Chapter One
Introduction

1.1 Introduction

The research presented in this thesis looks at understanding the factors that influence Pakistani physicians' career decision whether to remain in their country, migrate abroad or resettle back into their country after working overseas for some time. This chapter commences with the background to the study that outlines the previous research conducted on this topic, identifies the research gap and indicates the main research problem. A rationale for the research is provided, followed by the purpose and aims of the study. An introduction to the methodology is provided and the researcher's perspective with relevance to this study is presented. The limitations of the research are identified and outlined. This is followed by an outline of the thesis.

1.2 Background to the study

The recruitment, retention and migration of health workers from rural to urban areas within a country and from one country to another is a global phenomenon that affects the health systems in both the developing and developed countries (Diallo 2004:601). Migration of highly skilled professionals, defined as having tertiary education and a professional job (Stilwell et al. 2004:595), is a very 'heterogeneous phenomenon'. In the health sector, this migration attains multiple flows. In the context of developing countries, the pattern of migration called 'internal migration' usually takes place from the primary health care units to hospitals, from rural areas to major towns, from clinical and research based positions to administrative posts and from the public service to the private sector (Marchal & Kegels 2003:91). The other major flow of this migration is external and is often called 'external'

or ‘international migration’. This pattern of migration often represents a chain, that takes place from the most underdeveloped regions within the developing countries to middle income countries and from there to high income countries (Meyer 2001 cited in Marchal & Kegels 2003:92).

According to Martineau, Decker and Bundred (2004:1) and Scott et al. (2004:61), the migration of highly skilled professionals from poor to rich countries is not a recent phenomenon and has been going on since the 1960s (Carrington & Detragiache 1998:4). However, recently this debate has intensified partly becasue this out-migration of skilled health professionals has severely weakened the capacity of the world’s poorest countries to combat health crises and to attain the Millennium Development Goals (MDGs) (Alkire & Chen 2004:3, Joint Learning Initiative [JLI] 2004; World Health Organization [WHO] 2006). The Joint Learning Initiative (JLI) and the World Health Organization (WHO) published major reports in 2004 and 2006 respectively to bring global attention to human resources for health issues and both these reports called for increased attention no the situation of health workers.

This renewed focus on the migration of health professionals, including physicians from developing countries to developed countries, is due to the emergence of the double crises of escalating disease and human resource shortages in the developing countries (Alkire & Chen 2004:3; Gadit 2008a:67). While some authors have pointed to the remittances that immigrant health workers send home and to educational and professional skills that these migrant health workers attain and term it as ‘brain gain’, there is an increasing global concern about its negative consequences on health equity and health disparities. Moreover, in countries where HIV and AIDS are major health problems, out-migration of trained

health professionals is regarded as a setback for effective management of these crises (Chen et al. 2004:1984; Pang, Lasang & Haines 2002:499).

As identified in the literature, low salaries, work overload leading to unsatisfactory work conditions, shortage of supplies, political instability, insecurity, poor living conditions, inadequate social services, poor education services for children and lack of continued professional development in the source countries and better remuneration, gaining further qualifications and experience, safer environment and family related matters in the receiving countries are some of the economic, political and social factors influencing health professionals to migrate (Akl et al. 2007:1280; Bundred & Levitt 2000:245; Hagopian et al. 2005:1754; WHO 2006).

Furthermore, according to Berlinger and Ginzburg (2002:2743) demographic trends have played an important role in the increasing demand for health care in the more developed countries such as the ageing of the generation of the 1940s and 1950s. The other important causes for the increased demand for healthcare are the advances in medical technology, emerging new diseases and increasing expectations of the population regarding quality health care provision (Buchan 2000:200). On the other hand, appropriate measures to meet this increasing demand for health care are not being addressed, for example, by increasing the numbers of local health workers either by increasing the inflow or by retention measures. This was evident in some higher income countries, such as the USA, where a decrease in the number of applicants applying for medical schools was noted (Charatan 2000:1177). However, in some countries such as Australia, there has been a recent move towards expansion of undergraduate programs.

Today, skilled migrant health care workers constitute a quarter of the health workforces of Australia, Canada, the UK and the USA (Kingma 2005:287). International medical graduates (IMGs) constitute 23-28 percent of doctors in the USA, Canada and Australia, and low income countries provide 40-75 percent of these IMGs (Chen & Boufford 2005:1851; Hagopian et al. 2004). Overall, Australia, Canada, the United Kingdom and the United States are the largest overseas-trained physician dependent countries in the world (Mullan 2005:1810). The above figures do not convey the exact extent of global medical migration as there is a lack of data on physician migration to other developed countries. Researchers agree that a large number of doctors are migrating from developing to developed countries which affects their health systems; however, its exact statistical extent is not known (Awases et al. 2004:33; Hagopian et al. 2004; Stilwell et al. 2004:596; WHO 2006:98).

Despite renewed global attention to HRH issues and the huge magnitude of global medical migration, a literature review shows that there are only a small number of previous research studies that have explored the reasons for individual doctor's migration (Awases et al. 2004; Brown & Connell 2004; Hagopian et al. 2005; Akl et al. 2007; Oman, Moulds & Usher 2009a; Benamer, Bredan & Bakoush 2009). Furthermore, original research studies that explored the reasons for physicians' retention and resettlement in developing countries are almost non-existent. According to Oman, Moulds and Usher (2009a:1247), 'less has been published on the reasons doctors in developing countries actively choose to remain in their challenging and difficult jobs, often experiencing considerable professional fulfilment'. Awases et al. (2004:2), while presenting the justification for their multicounty study in Africa on health professional migration, were of the view that 'the issues that influence retention and return of health personnel are not well understood. … This is an

area of concern that has been echoed by most of the countries in the Africa region'. Similarly, Brown and Connell (2004:2196) have noted that there has been some resettlement of skilled overseas migrants into their countries of origin; however, they believed that in the health sector there is a lack of research that looked into this return migration of health workers.

Pakistan is a developing country that represents the third largest number of physicians working in the developed world (Mullan 2005:1814). According to Salafsky, Glasser and Ha (2005:520), much is written about physician migration and retention and its consequences in the African context, but these issues are not unique to Africa. Countries like the Philippines, Haiti, Thailand, Jamaica, Sri Lanka, Bangladesh, Pakistan and others have experienced similar problems. Talati and Pappas (2006:55) and Syed et al. (2008:61) have also expressed similar views and are of the opinion that, although the causes of physicians' migration and retention have been addressed in the African context in the literature, relatively little research has been done to evaluate the causes of such migration and retention in the Pakistani context.

Furthermore, according to the JLI report (2004:2), Pakistan is among the 45 countries in the world that is suffering from an acute shortage of health workers (doctors, nurses and midwives), which is defined as less than 2.5 workers per 1000 population, and high-mortality rates. In another study by El-Jardali et al. (2007) that looked into the HRH issues in the WHO, Eastern Mediterranean Region, of which Pakistan is a member, it was concluded that that there is a general lack of research on health workforce issues in the EMR region and that such research is needed to generate evidence that will help in the development of country-specific human resource policies and strategic plans. Therefore, it

is critically important to explore the factors that influence Pakistani physicians' career decision to remain in their country, migrate abroad or resettle back to their country after working abroad for some time. It is also important to explore if there are any difficulties or problems faced by the return-migrant doctors while resettling to Pakistan.

According to Astor et al. (2005:2493), the main constraints regarding the formulation of a policy related to physician retention and migration in both developed and developing countries is a lack of clear understanding of the phenomenon, the factors influencing physicians decisions' to migrate, the advantages and disadvantages of this migration and the effects of policies dealing with this phenomenon. Furthermore, most systematic studies and analyses focusing on physician migration were conducted before 1980 and recent articles addressing this issue are mostly editorials or viewpoints based on unconnected data or anecdotal evidence (Astor et al. 2005:2493). Stilwell et al. (2003:4) argue that this is largely due to the limited and unreliable data sources regarding physician migration, especially in the source countries.

This qualitative study is an attempt to fill this gap and broaden the base of systematically collected data on physician retention, migration and resettlement issues in a developing country context such as Pakistan. To the researcher's knowledge, only the following two recent studies have been conducted that have focused on physician migration and retention issues in the Pakistani context. In the first study, Astor et al. (2005) attempted to identify core issues surrounding physician migration from India, Nigeria, Pakistan, Columbia and the Philippines. The authors surveyed professors or health professionals working in a university or medical school setting; officials and researchers working for national and international governmental and development agencies; representatives of private

organisations and NGOs dealing with migration, health and development; physicians of different specialties; and experts from population studies and development economics. This study found that 90.8 percent of the respondents rated a desire for a higher income or more buying power as the most significant motivating factor for doctors to migrate. This was followed by other factors such as greater access to technology and equipment (74.1 percent), improved prospects for one's children (78.0 percent), to live in an economically stable country (72.5 percent), and general security and stability (51.9 percent).

The other most recent study conducted by Syed et al. (2008) was also a quantitative survey with final year students from two private medical universities, that is, the Aga Khan University (AKU) and the Baqai University (BU) in Karachi, Pakistan's largest metropolitan city. This study found that the majority of the students, over 93 percent in AKU and 65 percent in BU, rated poor quality of postgraduate medical education as the most important factor influencing their decision to go overseas. The other most important factors for their migration intentions were less salaries and the poor work environment facing postgraduate trainees in Pakistan. Furthermore, the study also found that the major reasons for those students who intended to stay in Pakistan were mostly personal and family related factors such as family ties, the desire to serve their nation and to settle in Pakistan.

1.3 Purpose and aims of the study

The study seeks to explore the perceptions of Pakistani physicians regarding their career decision to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. The focus is on understanding the Pakistani physicians' interpretations of their personal, professional and societal experiences that affected their

career decision about whether to stay in their country, migrate abroad or resettle back into their country after working and living abroad for some time. The term ‘physician’ in this thesis includes all Pakistani doctors who have obtained their primary medical qualification, that is Bachelor of Medicine, Bachelor of Surgery (MBBS) in Pakistan, and they may or may not have specialised in any discipline.

In order to address the purpose of this study, which is to explore the reality, perceptions and the lived experiences of Pakistani physicians, the following four aims were developed.

1. Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas.
2. Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad.
3. Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country.
4. Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time.

1.4 Significance of the study

This is a unique study of the reasons for Pakistani doctors’ retention, migration and resettlement into Pakistan as the majority of the studies have either looked only at the reasons for migration or, in some cases, the reasons for retention and migration. It is also unique in terms of the methods applied as this is the first study in Pakistan that has used the qualitative paradigm to study doctors’ retention and migration. Previous studies that have looked at this issue have been mostly quantitative in nature. It is also unique since three

different categories of doctors were interviewed who actually went through these experiences: non-migrants (*stayers*), migrants (*leavers*) and return migrants (*resettlers*).

The findings of this study will be significant at a number of levels. This study adds significantly to the existing body of knowledge regarding factors that influence physicians' retention, migration and resettlement in Pakistan and other similar developing countries. This study complements international efforts, especially by the World Health Organization (WHO), in striving to broaden the base of systematically collected data on physician retention and migration in a developing country context.

The findings of this study will assist in focusing attention on often neglected health workforce issues in Pakistan. It is anticipated that this study will help in better understanding the factors that help physicians to remain in their country and those that compel them to go overseas or hinder their resettlement into Pakistan. It is also hoped that the findings of this study will help in the design of viable and comprehensive health human resource strategies in Pakistan and other developing countries with similar socioeconomic and health system conditions. Overall, the findings in this study will have the potential to better inform future strategic approaches to health reforms in the organisation of the health delivery system in Pakistan.

1.5 Introduction to the methodology

To effectively address the above stated research aims and to understand the phenomenon of Pakistani physicians' career decision to remain in Pakistan, migrate abroad or resettle back into their country, a hermeneutic phenomenological research design was chosen. This research design is situated in the interpretivist paradigm. This interpretive research design

was chosen because it provides the most appropriate design to research the experiences of the Pakistani doctors about their career decisions from the unique perspective of these individuals (Becker 1992:7). According to Liamputtong and Ezzy (2005:11) ‘each individual’s life-world is different, and individual’s actions can be understood by situating them within the life-world of the actor’. Semi-structured interviews were used as the data collection method to study the perceptions of a diverse group of thirteen Pakistani physicians about their career decision in regard to retention, migration and resettlement. The detailed rationale for the research design is discussed in Chapter Three.

1.6 Researcher’s perspective

According to O’Brien (2003:197), in phenomenological research the researcher comes to the study with a level of preliminary understanding of the phenomena under study based on previous experience and the literature review undertaken for the study. It is important that the researcher’s background of experience, knowledge and assumptions are made clear as it will help the researcher to ‘test assumptions and new knowledge’ (O’Brien 2003:197). Therefore, the researcher’s perspective is presented in keeping with the principles and traditions of the Heidegger approach to phenomenology as opposed to the Husserl approach. There was an important distinction between the respective approaches of both these philosophers, that is, Edmund Husserl and Martin Heidegger, of the German phase of the phenomenology movement. Husserl believed that by putting aside the researcher’s individual and personal reality (bracketing), the research results will be true from the viewpoint of the subject, otherwise the data will be ‘contaminated’ with the researcher’s prior understanding of the phenomenon (Bassett 2004:158). In contrast, the Heidegger philosophy does not agree with this view and is of the opinion that the researcher’s pre-understanding of the phenomenon cannot be suspended as we all come to this world with a

pre-understanding based on our culture and other background experiences. In fact this pre-understanding helps in informing our interpretation (Basset 2004:158).

The researcher is a medical doctor who completed his Bachelor of Medicine, Bachelor of Surgery (MBBS) degree in 1995 from a public sector medical school in Pakistan. Following a one year house-job (compulsory internship after graduation) in a recognised tertiary care public teaching hospital, the researcher worked for approximately two years as a medical officer/practitioner in the medical services department of a public sector organisation not under the federal or provincial ministries of health, which are the major employers of doctors in Pakistan. From 2000 to 2002, the researcher completed his masters degree in Health Policy and Management (HP&M). Since then he has worked in different management and research roles in various national and international health organisations in Pakistan until 2007 when he was admitted to the doctoral degree course of the Doctor of Health Services Management (DHSM) in Australia. These organisations were mostly non-government organisations (NGOs) and donor-funded health strengthening projects, wherein the researcher worked with the federal and provincial ministries of health but was not on their payroll. This shows the researcher's involvement in the health sector of Pakistan both as a practicing physician and as a researcher and public health and health management practitioner.

While reflecting on both the experience of working for some years as a physician and health management practitioner and the literature review undertaken for this research, the researcher brought pre-understanding to this study which is expressed in the following perceptions about the Pakistani health system and its health human resource issues.

- Health, like other social sectors in Pakistan, has not received its due importance over the decades with human resources for health as one of the most neglected (Nishtar 2006:120).
- This issue has been complicated by the absence of comprehensive and viable human resource policy and planning leading to both qualitative and quantitative issues in the availability of a trained and motivated health workforce to the majority of the people of Pakistan.
- Over the years more doctors have graduated compared to other types of health workers; however, their capacity building, training and effective deployment have never received due attention. This has led to a lack of available doctors in the rural and remote areas while their concentration in major cities and towns has led to unemployment issues.
- The exact extent of migration of skilled health workers, especially physicians in the case of Pakistan, is not known (Talati & Pappas 2006:58). However, there is a prevalent view that a substantial number of Pakistani doctors go overseas due to a multitude of factors but primarily due to economic incentives complicated by other factors.
- The researcher was aware of the visible trend in Pakistan towards specialisation of the medical workforce; however, the exact nature and causes of this phenomenon were not known.
- In order to provide health care services to the majority of its people, especially those in rural areas, Pakistan needs to invest more in health and the health workforce. This investment should be guided by an evidence based health human resource strategy that takes into account the perspectives of the multiple

stakeholders involved in this issue, especially the providers and the receivers of health services.

