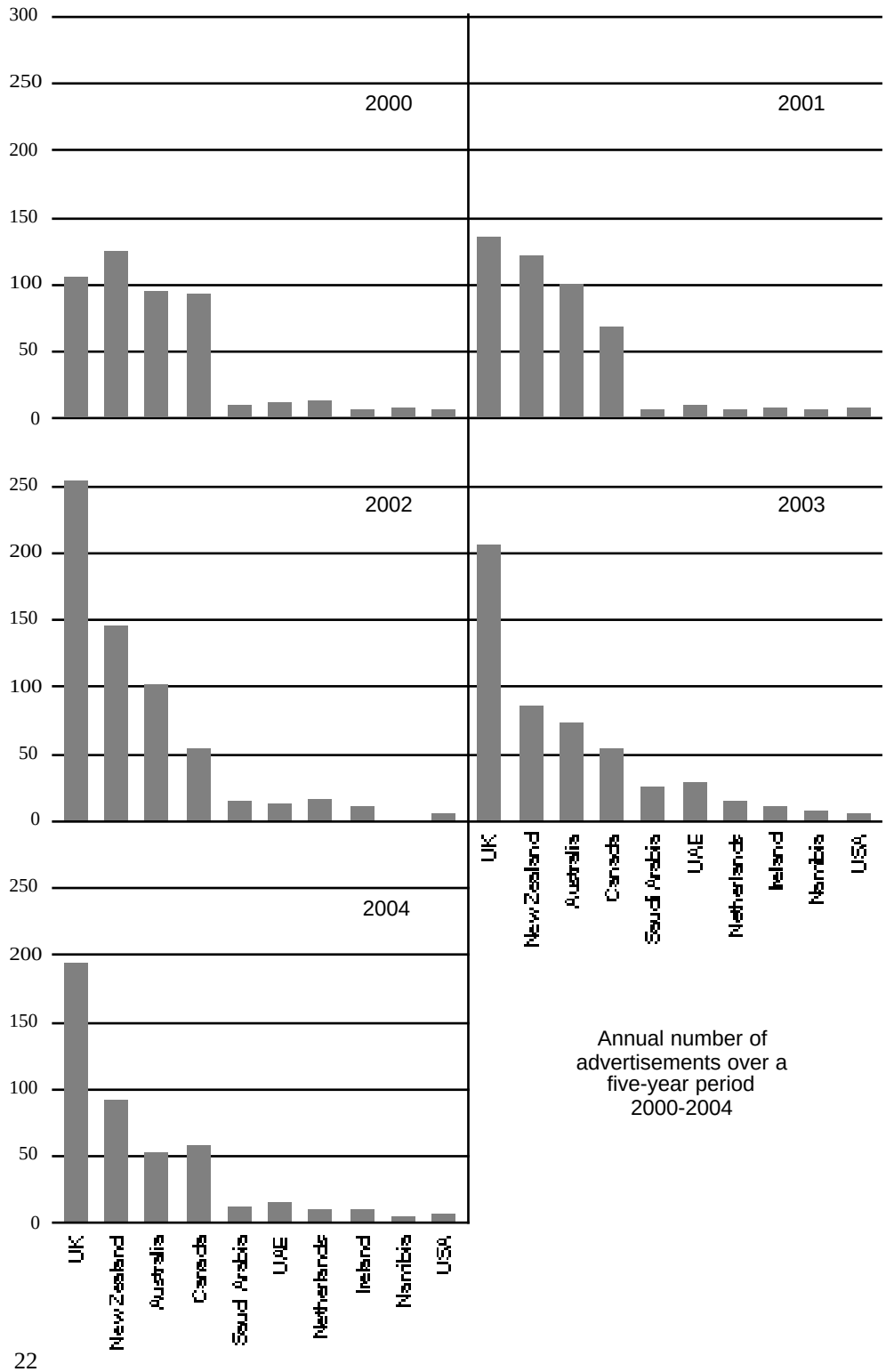


Figure 3: Share of Countries in Recruitment Advertising 2000-2004

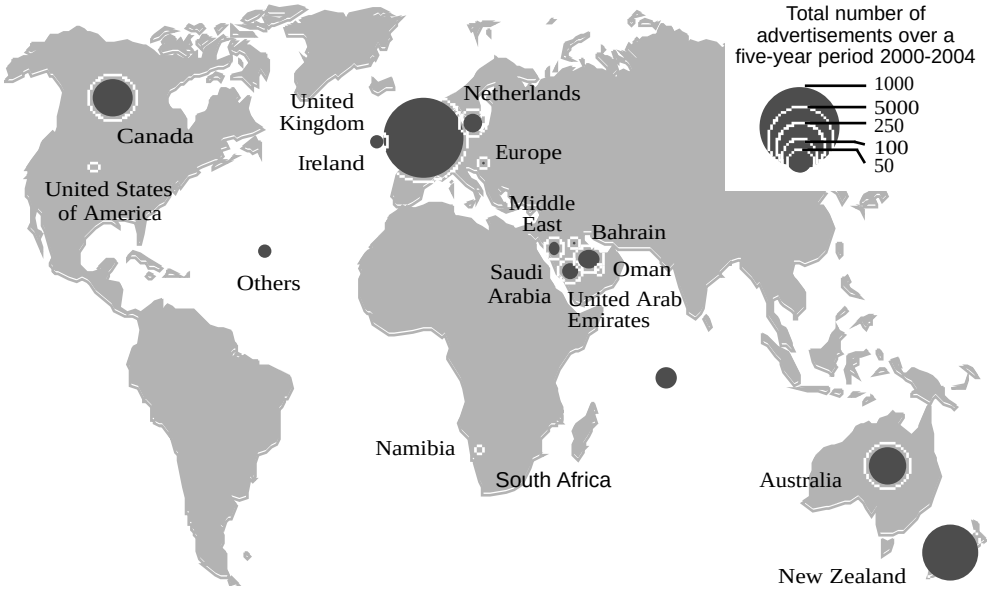


Table 4: Share of Recruitment Advertisements by Leading Country and Year					
	2000	2001	2002	2003	2004
United Kingdom	22.6	29.3	39.5	42.3	42.1
New Zealand	26.0	25.6	22.3	16.5	19.0
Australia	19.4	20.6	15.8	14.2	11.1
Canada	19.1	13.9	8.2	10.4	12.0
Rest of World	12.9	11.6	14.2	16.6	15.8

Of significance is the changing share of countries in the total volume of recruitment advertising (Table 4). In 2000 New Zealand was the leading source for recruitment advertising with 26% of the total, followed by the UK (22.6%), Australia (19.4%) and Canada (19.1%). From 2001 the UK was the most important destination for recruitment. By 2000, over 40% of advertisements were for the UK. By 2004, the number of advertisements for South African medical personnel to work in the United Kingdom matched the combined total from Australia, Canada and New Zealand. Canada became the third most significant source for recruitment advertising in 2004, in large part due to a marked cutback in advertising for Australia.

Table 5: Full Page Recruitment Advertising by Country/Region and Year						
	2000	2001	2002	2003	2004	TOTAL