1.7 Limitations of the study

A number of methodological issues and potential limitations were considered in this study. These include the sample size, the role of the researcher, the issue of generalisability, and representation of stakeholders related to the phenomenon of retention, migration or resettlement of physicians in Pakistan.

The participants were chosen using purposive and snowball sampling strategies rather than randomisation because the purpose of the study was not to obtain representativeness or generalisability of the findings, but rather to obtain rich, valuable data sampling a diverse range of participants. The study participants were selected based on their experience of the phenomena and their ability to convey their experience. Therefore, efforts were made to ensure variety through the sampling process to increase potential diversity based on the participant's age, gender, place and mode of practice and geographical representation. As the aim of phenomenological research is not to produce generalisable results but to understand and interpret the experiences of the participants (O'Brien 2003:197), it would be appropriate to note that this research was not designed to predict or make inferences from the study results.

Due to financial and candidature time constraints, other important stakeholders related to this issue of physician retention, migration and resettlement such as the Ministry of Health (MOH), the College of Physicians and Surgeons, Pakistan (CPSP), the Pakistan Medical

and Dental Council (PMDC), the Higher Education Commission (HEC) and the health consumers in Pakistan are not represented in this study.

1.8 Organisation of the thesis

This thesis consists of five chapters. The following sections provide a brief overview of the content of each of the chapters.

Chapter One outlines the study by presenting the background of the study, the purpose, aims and significance of the study, study design and a brief summary of the chapters that comprise the literature review, methodology, results, and discussion and conclusions in this thesis.

Chapter Two provides an analysis of the relevant body of knowledge relevant to this study, describing the importance of health workers, the development and expansion of health workforce literature, and the extent of medical migration and resettlement followed by a discussion of the previous research into reasons for physicians' retention, migration and resettlement both globally and in the context of Pakistan. A theoretical framework is presented that guided and informed each stage in this study. This theoretical framework utilises an eclectic approach based on different but complementary migration theories and decision-making models, as a single theory is not able to explain the multiple and complex factors that affect health workers' retention and migration decisions. This is further discussed in Chapter Two. Overall, this chapter forms the conceptual foundation for the debate and analysis that takes place throughout the study.

Chapter Three commences with a description of the research design and methodological approach used to address the aims of this study by providing greater depth and understanding of the perceptions of Pakistani physicians about their career decision to remain in Pakistan, migrate abroad or resettle back into their country after working abroad for some time. This is followed by providing a justification for the research design and methodology adopted in this study. The study setting, sample size, interview schedule, data collection procedure and data analysis technique used are discussed and methodological limitations are identified. The chapter concludes with a description of the strategies adopted to establish rigour and trustworthiness followed by the ethical considerations and participant protection of the study.

In Chapter Four, the profiles of the participants are first described followed by the results of the study which are presented about each research aim as themes under the three main categories that emerged from the data. These categories are personal and family factors' health system factors and societal factors. For each theme, relevant quotes from the data are presented that enrich and help in understanding the study findings by providing the context of the perceptions of the study participants.

Chapter Five presents and discusses the main conclusions from the study based on the researcher's interpretation in relation to the aims of the study and previous research on this topic. The implications of this research study for policy and practice relevant to the health workforce, especially in Pakistan and other similar developing countries, is discussed and presented with recommendations. The chapter concludes with recommendations for further research into this field of study.

1.9 Conclusion

In summary, this chapter has provided the basic foundation for the thesis. The chapter commenced by presenting the background to the research and the purpose and aims of the study. The researcher's perspective was presented, the significance of the research was discussed and it's theoretical and practical contributions identified. A brief explanation of the study methodology was given followed by the study limitations. At the end, an overview of the overall structure of the thesis was presented. The following chapter (Chapter Two) discusses a review of the literature relevant to the purpose and aims of the study and provides a theoretical foundation for this investigation.

Chapter Two
Literature Review

Section 1: Introduction

2.1 Introduction

The literature on human resources for health (HRH) issues and specifically retention, migration and resettlement of physicians and other health workers from developing to developed countries has evolved and expanded significantly during the present decade (2001–2010). However, despite this expansion, previous research addressing medical migration is quite limited and original literature that focuses on the reasons for doctors' retention and resettlement into their countries is almost non-existent. The aim of this literature review is to present the current global context of physicians' retention, migration and resettlement issues and explore its relevance to the present situation in Pakistan.

This chapter provides an overview of the literature, consisting of three sections, relating to the research problem identified in Chapter One and commences with a description of how the literature was accessed and utilised for the purpose of this chapter. This is followed by a discussion of the theoretical framework utilised for this research. An explanation of the importance of health workers and a review of the global health workforce literature with current statistics on medical retention and migration is presented, followed by a review of original research that looked at the reasons for physicians' retention, migration and resettlement globally. Following this, an overview of the health care system and health situation in Pakistan together with a discussion of the different factors that have influenced the development of the health care system in Pakistan is presented. Finally, a review of the

literature that looks at the reasons for physicians' retention, migration and resettlement in Pakistan is presented and discussed.

2.1.1 Identification of literature and modes of access

For the purpose of the literature search for this study both international and national sources were accessed and material available only in the English language was included. Due to the limited and scattered nature of the health workforce literature, multiple literature search approaches were adopted to locate relevant literature. Key words and a combination of key words used in searches included physician, doctor, international medical graduates (IMGs), overseas trained doctors (OTDs), retention, migration, resettlement and repatriation. Literature was identified by a computer search of the MEDical Literature Analysis and Retrieval System onLINE (MEDLINE) and Google Scholar. Some literature was also accessed by doing an electronic search on the websites of individual journals such as *Human Resources for Health*, *Lancet*, *British Medical Journal* (BMJ), *The New England Journal of Medicine*, *Social Science and Medicine*, *Medical Journal of Australia* (MJA) and *Journal of the Pakistan Medical Association* (JPMA). Data were also located by doing a manual search of the reference section of the key articles. Websites of the international development agencies such as World Health Organization (WHO), World Bank (WB) and United Nations Development Programme (UNDP) were also visited to locate statistics, reports and papers related to human resources for health.

Section 2: Theoretical Framework

2.2 Theoretical Framework for understanding health workers retention, migration and resettlement

This section defines and describes the theories of migration used to develop a theoretical framework for this study. An eclectic approach utilising multiple migration theories and decision-making frameworks is used in this study because health workers' career decision-making regarding retention, migration and resettlement is a multi-dimensional and complex phenomenon of interest that cannot be explained or interpreted fully on the basis of one theoretical approach. The theoretical framework for this study is based on the concepts from different migration theories and decision-making models discussed in this section.

Hagen-Zanker (2008) and Massey et al. (1993) have discussed a number of migration theories to explain international migration. These theories will be summarised in the following sections as it is beyond the scope of this literature review to provide a detailed account of each theory. An eclectic theoretical framework is appropriate because all these different migration theories have relevance in understanding the factors that affect Pakistani physicians' retention, migration and resettlement decisions. Such a framework will also assist in situating the current literature review as well as the study into a theoretical perspective. Hagen-Zanker (2008) has classified the migration theories according to the level of focus and unit of analysis into macro, meso and micro-level theories.

The Neoclassical Macro Migration Theory by developed by Lewis, Ranis and Fei, and Harris and Todaro to explain labour migration in the process of economic development

(Massey et al. 1993:433). According to this theory, international migration between countries and also internal migration within a country is a result of differences in the supply and demand of labour between different areas. Countries with a large supply of labour relative to capital have lower wages. As a result, workers migrate to countries with higher wages where the availability of labour is less relative to capital. The differences in wages cause workers to migrate from low-wage countries to high-wage countries. This theory assumes that at a certain stage an equilibrium will be reached, however, this equilibrium about wage equalisation and migration cannot be found in the real world (Hagen-Zanker 2008:7).

The Dual Labour Market Theory developed by Priore is a macro-level theory which argues that, contrary to the push factors such as low wages and high unemployment, international migration is the result of a strong labour demand inherent in the economic structure of the developed nations (Hagen-Zanker 2008; Massey et al. 1993). According to this theory, there are two sectors, primary and secondary, in the economy of developed countries. The primary sector is composed of highly paid jobs and the secondary sector provides low paid and unskilled employment. Due to 'structural inflation' there is a steady rise in the wages of the primary sector while a concomitant rise in the wages of the secondary sector is deemed to be too much expensive. Because of the low wages and prestige, native workers do not want to work in the secondary sector thereby making it attractive for migrant workers to work in these low status jobs. Therefore this creates a strong demand for migrant workers which acts as a pull factor for international migration. According to Hagen-Zanker (2008:7), this theory is important in explaining migration trends in Europe and the United States after World War Two; however, its 'focus is too narrow with only one pull factor being analysed and with no deeper analysis of migrant decision making'.

The World Systems Theory developed by Wallerstein is also a macro-level theory which claims that 'migration is a natural growth of disruptions and dislocations that inevitably occurs in the process of capitalist development' (Massey et al. 1993:445). Therefore, previously as a result of colonialism and now as a consequence of the expansion of the capitalist governments and multinational firms, there are socially uprooted populations in the peripheral non-capitalist societies. These populations have weak attachments to their countries of origin and so are more prone to migration. This neo-colonialism is not only done through capitalist expansion but also through propagation of culture, stronger modes of communication and transportation and military links. While this theory explains migration as a consequence of 'market economy and structure of the global economy', it ignores, however, individual motivations for migration (Hagen-Zanker 2008:8).

Another macro-level theory is the Migration Systems Theory developed by Fawcett, Kritz and Zlotnik views international migration as 'an independent dynamic system' between the sending and receiving countries (Hagen-Zanker 2008:8). Massey et al. (1993:454) argue that the migration between countries acquires stability and structure over time and space that leads to the creation of international migration systems which are characterised by the exchange of goods, capital and people between certain countries as compared to others. This migration system is generally composed of a main receiving region, that may be a country or a group of countries, which is connected to several sending countries with a comparatively large inflow of migrants (Massey et al. 1993:454). Migration Systems Theory can be linked to the World Systems Theory; however, as claimed by Hagen-Zanker (2008), it is very vague and does not provide solid 'predictions of migration trends'.

Stark and Bloom proposed a meso-level theory of migration called the New Economics of Migration (Hagen-Zanker 2008; Massey et al. 1993). Contrary to other macro or micro-level theories of migration that look either at aggregate migration movement or view migration as an individual decision, this theory assumes migration as a result of a collective decision of a family. Decision-making concerning migration is based on the well-being of the whole family. According to this theory, in order to maximise and diversify its income, a household sends a member or members to rich countries while some others stay in the local economy. Foreign labour markets are not or are very weakly dependent on local market conditions. Therefore, the members of the household can rely on the income support of the migrant in case they fail to earn the required income in their local market (Hagen-Zanker 2008:13; Massey et al. 1993:436). Likewise, the other members of the household also support the migrant during initial periods of job search or in case of unexpected unemployment of the migrant. This theory has made an important contribution in terms of looking at migration as a collective family level decision and links the causes of migration to the consequences (Hagen-Zanker 2008:16). However, the researcher believes that it is mostly concentrated on the economic side of migration and ignores other important non-economic factors that influence migration decisions.

Similar to the Neoclassical Macro Theory of Migration is a Neoclassical Micro Migration Theory which is based on the work of Sjaastad. This theory is also known as the Human Capital Approach. This theory views migration as an individual investment decision in which the individual based on his/her cost-benefit analysis, looks for positive returns, usually monetary, from migration (Massey et al. 1993:434). According to Massey et al. (1993:434), people choose to move to where they can be most productive …'. However, before being able to get these positive returns, that is higher wages, these individuals need

to make certain investments such as travelling and maintenance costs in the new place, costs of learning a new language and culture and the social costs of leaving one's family and friends and making new relationships in the new environment. According to Hagen-Zanker (2008:10), while this theory explains the selectivity of migrants, it does not, however, take into account more structural factors that influence migration decisions.

Another micro theory of migration proposed by Hoffmann-Novotony is called the Theory of Social Systems (Hagen-Zanker 2008). According to this theory, migration occurs because migrants want to resolve the questions of power and prestige in the sending country. They migrate because they want to achieve higher status in their destination country; however, this theory suggests that these tensions are transformed to the receiving country of the migrant instead of being resolved through migration. This means that migrants get low status positions in their destination country, whereas the low status holder natives move upwards in their society in terms of power and income. According to Hagen-Zanker (2008:11), while this theory takes into account wider structural factors, it is, however, very difficult to apply and test.

Hangen-Zanker (2008) has described micro-level decision-making behavioural models by developed by Wolpert and Crawford that try to look at migration decisions in terms of personal values and expectations which do not necessarily need to be economic. A person will migrate only if his/her values and expectations are met at the destination. It is a sort of individual cost-benefit analysis but can include other non-economic societal factors such as security and self-fulfilment that influence migration decisions. Hangen-Zanker (2008:11) argues that, although the behavioural approach also takes into account non-economic factors, 'it is very vague and rational decision-making is still assumed'.

Lee (1966) proposed a Pull-Push framework by looking at the supply and demand side of migration at the individual level. According to this framework, there are positive and negative factors at the origin and destination site that push and pull potential migrants either for migration or non-migration or retention. Furthermore, apart from these push and pull factors, migration is also affected by intervening factors such migration laws and the personal characteristics of individuals, that is, how they perceive these factors (Hagen-Zanker 2008:9). This theory can potentially explain both individual and structural factors that influence migration decisions. Hagen-Zanker (2008:9) is of the view that this is merely a clustering of factors that affect migration and does not consider the exact causal mechanisms.

Similar to the above discussed theories of migration, another body of literature that looked at rural medical workforce recruitment and retention has also sought to develop decision-making frameworks for rural doctor's preference for practice location. A recent study by Tolhurst (2008) with medical students and female GPs working in rural Australia developed a decision-making framework called the 'Landscape of Fulfilment'. This model incorporates the domains of 'self' such as age, gender identity, professional and place identity, experience, personality and ethnicity; 'place' such as physical, social and cultural environment; 'work' such as work content, health care resources, patients, professional colleagues and medical culture; 'significant others' such as own and extended family; 'recreation'; and 'significant others work and education' as the primary domains which influence rural doctors' decisions about practice location choice. It helps in understanding complex interactions between different aspects of life that affect a doctor's decision about work location. As explained by Tolhurst (2008), this model adds to the previous work by

Humphrey's et al. (2001) and provides further understanding of rural doctors' decision-making regarding their place of practice.

The 'Landscape of Fulfilment' framework by Tolhurst (2008) explores important personal, family and work aspects of rural doctors' career decision-making especially with respect to place identity and professional and gender identity; however, it does not address wider political, socioeconomic and health system influences that has relevance to retention and migration decisions in the Pakistani context. Furthermore, this framework is developed in the context of rural-urban physician retention and migration decisions in a highly developed country context and its adaptability to a developing country such as Pakistan is yet to be seen. Having said that, aspects of the 'Landscape of Fulfilment' framework provide valuable insights for this current study to explore such as the influence of 'place identity', which in this current study is the country of origin of Pakistani physicians and its culture. The other important domain in the Tolhurst framework that can be explored in the context of Pakistani physicians' retention, migration and resettlement decisions is the importance of 'significant others' such as parents, extended family and even friends in Pakistan.

Another systems approach to the health workforce is based on the concept of the rural health career pipeline. This was initially applied to medicine but can be applied to all health professionals (Fisher & Fraser 2010; Norris 2005). This considers the health workforce as a complex system. Health professional supply is a function of recruitment and retention into the system and these are considered to be different complementary processes. The ultimate goal is to train and retain a rural health professional in a rural region.

This approach promotes coordination of training and integration between different stages of training with an emphasis on decentralising training to rural areas where health professionals will hopefully ultimately work. This approach to training is based on the premise that students from rural areas are more likely to follow a rural career. This approach has not been used in this thesis as it is based on training within the same rural geographic region in developed countries. Its application in the context of migration of medical professionals from developing countries to developed countries is not proven.

From the above discussion of multiple migration theories and the factors that initiate migration, it is clear that a single theory does not explain the complex phenomenon of migration. This view is also supported by Teitelbaum (2008) who argues that none of the migration theories is able to explain this complex phenomenon in a coherent and convincing manner. According to Massey et al. (1993:432), 'although each [theory] seeks to explain the same thing, they employ radically different concepts, assumptions, and frames of reference'. According to Hagen-Zanker (2008:18), these different theories are not 'conflicting' and that 'they can be combined in a complementary fashion'. Even in the health sector, authors like Clark, Stewart and Clark (2006:51) held similar views and state that 'no single theoretical framework is adequate to examine the full range of social, economic, and political factors associated with the increasing migration of health-care professionals from developing to developed countries'.

As argued by Teitelbaum (2008:56), 'eclectic theoretical approaches offer real promise in understanding the factors that increase or lower the potentials for international migration …'. Therefore, drawing on the different migration theories as discussed above, this study seeks to understand individual and family factors that in turn are affected by the prevailing

political and socioeconomic conditions, including professional factors at the national and international level that led to Pakistani physicians' either remaining in their country, migrating abroad or resettling back after working abroad for some time. These different factors influencing Pakistani physicians' career decisions will be studied by putting them in the framework of Push-Pull Theory.

The Push-Pull Theory has been used widely in the literature on international migration of health professionals (Akl et al. 2007; Alonso-Garbayo & Maben 2009; Clark, Stewart & Clark 2006; Kingma 2001; Klein et al. 2009; Kline 2003; Mejia, Pizurki & Royston 1979) It is quite broad and can accommodate factors ranging from personal to family issues to socioeconomic and national and international factors that affect health workers' retention, migration and resettlement decisions. Furthermore, it presents the complex factors that led to the migration of health professionals in an easily comprehensible scheme. According to Alonso-Garbayo and Maben (2009), this theory is still commonly used to explain the migration of health workers, which suggests its flexibility and clarity.

Akl et al. (2007) used concepts from the Push-Pull Theory of migration by Lee (1966) in their study with graduating Lebanese medical students which explored their reasons for training abroad. According to the study results, there are push factors in Lebanon and pull factors in the Western countries that drive Lebanese medical students to train abroad. The main push factors identified in this study were the lack of availability of good postgraduate training, limited job opportunities, poor working conditions, financial problems, political instability and security issues, and social inequalities and a sectarian social system. The pull factors in the Western countries identified by the study respondents were mainly opposite to the push factors and were the availability of good postgraduate training, more

merit based job opportunities with lighter workload and continuous professional development opportunities, a better salary structure, political stability and an opportunity for an independent lifestyle.

Furthermore, building on the Push-Pull framework, this study identified another set of factors called 'repel' factors in the recipient country and 'retain' factors in the source country that also play a role in migration decisions but act in the opposite directions, leading to retention or return-migration of health professionals to their countries of origin. In the case of the Lebanese medical students, the main retain factors identified were unwillingness of the partner to travel, preference for social life in Lebanon and to stay close to family and friends, societal pressure especially for females not to travel alone and a sense of patriotism to stay in their country. The main repel factors, identified in the study, especially in the Western countries, that motivated these students to stay in Lebanon were living in a different culture, a lack of social support, a negative perception of people from the Middle East, especially Muslims, and dissatisfaction about policies of certain countries towards migrants.

Another study by Klein et al. (2009) with a group of nineteen IMGs looked into the personal factors associated with migration decisions of these physicians and their ultimate retention in the province of Alberta in Canada. This study found that there are 'the push' factors in the previous countries of IMGs, 'the pull' factors in Alberta and another set of factors termed as 'plant' that influenced these physicians' decision to stay in Alberta and not move to another province in Canada. The push factors identified were mainly violence and security and the poor living conditions in the source country of the IMGs. The pull factors in Canada identified in this study were other family members already migrated to

Canada, children considering moving to Canada, valuing of family life in Canada as compared to other Western countries and the perception of tolerance towards other cultures and multiculturalism in Canada. The plant factors identified in this study that helped these IMGs to stay in Alberta and not move to another province in Canada are similar to the retain factors identified by Akl et al. (2007) that motivated Lebanese medical students to stay in their country and not go overseas. These 'plant' factors included the availability of good public services, especially schools and health care, more opportunities for family recreation, such as more sunshine and longer summers and better personal life because of more free time to spend with family. The main limitation of this study was the selection of participants who came from one location and were all practicing in one province in Canada. Therefore, it would be difficult to know the transferability of these findings to other locations and contexts.

In summary, this section has identified and discussed the theoretical framework that will be used to explore the perceptions of Pakistani physicians' regarding their career decision to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. This theoretical framework utilised an eclectic approach based on different but complementary migration theories and decision-making models. This framework will guide each stage of the thesis.

Section 3: Human resources for health

2.3 Importance of health workers

The growth and success of any organisation is dependent on the availability of an appropriate and competent workforce and the level of effort it puts into accomplishment of the assigned tasks (Murray & Dimick 1978:752). Human resources are the most valuable

asset in any organisation (Koch & McGrath 1996:335), especially in service oriented organisations such as health organisations where the principal input is the various professionals, technicians, management and other health workers that make health interventions to be possible (Dussault & Dubois 2003). They are the ones who determine where, when and what services will be offered and what impact these services will have on the health of the population (Pan American Health Organization [PAHO] 2001:3). Unlike other organisations, health organisations are knowledge-based and the performance of the workforce depends to a large extent on the application of that knowledge. Thus, human resources are 'the intellectual capital of a health organization or health services system' (PAHO 2001:9).

The World Health Organization's Annual Report of 2000 emphasised that human resources are 'the most important of the health system's inputs' (WHO 2000:77). They have been labelled as 'the heart of the health system in any country' (Joint Learning Initiative [JLI] 2004:21), 'the most important aspect of health care systems' (Narasimhan et al. 2004:1469) and an indispensible component of health policies (Dussault & Dubois 2003). The performance of health care systems is very much dependent on the knowledge, skills and motivation of the human resources responsible for delivering services. However, despite this critical importance, there is a general agreement that 'human resources have been a neglected component of health system development', especially in resource constrained countries (Hongoro & McPake 2004:1451).

Human resources are important because they consume a high proportion of health sector budgets (Dussault & Dubois 2003). In most countries wage costs, including salaries, bonuses and other payments, consume up to three quarters of the recurrent health

expenditure (Kolehmainen-Aitken 1997:2). For example, the salary budget of the Dominican Republic is 67 percent and that of Ecuador is 72 percent (Berman et al. 1999:27). Despite this budgetary importance, human resources are the least strategically planned and managed resource of most health systems (JLI 2004:22).

Health workers are important because they manage all other health resources, such as financing, technology, information and infrastructure (JLI 2004:22). According to Chen et al. (2004:1984), 'it is people, not just vaccines and drugs, who prevent disease and administer cures'.

2.4 Health workforce literature: A global review

2.4.1 Expansion of the health workforce literature

The international literature addressing health workforce issues, especially medical retention and migration, has expanded and transformed during the current decade. During the initial years of the present decade, this literature was mostly composed of editorials or viewpoints discussing various aspects of the health workforce and their conclusions were mostly based on 'unconnected data' and 'anecdotal evidence' (Astor et al. 2005:2493). From 2003 to 2006, the health workforce literature was given a major boost with the establishment of a free-access, online journal, *Human Resources for Health*, by the WHO in 2003 and the publication of two major reports by the Joint Leaning Initiative (2004) and by the WHO (2006) which specifically focused on human resources for health.

In 2000, the world's nations committed to Millennium Development Goals to decrease poverty and improve health and welfare of the world's poorest nations by 2015. After some years it was observed that, despite sufficient international funding, some of the

poorest nations in the world were lagging behind in achieving the MDGs. It was identified that lack of skilled health workers was the main hurdle in achieving health related MDGs in many countries (WHO 2006:19). To tackle these HRH issues and to generate more critical evidence, the Joint Learning Initiative (JLI) was commissioned in 2002 to identify HRH challenges and to draw workable strategies to strengthen global health workforces. This was a major initiative involving more than 100 global health experts working together that spanned some years, and in 2004 it released its landmark report titled *Human Resources for Health: Overcoming the Crisis*.

The World Health Organization (WHO) has played a lead role in bringing the health workforce issue onto global development agenda. This can be gauged from the fact that the World Health Report (2006) *Working Together for Health* was entirely focused on human resources for health issues. Furthermore, to take the HRH agenda forward, in 2006 the WHO, with other stakeholders such as governments, international institutions, researchers and professional associations, launched the Global Health Workforce Alliance (GHWA) to identify, implement and advocate for global HRH solutions (WHO 2009a).

2.4.2 Review of the Joint Learning Initiative and the World Health Organization reports

In this section two major reports on health workforce issues will be reviewed and discussed. These reports are the Joint Learning Initiative Report (2004) entitled *Human Resources for Health: Overcoming the Crisis* and the World Health Organization (2006) Annual Report entitled *Working Together for Health*. These two reports are important because they set the stage for focusing the attention of governments, academia, researchers and health advocacy groups globally on human resources for health. These reports are also important because the policies and approaches advocated by international organisations,

such as, the WHO, to solve the current global HRH crisis would have direct and indirect effects on the present and future shape of the health workforce in Pakistan.

Both these documents are reviewed together due to their similarity in approach to HRH issues and their prescribed solutions. In fact, it would not be wrong to say that the WHO (2006) Report was a next step in taking forward the global HRH agenda that builds on the JLI (2004) Report. According to these reports (JLI 2004:3; WHO 2006:11), the total global health workforce is estimated at 59 million (doctors, nurses and midwives) with an estimated global shortage of 4.3 million workers. Further estimates shows that there are 45 countries in the world with a low-density of health workers (doctors, nurses and midwives), which is defined as less than 2.5 workers per 1000 population, and high-mortality rates, and Pakistan is one of these countries (JLI 2004:2). This shortage is attributed to the increased workloads on health workers due to HIV/AIDS, especially in sub-Saharan Africa but also increasingly in Asia, the Americas and eastern Europe; the international migration of health workers especially of doctors and nurses from countries having weak health systems; and the ‘chronic underinvestment in human resources’ in the previous decades due to the economic stabilisation programs pursued in those countries (JLI 2004:1).

Both these reports called for an immediate and extraordinary action from the global community as ‘business as usual’ will not be enough and will not achieve the desired results (JLI 2004:7). To make up for the shortfall, it was recommended that at least 40 percent (US$ 4 billion) out of the US$ 10 billion official development assistance for health should be utilised for human resource development (JLI 2004:7). The reports emphasised that the cost of inaction would be devastating to the health of people in the poorest

countries of the world. Both these reports advocated for a ‘decade of human resources for health’ (2006 to 2015), to implement the HRH agenda that also coincides with the remaining ten years for achieving MDGs.

The reports have taken a strategic view of the HRH crisis and have taken a ‘worker-centred’ approach. It was recommended that in order ‘to get the right workers with the right skills in the right place doing the right things!’ a ‘working lifespan’ approach was needed that focused on the entry, work life and exit of health workers from their profession (WHO 2006:XX). At the entry level, the reports recommended strategic investment in workforce development to produce the right numbers with the right capabilities and attributes so that they are accessible to diverse populations (JLI 2004:68-70; WHO 2006:41-65). During the working life of health workers, these reports called for enhancing their performance through supportive and fair supervision, reasonable salary support, sufficient supplies, improvement in physical infrastructure, improved career paths and continuous professional development through training, opportunities for innovation and teamwork (JLI 2004:68-73; WHO 2006:67-86). At the exit level, the strategies recommended were to manage migration, making health a career of choice especially for women, by improving their working environments and conditions and by developing retirement and succession plans.

The reports discussed in detail the migration of skilled health professionals both within countries, especially from rural to urban areas, and from poor to rich countries and its associated positive and negative impacts (JLI 2004:102; WHO 2006:101). It was observed that the remittances generated by migrant workers may help in alleviating poverty in their home countries and they can bring back skills and expertise upon their return. However,

the massive increases in the scale of international migration were referred as ‘fatal flows’, especially for countries already having weak and fragile health systems. Furthermore, keeping in view the magnanimity and importance of the migration phenomenon, both these reports noted with concern the overall lack of information on the migration of health workers. The main reasons that drive this migration were classified as ‘push’ factors (in the source countries) and ‘pull’ factors (in the destination countries). The push factors identified were lack of promotion prospects, poor management, heavy workload, lack of facilities, a declining health service, inadequate living conditions and high levels of violence and crime. Among the pull factors were better remuneration, upgrading qualifications, gaining experience, a safer environment and family related matters that drive overseas migration (WHO 2006:99).

In view of the complex nature of the migration phenomenon, actions were recommended in the source countries, receiving countries and globally (WHO 2006:103-105). In the source countries, the reports call for adjusting health workers’ training according to local needs and for improving local conditions to help remove the ‘push’ factors for migration and also to encourage return migration. At the receiving countries, it was advised to adopt ethical recruitment policies keeping in view its adverse effects on countries with fragile health systems, plus ensuring fair treatment of migrant workers and helping source countries through increased funding especially for health human resource development. Likewise, at the international level, the reports called for adopting ethical international recruiting policies at the world forums such as the World Trade Organization (WTO) and also for bilateral agreements between the source and receiving countries to manage migration.

Furthermore, the reports emphasised that to have a health system composed of properly trained and motivated health workers that is accessible to the majority of the population, each country needs to develop its own country-specific health workforce strategy based on its unique local conditions (JLI 2004:134; WHO 2006:119). It was recommended that all relevant stakeholders, including the health care providers and recipients, need to be consulted in diagnosing and solving the HRH problems. In order to develop and successfully implement these country-specific plans, the reports called for mobilising political commitment and collection of regular HRH data and information. Despite the limited evidence of what works and what does not work in improving the workers' motivation and retention, these reports called for immediate action backed by further research, monitoring of interventions and sharing of results (JLI 2004:139-140; WHO 2006: 128).

2.4.3 An overview of the global health workforce

According to the World Health Organization (2006:4), a moderate estimate of the size of the global health workforce is around 59 million workers. This report defines health workers as 'all people engaged in actions whose primary intent is to enhance health' (WHO 2006:1). According to this definition, mothers caring for their sick children and other unpaid workers are in the health workforce. However, the information available on health worker numbers is generally limited to people engaged in gainful activities and, therefore, the above reported numbers only include such workers. Health workers are further divided into 'health service providers', who are people that deliver personal and non-personal services, and 'health management and support workers', who are people not involved in the direct provision of services (WHO 2006:2).

Table 2.1 shows that health service providers account for 67 percent of all global health workers though only 57 percent in the Region of the Americas. In low and middle income countries, health service providers outnumber health management and support workers where they constitute over 70 percent of the total health workforce, while this is opposite in the case of high income countries where they have more health management and support workers as compared to health service providers (WHO 2006:4).