United Kingdom	6	23	64	62	70	225
New Zealand	9	4	8	2	2	25
Australia	3	0	7	0	0	10
Canada	0	0	0	5	1	6
Ireland	1	1	1	0	1	4
Europe	0	0	0	3	0	3
Namibia	2	0	0	0	0	2
Netherlands	0	0	0	2	0	2
Saudi Arabia	0	0	0	1	1	2
Middle East	0	0	0	1	0	1

Table 5 focuses only on the destinations in full-page advertisements during the period 2000-2004. Of the overall total of 278, 80.4% were for work in the UK. This analysis underscores, once again, the overwhelming dominance of recruitment initiatives for South African skilled health professionals to work in the UK.

THE RECRUITMENT BUSINESS

The business of recruitment is dominated by UK-based enterprises such as Global Medics, Medacs Healthcare Services, Corinth Health Care and NES Healthcare UK. Significant non-UK players recruiting in South Africa include Auckland Medical Bureau for New Zealand, AMAQ Services for Australia and Northern Medical Services in Canada. Many of the large UK recruitment agencies are long-established and have been in operation for 25 years or more. Some agencies deal only in placements in the UK but others, such as Medacs or Corinth, also advertise placements or opportunities in other parts of the world. Most offer placements in both the private sector and the National Health Service of the United Kingdom.