Table 2.1: Global health workforce, by density

WHO region	**Total health workforce**		**Health service providers**		**Health management and support workers**	
	Number	Density (per 1000 population)	Number	% age of total health workforce	Number	% age of total health workforce
Africa	1640000	2.3	1360000	83	280000	17
Eastern Mediterranean	2100000	4.0	1580000	75	520000	25
South-East Asia	7040000	4.3	4730000	67	2300000	33
Western Pacific	10070000	5.8	7810000	78	2260000	23
Europe	16630000	18.9	11540000	69	5090000	31
Americas	21740000	24.8	12460000	57	9280000	43
World	59220000	9.3	39470000	67	19750000	33

Source: WHO (2006:5)

2.4.4 Scope of global medical migration and resettlement

According to Stilwell et al. (2004:595), the movement of people from one place to another has shaped today's social, political and economic world and would continue to be a major influence on societies around the world. In 2010, it is expected that almost 214 million people, or 3.1 percent of the world's population, will be living outside their country of origin for one or more years (United Nations Population Division 2009:1). It is estimated that, since 1965, these numbers have almost doubled which is a cause of significant concern for many poor countries because they are losing their highly educated citizens to

richer countries (Salafsky, Glasser & Ha 2005:521). According to Stilwell et al. (2003), around 65 percent of all economically active migrants who have migrated to developed countries are classified as 'highly skilled'. Highly skilled professionals are those who have completed tertiary education and have a professional job. With respect to the healthcare workforce this includes doctors, nurses, dentists and pharmacists (Stilwell 2004:595).

The migration of highly skilled professionals from poor to rich countries is not a recent phenomenon (Scott et al. 2004:174; Martineau, Decker & Bundred 2004:1) as this has been going on since the 1960s (Carrington & Detragiache 1998:4). However, during the last few decades, this migration from developing to developed countries has gained importance due to the increasing disease burden and human resource shortages in developing countries (Alkire & Chen 2004:67; Connell et al. 2007:1877). While there is a general agreement that the migration of doctors, both within a country and between countries, is quite substantive and is affecting health systems in the sending countries, its exact statistical extent is not known (Awases et al. 2004:33; Stilwell et al. 2004:596; Hagopian et al. 2004; WHO 2006:98).

Mejia (1978:208) has reported that in 1972 there were at least 140 000 doctors in countries other than their country of origin or training. This number was approximately equal to 6 percent of the world's physicians at that time. In the United States, the number of foreign trained graduates rose from 76,500 in 1974 (Mejia 1978:208) to 208 733 in 2004 (Mullan 2005:1811). International medical graduates (IMGs) constitute 23-28 percent of physicians in the USA, UK, Canada and Australia, and out of these 40-70 percent of the IMGs come from the lower income countries (Mullan 2005:1813). A similar picture can also be observed in other major recipient countries. In UK, the number of IMGs rose from 20 923

in 1970 to 69 813 in 2003 (Connell et al. 2007:1877). Recent estimates of African physician migration by Clemens and Pettersson (2008) show that, in the year 2000, approximately 70 000 African-born physicians were working overseas in a developed country.

According to Awases et al. (2004:38), a substantial number of health professionals (doctors, nurses, midwives and pharmacists) interviewed in the six sub-Saharan countries of Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe showed their intention to migrate, ranging from 26 percent in Uganda to 68 percent in Zimbabwe. These numbers are underestimates of the actual number of physicians migrating from developing to developed countries such as the UK, USA, Canada and Australia because they do not include doctors who have migrated to other countries. Furthermore, as argued by Clemens and Pettersson (2008), these estimates are mostly based on census or professional society data that shows the occupation of each person that he/she is currently employed in. Therefore, an African-trained doctor working outside the health sector is not included in this count. They do, however, convey the magnitude of the global extent of medical migration.

While the extent of physician migration to developed countries has increased over time, this migration, however, is not uniform towards all the destination countries and is seen to be particularly prominent in the English-speaking countries (WHO 2006:99). Data from Organization for Economic Co-operation and Development (OECD) countries show that foreign trained doctors represent more than 20 percent of the medical workforces in Australia, Canada and the US and more than 30 percent in the UK and New Zealand; whereas, these figures are below 10 percent for Portugal, France, Germany and Finland

(WHO 2006:98). Furthermore, despite best efforts, statistical data on physician resettlement into their countries could not be found.

2.4.5 Previous research into reasons for physicians' retention, migration and resettlement: An international perspective

As previously mentioned, overall there is limited previous research available that has explored the reasons for physicians' retention and migration decisions in developing countries. This compares to an extensive body of work on retention in developed countries. Furthermore, studies that have investigated physicians' resettlement decisions are rare and almost non-existent.

In a study in the late 1970s conducted by Mejia (1978) for the World Health Organization (WHO) to study physician and nurse migration patterns, it was found that most physicians and nurses that migrate seek to further their financial and professional standing. It was also found that the main 'push' factor for physician migration in sending countries is their ability to produce more doctors than their absorption capacity to employ. This is reinforced by a 'pull' factor in the receiving countries that produce less physicians then their economic capacity to employ and therefore import physicians from other countries. The study linked the number of physicians per 10 000 population to GDP per capita and argued that countries such as the United Republic of Cameroon, Ethiopia and Gabon, with a lower number of physicians per 10 000 population than the average for all countries with the same GDP, experienced a 'net inflow' of physicians. Whereas, on the other hand, countries such as India, Philippines and Pakistan that produced more doctors than the average for that level of GDP per capita suffered a 'net outflow' of physicians. Generally, the study results were of value to all developing countries having problems due to migration of their skilled health professionals. However, the study also claimed that these results are not

sufficient for individual countries to make plans and strategies that will help them in better managing their individual situations and therefore recommended individual country-specific problem-solving strategies (Mejia 1978:214).

A recent research study that specifically looked at the issues of health workers' retention, migration and resettlement was conducted by Awases et al. (2004) with doctors, nurses, midwives and pharmacists in the six African countries of Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe. This was a mixed methods study that utilised both qualitative and quantitative data sources from three different categories of respondents, that is, those respondents who were staying and still employed in these countries, those who migrated and also those health workers who had returned from overseas. The most commonly mentioned factors that would motivate health workers to remain in the countries or return were better/realistic remuneration (67.8 percent), a conducive working environment (64.2 percent), provision of continuing medical education (66.6 percent) and better management of health services (54.9 percent) (see Table 2.2).

The reasons mentioned by those with the intention to migrate and those who had already migrated in this study were different from country to country but were more or less similar for the two groups. The main reasons identified were mainly health system related problems such as unsatisfactory remuneration, including a desire for better living conditions as the most common reason cited across the countries. Other health system related reasons mentioned were to upgrade qualifications, gain overseas experience and a lack of promotion opportunities (highest in Cameroon), heavy workloads, lack of proper career structures and professional development plans, and poor organisation and delivery of the health services. Some of the common societal reasons identified by the study

respondents for their decisions to migrate were violence and crime, economic decline, decline in values and safer environments.

Table 2.2: Factors motivating health workers in six African countries to remain in or return to their countries, 2002

Country	Motivational factors			
	Better/realistic remuneration (N)	Conducive working environment (N)	Continuing education and training (N)	Better management of health services (N)
Cameroon	67.8 % (215)	64.2 % (215)	66.6 % (215)	54.9 % (215)
Ghana	84.8 % (435)	80.7 % (435)	66.9 % (435)	70.1 % (435)
Senegal	90 % (627)	*	*	*
South Africa	77.5 % (559)	67.8 % (559)	51.9 % (559)	57.8 % (559)
Uganda	83.5 % (315)	36 % (315)	29 % (315)	29 % (315)
Zimbabwe	76.6 % (231)	69.3 % (231)	50.6 % (231)	63.3 % (231)

(N): number of respondents
For Senegal, * implies all the factors in the table are applicable although there are no ratings available.
Source: Awases et al. (2004:49)

Vujicic et al. (2004) conducted a quantitative study by using the survey data obtained by Awases et al. (2004) in the above described study in six African countries. The study looked at the trends in migration flows of physicians and nurses and the wage differentials between the sending and receiving countries. The study found little or no correlation between the willingness of health professionals to migrate from developing to developed countries at the present levels of wage differentials in these countries. The study concluded that the difference in wages between the source and destination countries is so large that small increases in salaries in developing countries would be unlikely to make any impact in

slowing down this migration. Therefore, the authors suggested that provision of non-wage incentives to health professionals in developing countries such as improving working and living conditions might be a better policy option to tackle this problem in these countries. However, the study indicated that much less is known about the effect of these conditions on retention and migration and that more research is needed to look into health workers' retention and migration decisions in response to improving these non-wage conditions. Similarly, another recent qualitative study by Alonso-Garbayo and Maben (2009) concluded that 'economic incentives may be just part of the solution' and that improving working conditions, offering professional development opportunities, improving material supplies and providing better monitoring and supervision are equally important in retention of health workers in their countries.

Brown and Connell (2004) conducted an econometric study in which 251 doctors and nurses from the South Pacific Nations of Fiji, Samoa and Tonga who were either migrants, returned migrants and those who had never migrated at the time of the study were surveyed. The study proposed a predictive model for migration that incorporated personal characteristics of the respondents such as age, occupation and income; material conditions such as ownership of a house and business; family situation such as living separately from spouse and one or more parents living abroad; and country specific unobserved differences such as socio-country of birth, political conditions and cultural differences. The results for doctors from all the three countries were presented together. The study results showed that almost half of the current migrant doctors (45.83 percent) and return migrants (42.86 percent) regarded income as the primary reason for their current working situation. The study concluded that income had a major influence on the respondents' decision to join the health profession and that it was also a key factor for international migration.

The study also mentioned that, apart from income, dissatisfaction with other health system organisational and professional factors were important contributors to migration. Migrants were highly critical of the lack of an evident career structure, promotion opportunities, training opportunities and access to modern technologies. The study also concluded that health professionals from these three countries were more likely to migrate and return if they have close family members overseas or at home, respectively. This finding shows the relation of the international migration to an extended family context showing the decision to migrate and return as a function of both individual and family aspirations and goals. While the study calls for addressing the issues of recruitment and retention, it also emphasises the importance of human capital transfers through return migration. The study recommends a policy framework that encourages return migration through improvement in local working conditions, availability of promotion opportunities and provision of investment incentives.

A recent questionnaire based survey was undertaken by Benamer, Bredan and Bakoush (2009) to study the possible reasons for emigration of Libyan doctors and also to identify factors that might motivate them to return to Libya. While the study response rate was quite low (35 percent), it shed some light on the issue of medical migration in the context of an upper-middle income country like Libya. The study results showed that a majority of 65 respondents (88 percent) cited a desire for further education and research as their main reason for going abroad followed by 9 respondents (13 percent) who indicated as their first rank a desire to seek a better income and living standard. Interestingly, none of the participants, even after living abroad for fifteen years, ruled out the possibility of returning to Libya, showing that these doctors would prefer to stay in their country if provided with the right kind of opportunities. Most respondents (49, 66 percent) quoted health system

factors such as reform of the Libyan health system and improvements in the prospects for research in the country could encourage them to resettle in Libya. However, it was not clear what specific health system reforms are required in Libya. Furthermore, the study did not include the views of those doctors who returned to Libya after working abroad for some time and those who had never gone overseas. These inclusions would have made this study more comprehensive. The study recommended the use of qualitative data techniques to explore further dimensions to this complicated issue.

Hagopian et al. (2005) conducted a qualitative study using interviews and focus groups with faculty members, administrators, students and postgraduate residents in Ghana and Nigeria. The study revealed that almost all the students and residents in both the countries showed a strong desire to go overseas. Apart from the common health system factors, such as low salaries and insufficient postgraduate training opportunities that encourage migration, the study also found a 'strong culture of migration' in both countries. Training and working abroad is regarded as a 'marker of success'. Even the faculty members in medical schools encourage migration and measure their own success by the number of their students who work in the Western countries. In both the countries, the study respondents described postgraduate training as 'frustrating'. The students complained about prolongation of their specialisation duration as they can only take exams when approved by their supervisors. Decisions about success in examinations were described as 'arbitrary' with a low pass rate of 30 percent. Poor salary structure was also described as a reason for residents doing private practice to increase their earnings that keep them from being ready to take exams. Societal factors such as labour strikes, political corruption, poor infrastructure and the general low standard of living in both Ghana and Nigeria were described as motivational factors for migration. The study has made a valuable

contribution to our understanding of this complex phenomenon by including the views of physicians and medical faculty members; however, the views of other important stakeholders in this issue such as the Ministry of Health have not been included.

Another qualitative study by Akl et al. (2007) was conducted with medical students in Lebanon to explore the factors underlying the decision to train abroad. The study categorised factors that encourage or discourage these students to train abroad into personal, social, professional and political dimensions; however, these were not described according to their relative contributions to migration and retention decisions. The health system factors identified were the lack of availability of good postgraduate medical training in Lebanon such as not enough training positions, quality of the training and teachers' commitment to training; poor salaries for trainees leading to financial dependency; and poor working conditions such as high workload, lack of professional ethics and lack of continuous professional development opportunities. The societal factors identified by these students that shaped their migration intentions were social valuing of overseas training by the society in general and also by the medical professional in particular, marketing of abroad training in movies and TV series, a well-developed culture of migration in Lebanon, regional and national instability, personal insecurity and discontent with social norms and the sectarian social system affecting social rights.

Furthermore, in addition to the usual 'push' factors in Lebanon and 'pull' factors in developed countries for overseas migration, the study also found that there are certain 'retain factors' in Lebanon and 'repel factors' in Western countries that contributed to the Lebanese students' decision to remain in their country. The personal and family related retain factors identified by these students were inability or unwillingness of the partner to

travel abroad, desire to stay with family, family and societal pressure not to travel alone especially in the case of females, patriotic feelings and lack of family support abroad. The only health system related attraction that led medical students to stay in their country was a chance to build their customers at home while still undergoing training. The study also found some societal factors that shaped Lebanese students' intentions not to go overseas for further training. These factors were worries about living and raising children in a different culture, apprehensions about general happiness while abroad and the negative perceptions of Western societies about Middle Easterners, especially Muslims, and the policies of certain governments towards migrants. Furthermore, the study also identified certain barriers such as the process of document certification, costs of travelling and related expenses, and visa issues that prevent intending medical students from going abroad; however, it is not clear to what extent these barriers prevent student migration.

Oman, Moulds and Usher (2009b) conducted a mixed methods study predominantly using qualitative interviews for data collection in Fiji. They interviewed only specialist doctors who completed their postgraduate training in Fiji about their career decisions for staying in the public sector, moving into private practice within their country and also for overseas migration. The main reasons cited by the majority of the respondents for overseas migration were the political instability after the 2000 coup in Fiji with concerns about raising families in an unstable environment and having problems with working conditions and career structure. Interestingly, some of the participants mentioned low remuneration as a contributing factor and none mentioned further postgraduate training as a reason for migration. On the other hand, according to this study, those who preferred to stay in Fiji, whether in the public or private sector, did mention work related problems and frustration; however, they were of the opinion that they stayed because of their desire to serve their

own people and their strong belief in God. Many doctors also described their commitment to their families and friends and a strong attachment to their country and culture that kept them in Fiji. Furthermore, the study had a few important limitations as it was focused on specialist doctors only and the views of medical students and doctors in rural areas were not included, and there was less representation of migrant Fijian doctors (35 percent) in the study sample. Additionally, the long involvement of the principal researcher in Fiji and in the design and development of the postgraduate courses for the study participants could have led to a response bias including the avoidance of certain topics by the participating doctors.

Overall, political instability, violence and personal insecurity as a factor motivating physician migration has not received its due attention in the health workers' migration literature (Burnham, Lafta & Doocy 2009:172); however, recent studies conducted by Akl et al. (2007) in Lebanon and Oman, Moulds and Usher (2009b) in Fiji have found violence and regional and national instability as a cause for physician overseas migration from these countries. Recently, Burnham, Lafta and Doocy (2009) conducted a study to measure the changes in numbers of specialist doctors in twelve Iraqi tertiary hospitals (in Baghdad, Basra, Erbil and Mosul) between 2004 and 2007 by using hospital staffing records. The study found a decrease in the number of specialists from 1243 on 1 January 2004 to 1166 by late 2007 which is 94 percent of the original number. In Baghdad, specialists decreased to 78 percent by late 2007, whereas, in other regions (Basra, Erbil and Mosul), the number of specialist doctors increased by 134 percent of the original number in 2004. The study also found that a total of 576 specialists left their positions in the twelve hospitals during the period of the study. Reasons for leaving their jobs were found for 549 specialist doctors and included moving/transferring (74 percent), retirement (12 percent), escaping threats (7

percent), violent deaths (4 percent), kidnapping or threats (2 percent) and non-violent deaths (1 percent). Of the 430 specialists who left for reasons other than retirement, 39 percent moved to other areas within in Iraq and 61 percent left for other countries. This study had a number of limitations that included inclusion of data only on specialist doctors in the four major cities and excluding other areas, problems with incompleteness of hospital records, recall problems, high turnover of clerical staff responsible for maintaining hospital records and the sensitive nature of information in a country having sectarian problems.

2.5 Background to human resources for health situation in Pakistan

2.5.1 Overview of Pakistan

The Islamic Republic of Pakistan is a federal republic that stretches from China in the north to the Arabian Sea in the south and from India in the east to Afghanistan and Iran in the west (sees Figure 2.1). On 14 August 1947, the separation of former British India led to the creation of Pakistan comprising East and West parts. In 1971, after a civil war, East Pakistan separated to form the independent country of Bangladesh.

Pakistan has a population of more than 169 million and a territory spread over 796 096 square kilometres (Government of Pakistan 2010). Administratively, it is made up of four provinces/states: Balochistan, Khyber Pakhtunkhwa (formerly North-West Frontier Province), Punjab and Sind along with the Federally Administered Tribal Areas (FATAs), Gilgit-Baltistan (formerly the Northern Areas) and the Azad and Jammu Kashmir. Each province is divided into districts which in turn are comprised of Tehsils/Taluks (sub-districts) which are further divided into a number of Union Councils depending on the area

and the size of the population in each district. A Union Council is the lowest administrative unit and is comprised of approximately ten villages in rural areas (Government of Pakistan 2010).

Figure 2.1: Pakistan – country map

While the national language of Pakistan is *Urdu* (Government of Pakistan 2010), which is the most commonly spoken language, there are multiple regional languages and dialects used throughout the country. *English* is the official language and is widely used for instructional purposes in higher education, including professional institutions, as well as commercial, legal, government and official businesses in the country.

2.5.2 The health delivery system of Pakistan

Health is on the ‘concurrent list’ in the Constitution of Pakistan where the federal government formulates the national health policies and helps the provincial governments in the implementation and delivery of health services (Collins, Omar & Tarin 2002:124-125). The role of the federal government (Ministry of Health) involves policy-making,

coordination, technical support, research, training and seeking foreign assistance (Nishtar 2006:3). It also operates a few tertiary hospitals (Jinnah Postgraduate Medical Centre, National Institute of Cardiovascular Diseases and National Institute of Child Health, National Institute for Handicapped, Pakistan Institute of Medical Sciences, National Institute of Health) and several federally funded preventive health care programs (Lady Health Workers' Program, Tuberculosis, Malaria and AIDS Control Programs, Nutrition Program, Expanded Program on Immunization, Prime Minister's Program for prevention and control of Hepatitis, National Maternal and Child Health Program and National Blindness Control Program). Due to the passage of the 18th Constitutional Amendment in March 2010, most of the subjects in the concurrent list of the Constitution, including health, have been transferred to the provinces. However, it is yet to be seen if the Federal Ministry of Health will retain some of its functions or will be abolished altogether and its functions transferred to the provinces.

The provincial and district departments of health are responsible for the delivery and management of health services. The provincial governments operate tertiary care hospitals in the major cities. In each district, the district government (local government) runs an extensive network of first care facilities and secondary care hospitals which were previously being run by the provincial governments before the devolution of health services to the district under the Local Government Ordinance (LGO) of 2001. However, during the present coalition government in Pakistan, efforts were being made by the provinces to take back the control of these health facilities from the district governments. Several federal programs including the community based Lady Health Workers' Program support this network. The government is the major provider of curative hospital services in rural areas and is also the main provider of preventive care services throughout the

country. Overall, Pakistan's health delivery system is a combination of both public and private providers (Shaikh & Hatcher 2004:50).

2.5.2.1 Government health services

The government or public health delivery system is organised in four tiers as shown in Figure 2.2. These four tiers are described as follows.

At the lower level, the Lady Health Workers are the frontline providers and are responsible for outreach and community based activities such as immunisation, sanitation, malaria and tuberculosis control, maternal and child health and family planning (Siddiqi et al. 2001:194).

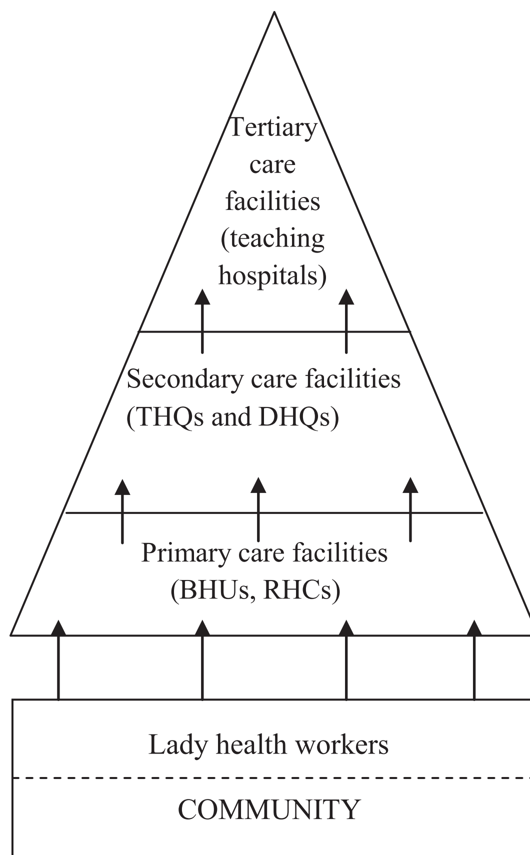

Figure 2.2: Pakistan public health service infrastructure
Source: Siddiqi (2001:194)

The second tier is composed of primary care facilities, that is Basic Health Units (BHUs) and Rural Health Centres (RHCs), which mainly provide outpatient care (World Bank 1998:15). A Basic Health Unit (BHU) provides curative and preventive services for an approximate population of about 10 000 – 20 000 people. It is staffed by a Medical Officer (doctor) and other technical and non-technical support staff. Rural Health Centres (RHCs), which are staffed by several doctors and paramedical personnel, provide more extensive outpatient services and some inpatient services to a population of around 25 000 – 50 000. These have 10-20 beds for admissions, x-ray facilities, laboratory and minor surgical operation facilities.

The third level is composed of secondary care facilities called Tehsil/Taluka Headquarter Hospitals (THQs) and District Headquarter Hospitals (DHQs) (World Bank 1998:15). The THQ Hospitals provide basic inpatient services and some specialist care as well as outpatient services with x-ray, laboratory and surgery facilities. They have around 40-50 beds and provide services to a population of about 100 000 – 300 000 people. DHQ Hospitals serve approximately about 1 – 2 million people and provide a range of specialist care in addition to basic hospital and outpatient services. These have around 80-100 beds for admissions.

At the top of the pyramid there are tertiary care facilities consisting of teaching hospitals, mostly attached to medical schools and under the direct control of the provincial departments of health. These have more than 1000 beds and provide all type of specialised medical care. In 1999/2000, tertiary care hospitals in the province of Punjab and Khyber Pakhtunkhwa were granted administrative and financial autonomy by their respective provincial governments to improve the quality, efficiency and availability of services and

also to improve the economic viability of these institutions (Abdullah & Shaw 2007:51-52).

Furthermore, some government departments/organisations such as the armed forces, Pakistan Railways, Pakistan International Airline (PIA), Pakistan Telecommunication Company Limited (PTCL), Water and Power Development Authority (WAPDA) and Employees Social Security Institutions run their own medical institutions for their employees and their families.

The Executive District Officer (Health), [EDO (H)] is responsible for all health services in his/her district. Managers of all first-level care facilities, Tehsil Headquarter Hospitals and District Headquarter Hospital report to him/her. Each EDO (H) reports to the Director General (DG) of Health who is supervised by the Secretary of Health at the provincial level. The DG of Health and is responsible for the overall organisation and management of the public health system throughout the province (Collins, Omar & Tarin 2002:126; Abdullah & Shaw 2007:49).

2.5.2.2 Private health services

The private health sector includes both the for-profit providers and the non-government organisations (NGOs) and is the provider of around 70 percent of the health care in Pakistan (Nishtar 2006:84). The sector consists of a diverse group of doctors, nurses, pharmacists, laboratory technicians, unqualified practitioners traditional healers and shopkeepers and is mostly concentrated in urban areas. However, in some cases the distinction between public and private sector is difficult to make as many public sector employees also work privately in the evening.

The most common form of private care is provided by general practitioners (GPs), who run their own office based practices. These GPs are qualified doctors who have completed their basic medical qualification and one year compulsory house-job/internship but are not properly trained or designated as general practitioners as in the case of Australia or the UK due to the lack of a general practice career pathway in Pakistan. Other private sector facilities include small maternal and child health centres (also known as maternity homes), dispensaries and small to medium-size diagnostic laboratories and private hospitals with, on average, about thirty beds per hospital (World Bank 1998:16). They can only provide basic surgical, obstetric and diagnostic services, and mainly provide low-risk care. Furthermore, there are few large private hospitals which are located in major cities.

Another very important part of the private health care sector is the private drug pharmacies and small grocery shops that sell medicines mostly in rural areas. Those running these retail outlets have no pharmacy training and medicines, including antibiotics and other drugs, can be freely purchased without the need for a prescription from a qualified medical practitioner. In addition to shop owners, many others such as school teachers and mosque prayer leaders practise medicine with little or no training (World Bank 1998:16; Nishtar 2006:83). The number of untrained providers practising medicine greatly exceeds that of trained physicians mostly in rural areas.

In addition to the practitioners who practice Western medicine, there is also a large number of alternative health care providers. These practitioners, such as traditional birth attendants, homeopaths, hakims, traditional/spiritual healers, *Unani* (Greco-arab) healers, bonesetters and herbalists, are also common especially in the rural settings (Shaikh & Hatcher 2004:50). According to the World Bank report (1998*),* approximately 20 percent of the

population uses government health services, 50 percent use private service providers, and 30 percent use other private traditional or untrained care-givers as their first contact for their outpatient medical consultation.

According to an estimate, there are more than 80 000 not-for-profit non-government organisations (NGOs) registered under various acts in Pakistan (Nishtar 2006:90); however, in Pakistan, the exact number of NGOs working in the health sector is not known. According to the majority view, the number of health related NGOs is not very large, most of them are very small in size and they are mostly based in urban centres (World Bank 1998:17). There are a few exceptions to this, such as the Aga Khan Health Services, which has been successful in implementing its community-oriented primary health care model in some districts of Gilgit-Baltistan. Another such example is that of the Punjab Rural Support Program (PRSP) which has managed the government primary care health facilities in some districts of Punjab province for the last couple of years.

In Pakistan, revenue generated through taxes and out-of-pocket expenses are the major modes of financing health within the country with some donor contributions (Nishtar 2006:2). Most people receive healthcare through private out-of-pocket payments made directly to the providers at the point of care. According to Nishtar (2006:3), less than 3.5 percent of the employees are covered under the Employees Social Security Scheme and although there are limited social protection funds such as *Zakat* (compulsory religious contribution made by every Muslim once a year) and *Bait-ul-Mal* (a government department for helping the poor and the needy), which serve approximately 3.4 percent of the population in need of medical care, there is an overall lack of a comprehensive social protection mechanism in Pakistan (Nishtar 2006:3).

Table 2.3: Pakistan health outcome indicators

Health indicator	1960-70	1980	1990	2000	2005	2007
Life expectancy	43	-	62	65	63	65
Infant mortality rate (per 1000)	137	127	95	82	75	-
Under 5 mortality rate (per 1000)	221	158	137	118	111	90
Maternal mortality ratio (per 100,000)	-	800 (1978)	400	350	350	-
Population growth rate	3	3	3	2	2	2
Vaccination coverage (children 12-23 months fully immunized)	-	-	-	49	77	80
Births attended by skilled health staff	-	-	35	23	31	39
Contraceptive prevalence	4	-	12	28	34	30

Source: Mahbub ul Haq Human Development Centre (1997), Nishtar (2007), WHO, UNICEF, DFID, UK & WB (2007) and World Bank (2010)

2.5.3 Current health situation in Pakistan

The health of the people in Pakistan has improved over the past few decades (see Table 2.3); however, the pace of improvement has not been considered satisfactory and is unlikely to meet the health related targets set out in the Millennium Development Goals (MDGs) (WHO, UNICEF, DFID, UK & WB 2007:8). Today, Pakistan still lags well behind its neighbours in terms of most health indicators, even though its' GNP per capita is above or almost comparable to these countries (see Table 2.4).

The factors behind this poor performance of health in Pakistan are many and include poverty, low education level, the low status of women, inadequate sanitation and water supplies and poor quality of health services both in the public and private sectors (Shaikh & Hatcher 2004:50). Within the health sector the problems are structural fragmentation, gender insensitivity, resource scarcity, inefficiency, and lack of accessibility and utilisation (Islam 2002:174).

Table 2.4: Regional comparison of selected health indicators, 2007

Health indicator	Pakistan	Bangladesh	India	Nepal	Sri Lanka	Australia
Life expectancy	65	66	65	64	72	81
Infant mortality rate (per 1000)	73	47	54	43	16	5
Under 5 mortality rate (per 1000)	90	60	72	55	20	6
Maternal mortality ratio (per 100,000)	320 (2005)	570 (2005)	450 (2005)	830 (2005)	58 (2005)	4 (2005)
Population growth rate	2	1	1	2	1	2
Immunisation, measles (% age of children 12-23 months)	80	88	67	81	98	94
Births attended by skilled health staff	39	18	47	19	99	99 (2000)
Contraceptive prevalence	30	56	56 (2006)	48 (2006)	68	-
GNI per capita (US $)	860	480	950	350	1540	35760

Source: World Bank (2009a)

The Burden of Disease (BOD) studies measure the loss of healthy life in the form of disability and premature death due to all episodes of disease and injuries occurring in a given year (World Bank 1998:13). According to the WHO (2009b), the total BOD in Pakistan in the year 2004 was about 26 112 disability-adjusted life years (DALYs) per 100 000 population per year. This is lower only than the corresponding figure for most sub-Saharan African countries and for war ravaged countries such as Afghanistan with 74 186, Iraq with 53 044, and Somalia with 68 800 DALYs per 100 000 population in 2004. It is about the same as India (27 316/100 000), but much higher than China (15 279/100 000) and is about three times the figure for Australia (11 070/100 000) in 2004. The distribution of Pakistan's BOD in broad categories of communicable, non-communicable, maternal and perinatal conditions and injuries is given in Table 2.5 below.