The advertising targeted at South African medical professionals typically offers "fantastic opportunities", "better lifestyles" and "great rates" of remuneration as well as, in one case, an assurance that "we will not mess you about, we have genuine positions." Assistance and advice is offered to recruited personnel about work placement; welcome and greeting on arrival; opening a bank account; mobile phones and answers to such questions as "What do I do regarding meals, washing and ironing?" The advertising mantra for one international recruiter conveys the message "With you every step of the way."[78] One of the most striking themes of recruitment advertising is place promotion and imaging.

Australian advertising emphasizes the lure of "the Tropical lifestyle in Queensland." In New Zealand, South Africans are drawn by "great fishing, great fun" or attracted by "a breath of fresh air..sea..country..or both. You'll find it New Zealand." One opportunity in the Bay of Plenty was advertised as "Looking for a great lifestyle at the beach?...And a working challenge? Then come to New Zealand." Another New Zealand placement stated: "Kia Ora! Sail the Bay of Islands, hike the Milford Track or ski a volcano." An opportunity in rural British Columbia, Canada was "located on beautiful Stuart Lake with excellent outdoor amenities, including ski hill and golf course." Other Canadian advertisements sought to assure potential applicants that "Saskatchewan is a wonderful place to live, raise a family and enjoy life!!" Likewise, Peace Country, Grande Prairie, Alberta was "a great place to raise a family and practice general medicine." In the United Kingdom applicants for positions in Poole were assured simply that it "is a beautiful place." Conscious of the global market for medical personnel, recruiters seek to offer comparative benchmarks for potential recruitment: "Forget the hassle with the GMC for registration – hop on a plane to Ozz where your South African qualifications and experience will be appreciated. Forget the rain and fog of the UK – go in leaps and bounds to the sunshine."

From the contact details provided on recruitment advertisements, it is evident that the largest share of advertising is placed by overseas recruiters. In 2004, for example, only 15% of advertisements included any local contact details, either in terms of an individual, a local telephone, fax or e-mail contact. For the remainder the channel of communication was through e-mail or web contacts outside South Africa and overseas telephone/fax communication. This finding is of considerable policy relevance for it points to the weak position and limited room to manoeuvre by the South African govemment in dealing with the activities of the international recruitment industry.

SOUTH AFRICAN PERSPECTIVES

Looked at from an international industry perspective, the operations of the cluster of recruitment agencies within South Africa are minor. Enterprises are small in size, often branch operations of UK-based operations, or represent independent niche operators. Some of the most prominent locally-based recruiting agencies are Elite Locums, The Locum Agency, RS Locums, Global Medics, Thomhill Recruiting, and Workforce Worldwide. Global Medics, the branch of the UK-based enterprises, is a more significant player as it operates offices in a number of South African cities. Examples of small niche operators include the Singapore-based Global Medical Services, which focuses on remote

emergency assistance in Africa, Medical Place, a home-based agency in Sandton, and Canada Calls, which, as the name suggests, is dedicated to recruiting South African medical personnel for work in Canada. Many members of this locally-based group of recruitment enterprises were established in the post-apartheid era. For example, RS Locums, based in Cape Town, was founded in 1996 and seeks to assist health care professionals "to achieve their dreams of working in the UK."[79] Some enterprises, such as Elite Locums, deal with both local as well as international placements of medical personnel. Most agencies, however, specialize in the overseas placement of South African health professionals. In certain instances, the entrepreneur who established the recruitment agency is a qualified doctor.

Interviews undertaken with these recruitment agencies cannot claim to be representative of the views of the entire South African medical recruitment industry. Nevertheless, they do offer powerful statements, perspectives and a fresh 'insider' insight into an industry about which little is known. Issues raised in the interviews focused around several central themes: doing business as a recruiter; recent trends and causes of migration; and addressing the policy challenge of the migration of health professionals from South Africa. The next section provides a selection of revealing statements made by the interviewees and allows them to 'speak' from a practitioner perspective to the key issues concerning the migration of health professionals from South Africa.[80]

ON DOING BUSINESS AS A RECRUITER

It is a small business that I run from home. It really consists only of me. It is a South African based company that finds placements for South African doctors overseas. It is a unique service that I place specialist doctors in the UK. I match specialist doctors with hospitals that are looking for a specialist. I usually get contacted by people after they see our advert in the SAMJ or in The Star. Many people hear about the company through word of mouth. I approach some specialists directly and ask if they would like to work in the UK. I find very few problems from this side. There are no laws and regulations.