Table 2.5: Percentage of the total number of DALYs lost in Pakistan, by cause

Causes of burden of disease	Percentage	
	1990*	2004**
Communicable diseases	38.4	27.6
Non-communicable diseases	37.7	42.9
Maternal and perinatal conditions	12.5	19.5
Injuries	11.4	9.8

Source: *World Bank (1998:14), **WHO (2009b)

Table 2.5 indicates that Pakistan is in a 'dynamic stage of epidemiologic transition' (Hyder & Morrow 2000:1239; Mohammad, Hafeez & Nishtar 2007:315). This shows that the burden of chronic disease is being added while it is still struggling with the existing communicable disease burden. The latest WHO estimates for 2004 show that this burden is gradually being shifted towards non-communicable diseases. This has important policy implications in terms of the present health resource distribution in public health and underscores the need for allocations for non-communicable diseases at par with the communicable diseases (Nishtar 2007:17).

2.5.4 The context of healthcare in Pakistan

Health is an issue that cannot be viewed in isolation as it is inextricably related to other socioeconomic and political conditions of a country. According to Zaidi (1988:3), the health care system in Pakistan is a 'highly inequitable, Western oriented curative care model which certainly does not fulfill the requirements of the majority of the people'. The problems of health care are linked directly to the prevailing social, economic and political system that determines the allocation of resources within and outside the health sector. Therefore, the following sections that analyse the historical, political and socioeconomic

conditions that have shaped the present day health care system of Pakistan are presented in order to situate the purpose of this study.

2.5.4.1 Historical conditions

The health care system and related services cannot be seen outside the larger structures of the society and of the economy of which they are an integral part (Zaidi 1994:1388). Often, health care is shaped by factors not specific to the health care alone. Countries which are under foreign rule or have had their social, political and economic institutions affected by such an experience have a health care system affected as a result of that foreign influence.

Like many former colonies, the context of the present day health care system in Pakistan is characterised by the system established by the British colonial rulers in British India (now Bangladesh, India and Pakistan) before independence in 1947. The history of British annexation of India dates back to 1601 with the founding of a trading company, the East India Company, until 1947 with the emergence of Pakistan and India as independent states (Jeffery 1988:16).

According to Banerji (cited in Zaidi 1994:1388), in the Indian subcontinent 'every facet of Indian life including the medical and public health services were subordinated to the commercial, political and administrative interests of the imperial government in London'. Initially the colonial health care system was designed to meet the needs of the British civil and military administrative personnel and their families stationed in the colonies. With the passage of time, the local elite were co-opted as administrators and were also given access to the educational and medical facilities formerly reserved for foreigners.

A sizeable group of British trained local professionals then emerged who worked closely with the British officials. This elite class of professionals was developed with the intention that they could take power at the time of independence of these colonies. In the health system, this was done through the neglect of indigenous/traditional medicine (Gish 1979:7) and by the establishment of the elite Indian Medical Service (IMS) during British rule (Jeffery 1988:41). According to Banerji (cited in Zaidi 1994:1388), as a result, when the colonial rule ended they retained considerable influence on the health services of the country by ensuring that the elite medical professionals remained dependent on them. However, according to Zaidi (1994:1388), it was not only the medical services but the entire civil, military, administrative and educational services which were handed over by the British to the local elite. Thus, they left behind societies which were completely transformed by this experience and despite their apparent independence, they had very strong social, cultural, educational and political links with their former rulers.

After gaining independence, the new rulers continued the policies of their colonial masters. As in every other sphere of life, health structures and institutions built by the colonial rulers remained dominant; the only change was in administration as local officials replaced foreigners. Despite independence it would be easy to conclude that the health care system has not changed much, and it would be fair to say that in principle the old pattern still remains intact (Zaidi, 1994:1388).

Given the post-colonial experiences in Pakistan and by choosing the capitalist path of modernisation and development without paying attention to social sector development, Pakistan now has a health care system that has the following salient characteristics (Zaidi 1994:1388):

- It is curative care oriented
- Primary and preventive health care has been recently added to the old system without much consideration and thought which has created a multitude of its own issues
- It is inequitable both by region and social class
- It is hospital and urban based
- It is doctor oriented with more doctors compared to other auxiliary health staff
- The medical education system is mostly based on surgical and medical skills with little emphasis on community or preventive medicine

2.5.4.2 Political conditions

The Constitution of Pakistan envisages a Federal Parliamentary System of government, with the President as the Head of State and the popularly elected Prime Minister as the Head of Government. The President is elected by the members of Parliament and the four Provincial Assemblies for a period of five years. The Federal Legislature is a bicameral Majlis-e-Shoora (Parliament), composed of the National Assembly and the Senate (Government of Pakistan 2010). In each province, there is a provincial assembly with a popularly elected Chief Minister. Furthermore, after the implementation of the Devolution Act of 2001, there is a district assembly headed by a popularly elected District Nazim (Mayor) in each district.

Despite being a federal republic, the political history of Pakistan is marred by constant disruptions and instability and real democracy was not allowed to flourish and take hold. This is evident from the fact that, since the creation of Pakistan in 1947, the government has changed twenty-three times and direct military rule has been longer than the elected

governments (Pappas et al. 2009). Even during the so-called democratically elected civilian governments, the military retained the upper hand in the decision-making. Khan and Heuvel (2007:282) claimed that no civilian government in Pakistan remained in power for more than three years thereby did not have the required time to pursue their desired policies.

Since the independence of Pakistan, the actual power has remained in the hands of an elite troika, which comprises the landed class, the urban industrialist class and the civil (including the judiciary) and military bureaucracy, which has become a part of the upper class through corruption and various subsidised land deals (Haque 2007). The political history of Pakistan shows that despite different civilian and military governments remaining in power from time to time, the basic socio-political structure of the society has remained the same as it was in the time of British rule. The status quo remained even during civilian rule no matter which political party (right or left wing or religious) was in power. This is because the real power always remained with the elite class. Therefore, in reality, Pakistan, in the words of Dr. Ishrat Husain (2000), former Governor State Bank of Pakistan, is an elitist state. As a result, no meaningful reforms have ever been introduced in Pakistan and whatever little effort was undertaken to bring about change has always been blocked by the entrenched elite class.

Another important political factor that has influenced the introduction of any meaningful reforms is that, soon after its independence, as in most other third world countries, Pakistan followed the path of a capitalist economic model of development (Zaidi 1985:473). The assumption that with a trickle-down effect higher growth would automatically result in the reduction of poverty has not been witnessed in the recent history of Pakistan. Instead there

has been a growing gap between the rich and the poor. As a result of these politically led economic policies, the proportion of people living under the poverty line (on a $2 per day criterion) is around 73.6 percent (Alam 2007). According to Husain (2007), it is being proved beyond any doubt that the benefits of economic growth have not been distributed equitably. Furthermore, Husain (2007) is of the view that, although the government has used the remedies of devolution and poverty-targeted interventions to spread benefits, the results have not been encouraging.

2.5.4.3 Socioeconomic conditions

Pakistan's economic growth rate remained favourable during the 1960s to 1990s averaging about 5.8 percent annually with some decline during the present decade (Etienne 2002:188). Despite this fair economic growth, it has made only marginal improvement in the development of its social indicators, particularly in the field of health (see Table 2.3), education and women's development. The quality of life among its people has not corresponded to the economic growth as successive governments did not translate its economic progress into human development.

According to the latest Human Development Index (HDI) rankings, which use data on life expectancy, education and income as the main sources, Pakistan ranks 141 out of 182 countries (United Nations Development Programme [UNDP] 2009). In contrast, Norway ranks at the top followed by Australia and Iceland, second and third respectively, on the HDI. It also ranks lowest in the South Asian region in most of the gender related human development indicators (Mahbub ul Haq Human Development Centre 2008:289-293).

Despite Pakistan's comparable per capita income to its other South Asian neighbours, budget allocations for the social sectors in Pakistan have remained consistently low (see

Table 2.6). As indicated in Table 2.6, Pakistan's allocation for health (0.8 percent) and education (2.8 percent) are the lowest among the listed developing countries; whereas, on the other hand, its expenditure on defence is the highest among these countries. According to Mohammad, Hafeez and Nishtar (2007:311), the government was spending Rs 375 (US$ 6.4) per head on health in Pakistan in 2004-05; however, the recommendation of the WHO Commission for Macroeconomics and Health is to increase public spending on health to at least to US$ 34 per head to achieve the MDGs by 2015. This would mean that Pakistan would have to increase its current health budget by 50 percent to achieve the MDGs targets by 2015. These budget allocations are indicative of the value placed on the social sector by the state and its policy and decision-makers. In contrast to Pakistan, industrialised countries such as Australia have placed high a value on education and health which is reflected in its budget allocations for these sectors (see Table 2.6).

Table 2.6: Per capita GDP and public expenditure on defence, health and education, 2007

Country	**GDP per capita**	**Public expenditure (as % of GDP) on**		
		Defence	**Health**	**Education**
Pakistan	881	3.6	0.8	2.8
Bangladesh	434	1.2	1.1	2.6
Bhutan	1,706	-	3.3	5.1 (2008)
India	1,046	2.5	1.1	3.2 (2006)
Nepal	364	1.6	2.0	3.8 (2008)
Sri Lanka	1,617	2.9	2.0	-
Australia	38,959	1.8	6.0 (2008)	5.2 (2006)

Source: World Bank (2010)

Recent research by Rajaratnam et al. (2010:1992) shows that 33 percent of deaths in children under-5 years of age are occurring in South Asia, and within South Asia, Pakistan has the second highest under-5 mortality rate of 80.3, less only than that of Afghanistan

with 121.3. Another such recent study by Hogan et al. (2010:1609) found that there were 342 900 maternal deaths worldwide in 2008 and more than 50 percent of all these maternal deaths occurred in only six countries: Afghanistan, Ethiopia, Democratic Republic of Congo, Nigeria, Pakistan and India. Both under-5 mortality and maternal mortality are Millennium Development Goal 4 and 5 respectively. These statistics attest to the level of priority that health and other social sectors receive in Pakistan.

Evidence shows that even the distribution of available meagre resources for health was done on political expediency and based on the misplaced priorities of the rulers. For example, the Government of Pakistan spent US$ 1.06 million on the overseas treatment of eleven members of the Pakistani elite which is more than the annual budget of a tertiary care hospital and is thirteen times more than government expenditure on the control and prevention of non-communicable diseases (Pappas et al. 2009). Likewise, according to Pappas et al. (2009), in October 2006, the Government of Pakistan approved the construction of two ‘medical towers’ to cater for medical tourism for high tech medicine at a cost of about Rs. 6.5 billion in the absence of any feasibility study or business plan. Similarly, Shafqat and Zaidi (2007:443) are of the view that due to inadequate and inappropriate investment in local health care systems, Pakistan, like other developing countries, is facing both a severe shortage of health care professionals and a high level of unemployment among physicians.

2.6 Health workforce literature: A Pakistani review

2.6.1 An overview of the Pakistani health workforce

Table 2.7 illustrates the total numbers and ratios of some of the selected human resources for health registered till 2008 in Pakistan. However, these are the total number of registered health personnel and there is no information available on the actual number of available health human resources in the country. According to Biggs (2008:61), the Pakistan Medical and Dental Council (PMDC) (which is the statutory body for physicians registration in Pakistan) produce an annual report based on physician registration every five to ten years. This report only contains information on the total number of registered doctors with basic medical qualifications and also those with additional postgraduate qualifications. However, this information is uncertain regarding the actual number of doctors working in the system, and their quantum of work, whether full-time, part-time or not currently working. Likewise, there is a common belief in Pakistan that a large number of female doctors leave medical practice soon after their graduation; however, there is no data to support this contention (Biggs 2008:61).

It is true that Pakistan has invested heavily in the production of doctors compared to other health workers such as nurses, paramedics and technicians (Nishtar 2007:193); however, some evidence suggests that Pakistan still needs doctors and will not be able to meet its physician needs given the current production levels and the dependency of its health care system on physicians (Talati & Pappas 2006:55). Therefore, although the 'imbalances in health workforce in terms of cadre, gender and distribution are well known in Pakistan' (WHO, UNICEF, DFID, UK & World Bank 2007:11), due to the limited data and research on health workforce the exact picture of the total human resources for health in Pakistan is difficult to determine.

Table 2.7: Number of registered health workforce, 2008, Pakistan

Category	Total numbers
Doctors	133,956
Dentists	9,012
Nurses	65,387
Lady health visitors	10,002
Midwives	25,534
Lady health workers	96,000
Population per doctor	1,212
Population per dentist	18,010
Population per nurse	2,993
Female population per Lady health worker	21,695
Female population per midwife	6,412

Source: Federal Bureau of Statistics (2009:226) and Khan (2009:171)

2.6.2 Scope of medical migration and resettlement in Pakistan

As stated above, due to the paucity of data and research on the medical workforce in Pakistan, it is difficult to obtain a concrete figure for physician migration; however, some researchers are of the view that a sizable number of Pakistani physicians are working abroad. According to Shiwani (2006:252), 'brain drain is a significant problem in Pakistan like many other developing countries'. According to Mullan (2005:1812), Pakistan is the third leading source of medical graduates serving in Australia, Canada, the United Kingdom and the United States with an approximate number of 12 813 physicians. This estimate seems to be an underestimate because it does not take into account Pakistani physicians working in other countries. On the other hand, Khan (2004:1) predicted that there were 25 000 medical graduates outside Pakistan. The extent of Pakistani physician migration can also be gauged from a recent study by Jenkins et al. (2010:4), wherein it was reported that approximately 1158 Pakistani psychiatrists were working in the UK, US, New Zealand and Australia and only 315 psychiatrists were remaining in the country. This

study further revealed that the ratio of psychiatrists per 10 000 populations in Pakistan would be four to five times higher had the psychiatrists from Pakistan currently working abroad remained in their country of origin.

Shafqat and Zaidi (2007:442) have quoted the example of the Aga Khan University Medical College in Karachi which has produced 1100 medical graduates till 2004, and out of these, 900 alone had gone to United States for postgraduate medical education. In another study by Syed et al. (2008:63), it is quoted that 70-80 percent of the Aga Khan University and around 50 percent of the Baqai University medical graduates were working outside the country. These study results show that over 95 percent of final year medical students from the Aga Khan University and over 65 percent of students from the Baqai University intended to go overseas for training. In another study conducted at a teaching hospital of Bahawalpur, Pakistan by Ghazali et al. (2007:43), it was found that 78 percent of doctors who participated in the study were willing to serve abroad.

According to Shafqat and Zaidi (2005:493) and Talati and Pappas (2006:56), resettlement requires a lot of motivation and resources but those physicians who do return to their countries of origin contribute to becoming trend-setters in clinical practice, leaders in education and research and also contribute to the country's health policy and public health. In the case of Pakistan, due to the absence of systematic data on physician retention, migration and repatriation, it would be hard to find rigorous numbers but the general sense is that only a small proportion of Pakistani physicians return home after training or working abroad. According to an estimate by Shafqat and Zaidi (2005:493), around 200 US-trained and several-fold more UK-trained Pakistani consultants and specialists are now resettled and working in Pakistan. Likewise in another paper by Shafqat and Zaidi

(2007:442), it is quoted that only 300 of the 10 000 Pakistani physicians working in the United States have resettled back home.

2.6.3 Previous research into reasons for physicians' retention, migration and resettlement: A Pakistani perspective

2.6.3.1 Previous research

Overall, while the international literature on physicians' retention, migration and resettlement is limited, previous research that looked at this issue in the Pakistani context is even more constrained. To the researcher's knowledge, there are only two studies that have looked at the reasons for Pakistani physicians' migration decisions and there is no study that has researched the reasons for Pakistani doctors' retention or resettlement issues.