Global Medics is a UK based company, which has offices in South Africa. There are over 140 companies recruiting doctors worldwide in the UK at the moment. Many of them have South African doctors on their books. We source the positions in the UK and then go through our database to match the job with the right person. The company specializes in transferring health care

skills to the UK. The appointments are on a short to medium term basis.

The company that I run with a colleague is based in Canada and has been running for the past ten years. Both partners are originally from South Africa and we specialize in placing South African health professionals in Canada. We advertise certain positions but usually we ask people to submit their CV and we try to fit with them specifically. We advertise in the SAMJ and call for people to submit their CVs. These are screened and we source a position for that person, as an agent for them. We access the positions in Canada either directly or through an overseas recruitment company.

The company based abroad specializes in recruiting all kinds of professionals. A large proportion of the recruitments are doctors. We advertise globally. There are always adverts in the SAMJ from places like Australia and New Zealand looking for South African graduates. We advertise in South Africa for doctors because they are highly regarded. We have a data base of doctors on our system. We then offer a doctor a contract if they fit the profile and if the job is suitable. They are not always suited.

There are so many people that are looking to leave. There are other companies that we compete with but there is enough work so there is not much competition.

TRENDS AND CAUSES OF MIGRATION

Most of the doctors that are leaving are younger doctors, looking overseas for experience. They are looking to make some money overseas and most of them return to South Africa, especially those that go to the UK. There are others that I send to New Zealand, but they tend to be more permanent and a bit older.

When they go overseas it is almost entirely in the public sector. They make money and open a private practice when they return. The ratio is strongly in favour of recent graduates but they often return after a short stay. Some do repeat the locum but this is uncommon. From my experience the market is definitely quieting down. There are many people who want to do temporary locums to make money, but there are not so many people leaving permanently. The permanent placements are less

popular. People are looking to make some money and return. The biggest problem that I have is that there are not enough specialists that want to go overseas.

The positions in Canada are usually long term or permanent but we have started finding placements in the UK and Ireland which are often not so long term. We send many younger doctors to the UK to work for a short period, to make money to bring back to South Africa. It is older people who go to Canada usually. Since 2000 there has been a steady stream that includes younger professionals leaving the country to live in Canada or the UK. It is not always a case of simply money, although some are keen to go for a short period and make a lot of money. For those that emigrate there are considerations of their families, their schooling and their future prospects. Some doctors think that Canada holds a better future for them. About 50 percent of the doctors that leave are black doctors. Many of them also do not want to come back. So it is not a question of race. The Canadian health system is so good that there is ample opportunity to practice as a doctor.

There is a shortage of doctors in the UK but they are reluctant to poach from poor countries. At the moment the South African companies that are recruiting South Africans to the UK are only allowed to do so for temporary jobs and locums. But people will go to earn money. The exchange rate is a big factor. Nowadays there is more money to be made in other places. The other day I sent a doctor to Mali on behalf of Anglo-Gold. These jobs pay in dollars.

Why do people want to leave the country and work abroad? Recently qualified doctors go to the UK end up working as RMOs [Resident Medical Officer] for six months or more. It's not very stimulating work for them. But it is an opportunity to earn some money. Most of them bring that money back to pay their study loans and maybe start a practice.

There was a noticeable exodus of medical professionals in the late 1990s. After 2003 it became more difficult to get into the UK. South African graduates now have to write some exams in the UK and this has stemmed the flow to some degree. Many older doctors won't go back to school. But there are some other

places where doctors can go to such as the Republic of Ireland. The Middle East is now open.

Doctors in the UK are paid poorly by British standards but the money is still so good for local doctors that they can go there and make some money. It's almost more affordable to do locum work in the UK than be a junior doctor in South Africa. It's almost more affordable to go and do bar work in the UK! Probably most that are abroad do not want to be there but they are there because they can make money. I know that many of the doctors there do not like being there. It's not a great place to live. But there are few possibilities here.

Locum work is a lifeline for many doctors in private practice. They can earn some extra money, and can then buy new equipment for their practice. Much of this stuff is paid for by British pounds. Health care in this country is in a crisis. There is very little buy in. Many young guys are going abroad. Once they think there is no future here then they will consider staying abroad. We can catch them before they leave but once they have a wife and kids in the UK they are there forever. It's only the climate that pulls people back to South Africa. There is not much else.

The major problem that is facing doctors in South Africa is Manto Tshabalala.[81] *The situation of doctors in South Africa is stimulated by what is happening here at home. Dr Garlic has made a mess of the whole industry. That woman is a bigger threat to South Africa than Robert Mugabe.*

To stand in a world forum and proclaim that HIV patients must take garlic is an embarrassment.

ADDRESSING RECRUITMENT POLICY CHALLENGES

In the 1990s there was a lot of pressure from the South African government to stop recruiting South African doctors for emigration to Canada. In 1997 the company had a call from the office of President Nelson Mandela to ask us to stop sending doctors away. But there is no chance. If people want to leave they will leave.

We have lots of South Africans on the data base but it doesn't

necessarily mean that they will all be going out of the country. After their locum most of them will return. It's the money that people are after. In order for people to stay in South Africa they must be paid properly. Not all doctors want to leave the coun - try. If people are paid properly they will work hard.

The crux of the issue is that when you deal with doctors you can't bullshit them. They are educated people. They can think out of the box and see the bigger picture. They will always find other places to carve out a future if they are not happy. It's the same as all professional people. They can objectively look at the situation and decide what the best option is. I have been in the company for four years. I know all the complaints and opinions. I want the doctors to stay in South Africa. I know all the doc - tors on the data base and I have heard from them what they think. There are organizations trying to encourage graduates to return to South Africa. But they are punting the climate and the friendly people. It's airy-fairy bull-shit! They are not addressing the problems as to why people are there in the first place.

Many companies have approached the Health Minister. Netcare wanted to bring doctors to South Africa from India. We could bring people who are willing to work here from the Philippines, India and China tomorrow if we were allowed to.

It is a big mistake to prevent people from moving to places they want to go to. In South Africa we have a constitution that guar - antees freedom of movement. The thing is people are leaving for other reasons. Unless the health care system changes then people will leave for good. In my mind the health department should facilitate locums and sort working holidays abroad. After all, the people are bringing money back into the country. People don't all want to leave for good – most want to come back. It's the money that they are after. After working for a short period in the UK they can make enough money to sustain a private prac - tice, or repay a student loan. The govemment needs to see the potential. It needs a policy turnaround.

KEY POLICY IMPLICATIONS

Several key policy implications are raised by the interviews and advertising analysis:

- South Africa currently lacks adequate knowledge and data on the numbers of medical personnel that are leaving the country.
- The core of the recruitment industry is based outside South Africa and the local enterprises emerge as only minor players in the global context.
- The recruiters are responding to a demand that is being fuelled by shortcomings in the existing wage and working conditions in the South African health care system. As the editor of the SAMJ noted, "It is not the advertisements that are making people leave the country and go abroad. These adverts are taking advantage of a number of other issues"[82]
- At least two different recruitment channels may be differentiated. The largest channel is that of young South African medical graduates seeking short-term appointments as locums or RMOs in the UK health system. The majority of such recruits now return to South Africa after the close of their temporary contract appointments. A subsidiary channel is the permanent movement of older and more experienced medical personnel to appointments in New Zealand, Canada or Australia.
- In recent years there is evidence that the trend towards the recruitment of South African medical personnel for permanent appointments abroad has slowed and been replaced by temporary appointments.
- The major catalyst for temporary recruitment is that of the 'wage gradient' which is attracting medical personnel to the UK, the Middle East and other destinations (including recently Iraq and Iran). For permanent migrants issues of long-term working prospects and family considerations are of importance.
- South African recruiters have identified potential sources of medical skills in several Asian countries but have not been permitted so far to tap these pools of medical talent.
- Africa offers another potential space for replacement recruitment. As the editor of the SAMJ noted: "We need to recognize that there are doctors in other parts of Africa who would be willing to come and work in the rural areas of South Africa. During apartheid all the hospitals in the Bantustans were staffed from people overseas. Ironically, with the change in the political dispensation there has been a shift of policy and these people have been kept out."[83]

WHITHER SOUTH AFRICAN RECRUITMENT POLICY?