A questionnaire survey was conducted by Astor et al. (2005) among professionals still working in Columbia, India, Nigeria, Pakistan and the Philippines (but not those who have migrated) regarding the factors that motivate doctors in their respective countries to migrate abroad. The study respondents included professors or health professionals working in a university or medical school setting; officials and researchers working for national and international governmental and development agencies; representatives of private organisations and NGOs dealing with migration, health and development; physicians of different specialities and experts from population studies and development economics. A total of 644 professionals participated in this study with Colombia (n=150), India (n=115), Nigeria (n=133), Pakistan (n=134) and the Philippines (n=112). The study results were reported in aggregate and the findings showed that 90.8 percent of the respondents rated a desire for a higher income or more buying power as the most significant motivating factor for doctors to migrate. This was followed by other factors such as greater access to

technology and equipment (74.1 percent), improved prospects for one's children (78.0 percent), the desire to live in an economically stable country (72.5 percent) and general security and stability (51.9 percent).

The other study conducted by Syed et al. (2008) was also a questionnaire based survey in which final year students of two private medical schools at the Aga Khan University (AKU) and Baqai University (BU) in Karachi, Pakistan were asked about the reasons for their intention to migrate aboard or remain in Pakistan. The study participants involved 86 students at AKU and 150 students at BU. Over 93 percent of the students at AKU and 65 percent at BU cited poor quality of postgraduate medical training in Pakistan as the most important factor influencing their decision to go overseas. This was followed by lower salaries offered to the postgraduate trainees in Pakistan. Post-training economic prospects was the third most important factor in their intention for migration. Over 50 percent of the students who responded to the open-ended questions mentioned poor working environment and lack of rigour in the postgraduate education programs in Pakistan as the major factors behind their migration intentions. Poor work environment was defined as poor physical work environment, rude behaviour of seniors, unfriendly attitudes and lack of cooperation.

On the other hand, the major reasons mentioned by students who intended to stay in Pakistan were personal and family related factors such as family ties, the desire to serve their nation and to settle in Pakistan. Some students also mentioned the huge number and variety of patients encountered during their training in Pakistan as compared to the West that assisted them in gaining broad clinical experience. Interestingly, only 10 percent of the study respondents from both the universities who intended to go overseas for postgraduate training wanted to settle abroad after completing their training overseas. This showed that

majority of the students were going overseas with the intention of coming back into their country.

An overall lack of facilities and incentives for doctors to serve in rural areas leads to their increasing concentration in urban towns. This may lead to oversaturation, unemployment and eventually overseas migration. Javed and Amin (2007:19) have identified an unwillingness of physicians to work in rural areas as one of the most important reasons for the lack of adequate health care provision for people living in the rural areas of Pakistan. They further stated that this is due to the lack of social networks, civic amenities, limited opportunities for professional development and even fewer opportunities for education of children. In another study by Farooq et al. (2004), 70 percent of all the interviewed physicians were unwilling to work in a rural health facility and the main reasons were the lack of professional growth and delay in their postgraduation training by working in rural areas. These study results showed the presence of electricity in only 33.3 percent of rural health facilities, functional toilets in 36.5 percent, safe water at 20.6 percent and telephone services at 6.3 percent, while natural gas for domestic use was present at only 1.6 percent of the facilities, showing the importance of these utilities in the retention of physicians in rural health facilities. In an earlier study by Zaidi (1988), it was reported that only 17 percent of the medical students were ready to serve in rural health facilities after their graduation.

2.6.3.2 Motivation, job satisfaction and dissatisfaction among Pakistani doctors

Due to the very limited previous research that looked into the reasons for Pakistani physicians' retention, migration and resettlement issues and problems, in this section, the literature on doctors' motivation, satisfaction and dissatisfaction in Pakistan is discussed even though it may not directly address the issues of retention, migration and resettlement.

However, it can be assumed that satisfied doctors are more likely to stay in Pakistan or resettle back into their country after staying overseas for some time either for work or training and dissatisfied physicians are more likely to go overseas.

Khuwaja et al. (2004) conducted a postal survey in which 182 doctors working in teaching hospitals of Karachi, Pakistan participated. The study results showed that the majority (68 percent) of the doctors were not satisfied with their jobs and females were more dissatisfied than males (65 percent males and 72 percent females). The least satisfying factor was salary and benefits, followed by safety and security, workload, adequate resources and physical working conditions. Furthermore, about half (48 percent) of the respondents reported high to very high job stress that impacted on their personal and family lives.

Saeed and Ibrahim (2005), in their study that looked into the reasons for the problems faced by patients in public hospitals, surveyed fifty doctors of a public sector tertiary care hospital in Karachi, Pakistan. The study respondents had the view that most problems encountered by patients in public hospitals were mainly due to the inadequate salary of doctors and paramedical staff (80 percent), lack of facilities and security of doctors (80 percent) and illiteracy and poverty of patients (80 percent). According to this study, the low salaries paid to doctors in Pakistan in the public sector leads to doctors engaging in evening private practices to increase their earnings. This pattern of work especially applies to senior doctors. This not only affects their patients' care but also affects the mentorship of their postgraduate trainees leading to decreased quality of training.

Furthermore, another quantitative study was conducted by Ghazali et al. (2007) with fifty doctors of different grades in a teaching hospital in Bahawalpur, Pakistan about their job satisfaction. The study results showed that the main factors in the doctors' dissatisfaction were the present career structure and career prospects in Pakistan (92 percent) followed by low income (56 percent) and their present working environment (48 percent).

Another important area that could play a role in overall job satisfaction and dissatisfaction are the opportunities for continuous professional development for doctors during the course of their professional careers. In a self administered cross-sectional survey by Siddiqui, Secombe and Peterson (2003), in which 309 doctors participated, all the study participants agreed to a need for professional development. Furthermore, the majority (67.3 percent) of the respondents were even willing to participate in a mandatory program as compared to 32.7 percent who favoured a voluntary program.

Similar studies conducted in Pakistan indicate that lack of opportunities and incentives for conducting research is another potential area that may affect Pakistani doctors and medical researchers' job satisfaction and dissatisfaction. In a study by Hyder, Akhtar and Qayyum (2003) in which fifty-four Pakistani PhD researchers in health who went abroad for doctoral training on the funds of the Government of Pakistan were surveyed about their work experiences in Pakistan upon their return from overseas. The study found that 82 percent of the researchers returned to Pakistan within three months of completion of their studies and they had an average of 14.6 years post-PhD time in Pakistan at the time of the study. Furthermore, the study found that these researchers had published fifteen papers per person both internationally and nationally. Fifty percent of the researchers had an average of seven publications and one third had no international publications. Likewise, these

researchers had received five to six research grants after completing their doctoral training and only 2 percent had received more than two grants from international and national sources. Likewise, after completing their studies, the average number of doctoral, masters and other postgraduate level students supervised by these scholars were one, ten and three, respectively. One third of the scholars had not supervised any doctoral student. Interestingly, lack of academic autonomy and necessary funds and incentives for research were identified by the study respondents as the main reasons for not being able to sustain their research and academic activities. This study investigated the problems faced by Pakistani health researchers who returned to Pakistan after completing their doctoral training but did not study those researchers who did not return to Pakistan or those who leave again after returning.

Similarly, Sabzwari, Kauser and Khuwaja (2009) conducted a cross-sectional survey recently in which experiences, attitudes and barriers towards research amongst 176 junior faculty members from four public and private medical universities/teaching hospitals were studied. The Majority of the study participants indicated a positive attitude towards research and about half of them reported that research improves patient care. However, on the contrary, the study found that only 41.5 percent of the participants were currently involved in research. A significant factor associated with current research involvement was research training during postgraduate education. The study findings identified lack of research allotted time, research training, statistical support, mentorship and lack of financial incentives as the main barriers towards research. This is one of the few studies that looked at the characteristics and problems faced by physicians involved in research; however, it did not looked at the quantity and quality of their research output. Similar results were found by other studies conducted with medical students and postgraduate

medical trainees in Pakistan (Aslam et al. 2004; Khan et al. 2006; Khan, Khan & Iqbal 2009).

Avan et al. (2006) conducted a cross-sectional survey with 341 registered postgraduate residents in four teaching hospitals in Karachi, Pakistan to assess the perceived status of the work environment in different specialities. Three components of the residency work environment were analysed: the distribution of work hours, academic contribution through different modes such as faculty members, colleagues, undergraduate teaching, routine ward rounds, grand rounds, lectures and seminars or workshops and mistreatment during training. The study participants reported average working hours of 61.59 hours per week to 82.03 hours per week. In the absence of any official work limit on residents' work hours, the study recommended reforms in rationalising residents' working hours because fatigue due to lack of sleep could affect patients' safety. The study also reported low scores given to faculty members' contribution to teaching and learning of postgraduate trainees. This is suggestive of the lack of interest of faculty members in the teaching and supervision of their students leading to their dissatisfaction with their training. Furthermore, the study also found varying degrees of mistreatment of residents that included due credit not given, humiliation in front of others, sexual harassment and sexual discrimination and ethnic discrimination at the hands of faculty members, colleagues, nurses, patients and students. However, the study cautioned about careful interpretation of the study results pertaining to the mistreatment components since these responses were not qualitatively assessed.

In a survey by Ahmer et al. (2009) conducted with postgraduate psychiatry trainees in Pakistan, it was found that 80 percent of the trainees faced one bullying behaviour in the preceding twelve months and in the majority (73.3 percent) of cases they were being

bullied by their trainers/consultants. This high prevalence is due to the fact that there is an unequal power relationship between the trainee and trainer; for example, it is the trainer who decides whether the trainee is ready to appear in a postgraduate exam (Ahmer et al. 2009:337). This might contribute to increasing job dissatisfaction and also in lowering the quality of postgraduate medical training as mentioned above.

2.6.3.3 Other literature related to medical workforce issues in Pakistan

Apart from the above mentioned two sources of literature dealing with medical workforce issues in Pakistan, the following section discusses reports and publications of local and international organisations, journal editorials and opinions, and letters to the editors that commented on doctors' retention, migration and resettlement and human resources for health issues in Pakistan. While this section is not research-based, it is important as it helps to further show the current situation in Pakistan.

Health workforce policies are viewed as a pre-requisite for successful implementation of overall health policies and health care reforms in a country. However, according to a report by a joint mission of the World Health Organization (WHO), United Nations Children Fund (UNICEF), Department For International Development (DFID), United Kingdom and the World Bank in Pakistan (2007:11), 'there is a lack of clear long-term vision of human resource development' and there is an absence of any specialised section or unit both at the federal and provincial/state level for such an important health system function. Similarly, Nishtar (2006:120) was of the view that the absence of a well-defined policy on human resource development is a major constraint for developing and maintaining individual and institutional capacity for health system development in Pakistan.

Gadit (2006:465, 2008b:342), while discussing the causes of medical migration in Pakistan, has mentioned the few poorly paid postgraduate training slots available as compared to the number of doctors produced, the high value placed on foreign qualifications and the rampant corruption and the state of general insecurity as the main causes of overseas migration of Pakistani doctors. Aly and Taj (2008:7) in their paper have mentioned the same causes for overseas migration from Pakistan. Shahid (2007:429), in his letter to the editor while discussing stress among Emergency Physicians (EPs) in Pakistan, was of the opinion that 'EPs do not earn enough money in Pakistan to support their families and go overseas to work'.

The results of the above discussed study by Syed et al. (2008:66) showed that the majority of the Pakistani doctors who intended to go overseas for their postgraduate education wanted to return to their country after completing their education. However, Shafqat and Zaidi (2007:442) were of the opinion that there are certain issues and problems in Pakistan and, as a result, overseas Pakistani doctors could not readily return so they permanently settle abroad. The most important problem in the opinion of these authors that impedes Pakistani doctors' resettlement into their country is the lack of local capacity to absorb highly trained physicians and finding a suitable job.

In brief, the above review of Pakistani literature shows that previous research which identified the reasons for Pakistani doctors' migration is very limited and the literature regarding the reasons for physicians' retention and resettlement is almost nonexistent. The available literature related to doctors' satisfaction and dissatisfaction shows that it is mainly health system issues and problems that motivate Pakistani doctors to move overseas. The main factors identified were lack of a viable health workforce policy and

planning, lack of incentives for doctors to serve in rural areas, lack of good postgraduate medical education, lower salaries, the absence of a proper career structure and career progression and the lack of professional development. These problems are further compounded by the general state of insecurity and corruption in Pakistan. Similarly the same problems impede overseas Pakistani physicians who otherwise wish to return to their country.

2.7 Conclusion

In this chapter, to develop a theoretical framework for this study, multiple migration theories and decision-making frameworks were reviewed. However, given the complexity of career decision-making regarding retention and migration, an eclectic theoretical framework was developed to guide an understanding of the experiences of Pakistani physicians regarding their retention, migration and resettlement decisions. This framework is used to guide the entire study. Then the literature relevant to this study was reviewed including the development of the medical retention and migration literature over this decade, the extent of global medical migration and resettlement and the available global research that addresses the issue of medical retention, migration and resettlement. This was followed with the relevant literature from Pakistan that looked into the extent and reasons for Pakistani doctors' retention, migration and resettlement.

The literature review showed that, overall, there is a general scarcity of literature on health workforce issues especially in the developing countries context, with recent expansion during this decade, especially after the landmark reports of the Joint Learning Initiative (2004) and the World Health Organization (2006) annual report. It also showed that the available literature is mostly focused on the factors that lead to health workers' retention

and migration while there is no research that addressed the factors that lead to their return-migration and the difficulties and problems that they face while resettling back into their countries. Further research in this field will help countries to devise policies and strategies to effectively manage repatriation of their health human resource that went overseas for further qualifications or work.

The next chapter explores the study methodology and an explanation and justification for the research design is presented. This chapter also describes the methods for data collection and analysis used by the researcher in this investigation to address the aims of the study. It also describes the ethical considerations and the criteria used to judge the quality of the research.

Chapter Three
Methodology

3.1 Introduction

This chapter discusses the methodology chosen to explore the decision-making of Pakistani physicians regarding their decision to either stay, migrate abroad or resettle back into their country from the perspective of these physicians. A justification for the research design and methodology is presented, and the procedures and techniques used in the study are outlined. The setting and sample utilised in the study and the researcher's role are described. The chapter then describes the interview schedule, which is followed by an account of the data collection and the analysis procedures. Finally, the rigour and trustworthiness of the study is addressed, the methodological issues and limitations of the study are identified and the ethical issues are discussed.

3.2 Justification for the research design and methodology

The overall purpose of this study was to explore the perceptions of Pakistani physicians regarding their career decision to remain in their country, migrate abroad or resettle back into their country after working and living abroad for some time with the following four aims.

1. Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas.
2. Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad.

3. Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country.
4. Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time.

This study's primary focus was on the phenomenon of the career decision of Pakistani doctors in regard to retention, migration and resettlement. To effectively address the research purpose and aims and to understand the phenomenon of Pakistani doctors' career decisions, an exhaustive review of the available literature regarding how to develop and conduct a research enterprise was undertaken in an attempt to find a suitable approach. According to Berg (2004:15), it is important to consider the relationships between ideas, theory, concepts and the operationalisation of research when developing a research design. Thus a methodological decision was made, taking into account this study's characteristics, its aims and the researcher's context.