South Africa faces an increasingly competitive and aggressive global marketplace for the recruitment of skilled professionals, including health workers. The uncertainties of the country's new democracy made South Africa vulnerable to the growing number of 'skills-raiding' initiatives that were mounted in the late 1990s, most famously by the two Canadian provinces of Alberta and Saskatchewan.[84] Since the 1990s, South Africa has moved from *ad hoc* reactions to a more organized set of strategic responses to the challenges posed by the international migration of health personnel.

AD HOC RESPONSES

South Africa's initial response was to protest to the Canadian government in 2001 against this 'organized poaching' of the country's medical skills base. Essentially the provincial governments of Canada were responding pro-actively to the dynamics of the international marketplace for skilled talent and more particularly the 'global conveyor belt.' Indeed, these govemments were competing in the international marketplace through the activity of 'replacement recruiting', which was made necessary by the continued poaching of Canadian-trained health professionals by the USA. By contrast, South Africa's own recruitment policy at the time was based upon the ethical stance wherein the country refused to undertake 'replacement recruiting' in other parts of Africa and thus be complicit in the draining of precious skills from poorer neighbours.[85] Rather than recruit medical personnel from Zimbabwe, Nigeria or DRC, South Africa entered into a bilateral agreement with Cuba to supply doctors and other medical personnel on short-term contract assignments. This 'principled stand', Crush asserts, "benefited neither South Africa, Zimbabwe nor the region."[86]

Since 2001, South Africa's response to the international competition for talent and the activities of 'global raiders' has become less naïve. A policy shift is discernible away from righteous protest. Indeed, between 2002 and 2006 South Africa moved away from ad hoc responses towards a more organized and strategic policy intervention, which itself is part of wider human resource planning for the country's health sector. Between these years a shift can be noted also from a focus on 'control' towards a more active agenda of 'managed migration' of health professionals. Bach observes more widely of the intemational policy experience that a "central component of any such agenda is an enhanced recognition of the importance of improved working conditions and more effective human resources planning to encourage retention of health workers."[87]

During 2002, South Africa's Department of Health issued an official policy statement and guidelines on the recruitment of foreign health professionals.[88] This policy "expressly describes such initiatives as designed to recruit personnel to work in underserved areas in the country."[89] Alongside this rural focus for recruitment was the critical stance that the Department of Health would not support the recruitment of individual applicants for permanent work in South Africa from any developing country. Furthermore, it was recommended in guidelines issued in 2003 that employers should refrain from recruiting in developing countries, especially from the Southern African Development Community (SADC). This policy "emanated from the Ministers of Health in the SADC region" and aimed to ensure that South Africa did not participate in the "brain drain taking place in fellow developing countries."[90] The 2002 policy encourages the setting up of bilateral government agreements with the purpose of "better control" of the movement of health professionals.[91]

The endorsement of bilateral agreements as the most appropriate policy response to the recruitment of health workers from developing countries was announced by South Africa's Minister of Health at a meeting with Commonwealth Ministers of Health in May 2002.[92] In 2003, a Memorandum of Understanding (MOU) was signed between South Africa and the UK on the reciprocal exchange of health care personnel. This agreement committed both parties to formulating an agreed plan "including whereby South African healthcare personnel can spend education and practice period for a limited time in organisations providing NHS services." The South African government argued that "this strategy will go a long way to reducing the brain drain from South Africa while at the same time ensuring that South African health professionals have an opportunity to get international exposure." Among the provisions of the MOU was that health personnel from the UK could be engaged in strategic placements and would be enabled "to work alongside health personnel in South Africa with particular emphasis on rural areas."[93]

MIGRATION AS PART OF HUMAN RESOURCE PLANNING

By 2005 the South African policy discourse on recruitment had shifted to 'human resource planning' as a whole. In a statement issued in May 2005 the Minister of Health proclaimed that, "We need to ensure that international migration and recruitment of health personnel does not undercut our national plan to improve human resource supply and distribution."[94] She also argued that:

Addressing international migration and recruitment of health

> *personnel is one of several interventions that the Department of Health is making to address the challenges of human resource supply and distribution in South Africa. Other interventions involve improving working conditions for health workers and providing scarce skills and rural allowances to attract and retain health workers in the public health sector in general and rural or underserved areas in particular.*[95]

An important milestone was the release in August 2005 of the Draft Framework for the Human Resources for Health Plan.[96] The Minister noted that the Human Resources for Health Plan "should provide an overall framework that brings together various interventions that are currently underway to deal with the challenges around human resources."[97] The release of this document was described by some observers as "a damp squib that is thin on practical solutions to the critical shortage of health staff."[98] Nevertheless, others welcomed it as a basis for opening up discussions among health stakeholders on the issue of human resource management. Among the recommendations in the draft framework was the negotiation of "strong bilateral and multilateral agreements to manage the intemational migration of health personnel."[99]

The release of the draft framework was followed by a period of input and discussion with stakeholders that culminated in the revision and release in 2006 of the final document titled *A National Human Resources Plan for Health to Provide Skilled Human Resources for Healthcare Adequate to Take Care of All South Africans*. This document represents the most comprehensive and strategic response yet to issues regarding the recruitment and retention of health professionals in South Africa's public health sector.[100] The plan is seen as a watershed as the first human resources plan for South Africa's health sector as a whole. A key underlying premise of this strategy is that "migration is not something that can or should be stopped." Another fundamental starting point is that, as it is not realistically possible to stop private sector recruitment, "the question then is how best to manage the problem."[101]

The Deputy Director General for Human Resources in the Department of Health described the background thinking that informed the final analysis and planning as follows:

> *There is a strong sense among some stakeholders that the answer to the migration issue is to pay doctors and medical professionals more money. But the reality is that there are huge disparities among countries' ability to pay. Money is not the only issue, I think. It is important to improve the conditions of service, the equipment and machinery and the ability of health professionals*

> *to save lives. It's not just the pay, but the ability to be effective, save people's lives and do your job… My approach to recruitment agencies is to say that we want people to provide a service. We cannot constitutionally stop people from going, but the grass is not always greener on the other side… So we cannot stop anyone from leaving but we certainly do not encourage it.*[102]

With regards to the continued short-term flow of recent South African medical graduates to the United Kingdom, he noted:

> *Recent graduates tend to go the UK and do a year or two of work experience. Most recruitment agencies want people with experience. Personally I do not want to stop people moving. That is not the kind of values that our Constitution enshrines. There can be benefits of interaction and movement. People go to the UK, they get experience, and they bring experience and innovation back to South Africa. South Africa is many people's home and we can plough these skills and experiences back into the public or the private sector.* [103]

Accordingly, the response of South Africa's Department of Health in the 2006 framework plan is wide-ranging.[104] It incorporates important commitments to undertake with Treasury a review of wage conditions. But it is also anchored upon further guiding principles relating to work conditions: "Work environments must be conducive to good management practice to maximize the potential for the health workforce to deliver good quality health services." Proposed initiatives include (a) improvement in conditions of service; (b) improved remuneration; (c) payment of scarce skills and rural allowances; (d) increases in the number of health professionals trained; and (e) further recruitment of foreign health professionals through inter-governmental agreements.

In relation to recruitment of South African health professionals to work outside the country and to the replacement recruitment of foreign health professionals for work in South Africa, the 2006 framework elucidates two critical guiding principles. Principle 7 asserts that "South Africa's role in international health issues contributing to leadership, scientific advances and global health professionals is critical."[105] Activities aligned with this guiding principle are the design of MOU agreements in line with the strategic focus of the South African health system and the undertaking of a review with the objective of developing clear policies on recruitment and employment of foreign health professionals.[106] Guiding Principle 8 states that "South Africa's contribution in the short and medium term to the global health market must be managed in such a way that it contributes to the skills development of health professionals."[107] Activities under this umbrella include the "opti-

mization of the bilateral agreements that South Africa enters into with various countries" involving the placement of South Africans in institutions that would allow them to acquire new skills.[108]

Although the 2006 strategic plan provides a foundation for the 'managed migration' of South African health professionals, an unresolved issue is that of foreign health professionals seeking work in South Africa. The plan states that the national department of health will review the policy in this regard. The key issues under review are that:

- International recruitment shall preferably be done in terms of government-to government agreements.
- No active recruitment for permanent employment in South Africa will be directed at other developing countries in the African region.[109]
- Foreign health professionals who do not enjoy permanent resident status shall not be permitted to enter private practice.[110]
- The position of the group of African health professionals, who have been working outside their country of origin for periods of between 5-10 years and "do not feel that employment in South Africa will be robbing their own countries of the skills they dearly need."[111]

CONCLUSION AND RECOMMENDATIONS

Health worker migration, as Bach stresses, "is an inescapable feature of the health sector."[112] In this study the issues relating to the international migration of health professionals were positioned as part of the wider dynamics of globalization and of the development of an intemational marketplace for 'talent.' 'Competing for talent' is now recognized as an essential element of intemational competitiveness in the current world economy. In this regard a central role is played by private and public sector recruitment agencies in shaping the international mobility of talented or skilled individuals.

South Africa's re-integration into the global economy in 1994 exposed the new democracy to the full forces of this new intemational competition for talent. The initial *ad hoc* policy responses were weak and failed entirely to comprehend the organizational dynamics and structures that shape the new global movements of professionals. In terms of the health sector, it is conceded that the country hemorrhaged an important segment of its most experienced medical personnel. Moreover, without the enactment of counter-veiling replacement strategies and a national strategy for managing the country's human health resources, South Africa was vulnerable to the activities of 'global raiders.'

In terms of health professionals there has been an important and welcome policy shift away from the early reactive *ad hoc* policy responses to the development by 2006 of a more comprehensive strategic response that seeks to manage the mobility of health professionals. The research conducted in this investigation discloses a number of important findings concerning the activities of recruiters and of the changing policy response to their activities, which leads to recommendations about how to deal with recruiters.

- First, the existing lack of knowledge and data to monitor flows of health professionals into and out of South Africa demands immediate attention. The recruitment agencies operating in South Africa can be an important source of information and reporting for such a data base. *In line with the observations made by other researchers it is recommended that improved monitoring systems be established to track the flows of South African health professionals overseas and of foreign health professionals entering South Africa. In addition, a data base should be established to monitor the activities of local recruiters of health professionals.*
- Second, the majority of initiatives for the recruitment of the country's health personnel are undertaken by agencies based

outside rather than inside South Africa. The small cluster of local recruitment agencies are thus only minor actors in the overall international recruitment industry. For South Africa, the heart of this global recruitment industry is operations anchored in the United Kingdom and to a much lesser extent, in New Zealand, Australia and Canada. *An appropriate and recommended response is the strengthening of existing bi-lateral and multi-lateral inter-govemmental agreements that affect the flow of South African professionals to the UK and other Commonwealth countries. One element of strengthening inter-governmental agreements especially with the United Kingdom would be to seek to secure a set of reliable and regular information on the recruitment of South African profes - sionals for locum work in that country.*

- Third, local recruitment agencies cannot be blamed for the creation of a desire to migrate among certain groups of South African health professionals for either temporary or permanent employment abroad. It must be acknowledged that the core reasons for migration cannot relate to the operations of these small agencies. Instead, they link to the wider set of 'gradients' of wages and working conditions that impel talented South Africans to make a decision to step on the global conveyor belt of health. *Support for the comprehensive implementation of the strategies as set forth in the 2006 framework, including those con - cerning a review of wage conditions, will be an important basis for managing the future migration of South Africa's health workers.*
- Finally, local recruitment agencies have been constrained in their activities in terms of South Africa's ethical stance on recruitment of health workers from other developing countries. The research disclosed, however, the potential for recruitment of health workers from developed countries and health professional exporting countries such as India, the Philippines, Sri Lanka and even China. *It is recommended that the mandate of the future gov - ernment review on the potential recruitment of foreign health profes - sionals, especially from developing Africa, be extended to incorporate these potential recruitment sources of medical talent in Asia and to move away from a focus on inter-governmental agreements and the sole focus of policy on skills import.*

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