This research study has been informed by hermeneutic phenomenology. This interpretive research design was chosen because it provides the most appropriate design to research the lived experience from the unique perspective of the individual at a particular point in time. The intention of the researcher was not to quantify the process of decision-making but rather to draw out the experiences of the individual doctors about their career decision to remain in Pakistan, migrate overseas or resettle back into Pakistan. The researcher was interested in describing the experiences of the Pakistani physicians regarding their career decision to remain in their country, migrate abroad or resettle back into their country (that is, what they experience) and to uncover new meanings and ways of understanding it (that is, how they interpret and integrate that experience). The individual experiences of these

physicians were used to better understand the social, cultural, political and economic context in which those experiences occurred (Polit, Beck & Hungler 2001:212). Furthermore, phenomenology as a research methodology allows an exploration of the rationale for complex decision-making from the individual's perspective. It has application to developing countries' health workforce as evidenced by Troy, Wyness and McAuliffe (2007) who used phenomenology as a research methodology to study the recruitment and migration experiences of nurses from developing countries working in Ireland.

Phenomenology can be described as a philosophy, an inquiry paradigm, an interpretive theory, a social science analytical perspective or orientation, a major qualitative tradition or a research framework (Patton 2002:104). However, the main focus of all these various phenomenological approaches is 'on exploring how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning' (Patton 2002:104). Andrews, Sullivan and Minichiello (2004:63), describe the goal of a phenomenological study as 'to walk in another person's shoes', or to 'see the world through their eyes'. These authors further state that in a phenomenological study, the researcher describes 'people's world views'. This means to understand these people's experiences and the meanings they ascribe to these experiences 'in terms of thoughts, feelings, understandings or interpretations' (Andrews, Sullivan & Minichiello 2004:63). Therefore, this methodology was considered appropriate to gain an understanding of Pakistani physicians' experiences of retention, migration and resettlement decisions and the interpretations that they give to their experiences. Phenomenology is said to be developed in various stages following from Immanuel Kant's theory of phenomenology in 1764. This included the preparatory phase of Brentano (1838-1916) and Stumpf (1848-1936), the German phase of Husserl (1859-1938) and latterly Heidegger (1889-1976) and

the subsequent French phase of Marcel (1889-1973), Sartre (1905-1980) and Merleau-Ponty (1907-1961).

According to Patton (2002:106), an understanding of an experience essentially involves interpretation and both of these are often intertwined. Van Manen (1997:25) is also of the same view and argued that 'all description is ultimately interpretation'. However, some philosophers such as Silverman, according to van Manen (1997:25), make a distinction between descriptive and interpretive or hermeneutic phenomenology. Hermeneutics is defined as 'the science of interpretation that is based on the belief human actions are meaningful and so can be interpreted in some sensible way' (Gerber & Moyle 2004:52). According to van Manen (1997:25-26), researchers who follow Husserl's method 'would insist that phenomenological research is pure description and that interpretation (hermeneutics) falls outside the bounds of phenomenological research'. On the other hand, Heidegger (1962 quoted in van Manen 1997:25) argues that 'the meaning of phenomenological description as a method lies in interpretation ... The phenomenology ... is a hermeneutic in the primordial signification of this word, where it designates this business of interpreting'. It is this latter perspective of hermeneutic phenomenology, as adopted by Martin Heidegger, having its focus on the interpretive process of expanded meanings, which has informed the methodology adopted for this study. It is therefore important to understand the changes within the philosophy of phenomenology from its Husserlian beginnings to the more recent interpretations of Heidegger. These are briefly described in the following sections.

The German philosopher, Husserl (1859-1938) is regarded as the founder of the 20th century phenomenological movement. According to O'Brien (2003:194), Husserl

described human beings as ‘subjects in a world of objects’ and it was ‘the study of consciousness of those objects’ that he referred to as phenomenology. This is the central notion of Husserlian phenomenology called the concept of intentionality. As Berger and Luckmann (1967:34) put it, ‘consciousness is always intentional; it always intends or is directed towards objects’. According to Koch (1995:828), Husserl’s phenomenology was the culmination of the Cartesian duality of mind-body split as presented by the French philosopher and mathematician Descartes (1596-1650). This means ‘the study of phenomena as they appear through the consciousness’, which signifies the recognition of experience as the ultimate ground and meaning of knowledge (Koch 1995:828).

Another important concept in the Husserlian phenomenology was the notion of bracketing. This means the suspension of our presuppositions and understanding of the phenomena under study and to see the phenomena as it is (Becker 1992). Husserl proposed that the ‘personal and individual reality of the researcher could be put aside when analysing the data by bracketing or holding it in suspension ...’ (Bassett 2004:157). For Husserl, phenomenological inquiry demands an examination of one’s own personal experience of the world and a readiness to set aside one’s current beliefs about the phenomenon under study. According to Schutz (1970 cited in Koch 1995:829), this bracketing or suspension of belief in the reality of the natural world was the lever for Husserl’s phenomenological methodology. Therefore, through this process of bracketing, Husserlian phenomenology ‘defends the validity or objectivity of interpretation against the self-interest of the researcher’ (Koch 1995:829).

Martin Heidegger (1889-1976), Husserl’s student and colleague, rejected Husserl’s Cartesian duality of mind and body and the notion of bracketing. He developed a

hermeneutical orientation to phenomenology which extended the concept of providing a description to the phenomena to also include an interpretation (van Manen 1990:25). According to Koch (1996:176), Heidegger believed that any description of a phenomenon without its interpretation is impossible and challenged the Husserl construction of phenomenology as pure descriptive philosophy. Heidegger rejected the notion of a person (subject) as a viewer of objects, disengaged from the world and regarded both object and subject as inseparable, which was termed as 'Being-in-the-world' (Mackey 2005:181). He introduced in his major work, *Being and Time*, the concept of 'Dasein' meaning 'to exist', thus emphasising the essential part of being human and the context that gives meaning to people's lives as being-in-the-world. Therefore, 'Heideggerian phenomenology is ontological in that it seeks to understand the conditions whereby human beings can understand their existence and thus the nature and the meaning of being' (O'Brien 2003:194).

According to Heidegger's philosophy, we come to the world with a pre-understanding shaped by historical, cultural and personal characteristics, which cannot be suspended or eliminated and from which further understanding of 'Being' is developed (Bassett 2004:158). This was referred to as the 'hermeneutic circle' which involved moving from the part of the experience to the whole and back and forth until a sophisticated understanding of the phenomena is developed (Ezzy 2002:25). According to Bassett (2004:158), the basic difference between Husserl and Heidegger approaches to research is that 'Heidegger believed that presuppositions are not to be eliminated or suspended' because these help in the understanding of meaning within the phenomenon.

This hermeneutic phenomenological study is situated in the interpretive paradigm. According to Harper and Hartman (1997:20), the development of scientific knowledge is influenced by philosophical viewpoints, also called paradigms or world views which create knowledge that can describe and explain the phenomenon under study. These paradigms carry their own distinct philosophical assumptions or principles about reality (ontology) and human knowledge (epistemology) that in turn direct the type of knowledge that will be generated (Harper & Hartman 1997:23-24). This defines the criteria for knowing the 'truth' and provides a context for the conduct of the research study (Crotty 1998:2-3). The literature suggests that traditional academic research has been influenced by the two major and different paradigms of positivism and interpretivism (Allan 1998:1).

The positivist philosophy of science emerged in the 19th century and later became known as logical positivism, empiricism or quantitative paradigm (Harper & Hartman 1997:25). According to these authors, this paradigm influenced philosophical thinking until the 1960s and 'shaped the development of both medicine and nursing as scientific disciplines' (1997:25).

Researchers operating within the positivist paradigm believe that 'it is possible to make objective observations, measurements and recordings that are analysed to produce verifiable results' and so 'reality is viewed as being external to the researcher' (Greber & Moyle 2004:36-37). Therefore, according to this paradigm, 'there is an objective reality that exists independently of the observer' and it can only be accessible to observation and measurement driven by natural laws (Harper & Hartman 1997:25). Thus, any research conducted from the positivist approach will employ 'the methods of the natural sciences and by way of allegedly value-free, detached observation, seek to identify universal

features of humanhood, society and history that offer explanation and hence control and predictability' (Crotty 1998:67). The epistemology, that is the nature of knowledge, which informs the positivism, is objectivism which holds that reality 'exists as such apart from the operation of any consciousness' (Crotty 1998:8).

The opposing view to positivism and the one which has predominantly informed this research study is the interpretivist paradigm. This paradigm, according to Crotty (1998:66-67), emerged as an alternative to positivism for understanding and explaining human and social reality. The ontology of this perspective is 'based on the premise that reality is mentally constructed and is socially and culturally based' (Harper & Hartman 1997:30). Thus, interpretivists reject the idea of a single, objective truth and that reality is something that exists independently of our perceptions and thoughts but they believe that it is constructed and created by our knowledge and understanding (Jackson, Daly & Chang 2003). Another important characteristic of this paradigm is the relationship between the researcher and participant. Research participants are viewed as 'knowers' as 'they have lived through an experience' and they are part of the culture that the researcher is examining (Jackson, Daly & Chang 2003:142).

Researchers working within this paradigm study attitudes, perceptions, behaviour and interpretations and to them research is a process of 'describing, interpreting and seeking understanding and possibilities in order to reach a shared meaning, and not as a search for causal relationships' (Allan 1998:3). The epistemological view that informs the interpretivist paradigm is constructionism. According to constructionism, there is no truth or meaning waiting out there but it 'comes into existence in and out of our engagement with the realities in our world' (Crotty 1998:8). Furthermore, according to this view,

'meaning is not discovered, but constructed' and so 'different people may construct meaning in different ways, even in relation to the same phenomenon' (Crotty 1998:9).

3.2.1 Justification for in-depth interviews

Data was obtained by conducting semi-structured in-depth interviews with the Pakistani physicians working in Australia and Pakistan via telephone. According to Minichiello, Aroni and Hays (2008:68), two major rationales, that is the researcher's view of social reality and practical issues, determine the choice of research methods. In-depth interviews were used first, because the primary focus of these interviews was to understand people's experiences from their perspective and to facilitate analysis and interpretation of these perceptions by the researcher (Minichiello, Aroni & Hays 2008:11). This is aligned with the purpose of this study to explore the perceptions of Pakistani physicians regarding their career decision to remain in their country, migrate abroad or resettle back to their country from their perspectives. Second, in this study the researcher wanted to determine the understanding and meaning from a broad range of Pakistani physicians in a short span of time, therefore an in-depth interview was preferred as a data collection method compared to other methods (Minichiello, Aroni & Hays 2008:69). Third, this data collection method is congruent with the research design and the interpretive paradigm.

Apart from semi-structured in-depth interviews, focus group discussions may have been used as an acceptable method of data collection in this study but were rejected because of the logistical and financial issues involved in gathering the three different groups of Pakistani physicians together from across Australia and Pakistan. Also, the researcher was concerned that focus groups could generate a broader but consensus-achieved view as opposed to the more desirable and diverse views from semi-structured interviews.

Furthermore, focus groups were rejected as it was feared that in grouping together Pakistani physicians there was the potential for bias. Different levels of physicians at different stages of seniority could potentially influence individual participant's views and responses in a focus group (Liamputtong & Ezzy 2005:71-72).

3.3 Methods

3.3.1 Study setting and population profile

This study was conducted via telephone interviews in both Pakistan and Australia. Semi-structured interviews were conducted with Pakistani physicians working in the four provinces of Pakistan namely Balochistan, Khyber Pakhtunkhwa (formerly North West Frontier Province), Punjab and Sind and in the states of New South Wales, Queensland and Western Australia in Australia. The population for this study consisted of Pakistani physicians who obtained their primary medical qualification from Pakistan and were working as physicians either in Pakistan or Australia at the time of the study. The term 'physician' in this study includes all Pakistani doctors who have obtained their primary medical qualification, that is, Bachelor of Medicine, Bachelor of Surgery (MBBS) in Pakistan. They may or may not have specialised in any discipline.

3.3.2 The sampling frame

In line with the purpose of the study, the population of interest was divided into three broad categories, that is, 's*tayers'*, *'leavers'* and *'resettlers'*. *'Stayers'* are those Pakistani physicians who obtained their primary medical qualification in Pakistan, never migrated to another country and were working in Pakistan at the time of this study. *'Leavers'* are those Pakistani physicians who obtained their primary medical qualification in Pakistan and at the time of the study were working in Australia. *'Resettlers'* are those Pakistani physicians

who obtained their primary medical qualification in Pakistan, migrated to another country and had resettled back and were working as physicians in Pakistan at the time of this study. Within these three categories of Pakistani physicians, sampling was initially undertaken using a theoretical sampling frame that guided the selection of participants (see Table 3.1). The use of a theoretical sampling frame provided broad categories for inclusion of participants in the study. These were identified based on relevant categories and themes as identified in the literature as well as within the data. During data collection, the categories for inclusion in the study broadened and participants were recruited based on their representation from all the four provinces of Pakistan as previously mentioned.

Table 3.1: Sampling frame describing categories used for recruitment of participants

Categories	Sub-categories
Age groups	< 35 35 – 44 45 – 54 55+
Gender	Male Female
Position	General Practitioner/Medical officer Specialist Trainee
Mode of practice	Public only Private only Public & private
Provincial representation	Balochistan Khyber Pakhtunkhwa Punjab Sind

Source: Arif (2010)

Pakistani physicians working in Australia who obtained their primary medical qualification from Pakistan but were either Australian permanent residents or citizens before starting their primary medical education in Pakistan were excluded from the study. These physicians were excluded because they had already migrated to Australia with their parents

and they only went to Pakistan to obtain their primary medical qualification. These physicians had to return to Australia as they and their parents were already settled there. Also, the study excluded those Pakistanis who obtained their primary medical qualification in Pakistan but were not currently working as physicians either in Australia or Pakistan. This group of physicians was excluded because their motivation for migration or remaining in Pakistan was not within the scope of this study.

3.3.3 Sampling and sample size

To gain an insight into the complex phenomenon of the Pakistani physicians' career decision to remain in their country, migrate abroad or resettle back into their country, a combination of both purposeful and snowball sampling strategies were employed to achieve the required sample from Pakistani physicians working in Pakistan and Australia (Llewellyn, Sullivan & Minichiello 2004:226). The rationale for purposefully selecting participants was to provide 'information-rich cases' (Patton 2002:230) that would answer the purpose and aims of the study. Using hermeneutic phenomenology as the theoretical perspective, the purpose of the study was to seek a greater understanding of the Pakistani physicians' career decisions from their descriptions and understanding of these decisions and the meaning Pakistani physicians gave to these experiences.

The next step in the research process was to find a sample of appropriate participants. According to Sandelowski (1995:182), an adequate sample size in qualitative research is one that provides a new, deep and rich understanding of the experience. Instead of recruiting large numbers of participants, Creswell (1998:113) has indicated that two to ten participants are sufficient to reach saturation in a phenomenological study by sampling participants who represent diverse differences within the sampling framework. Morse

(1994) has suggested six participants for phenomenological studies in which the primary aim is to understand the essence and meaning of the participants' experience.

This study is primarily concerned with understanding the career decisions of Pakistani physicians rather than representing the statistical frequency of this phenomenon. Therefore, sample size was not a limitation of this study, rather the researcher aimed intentionally to recruit a small sample of approximately thirteen Pakistani physicians who agreed to share their experiences of remaining, migrating or resettling back into their country and to enquire deeply about those experiences. The sample reflected different characteristics as described in the sampling framework.

3.3.4 Recruitment of participants

As previously mentioned, participants for this study were recruited from three different groups of Pakistani physicians, with two groups in Pakistan and one group in Australia. The first of the two groups in Pakistan comprised *'stayers'* that is, Pakistani physicians who obtained their primary medical qualification in Pakistan, had never migrated to another country and were living and working in Pakistan at the time of this study. The second group in Pakistan was *'resettlers'* that is, Pakistani physicians who obtained their primary medical qualification in Pakistan, migrated to another country and had resettled back in Pakistan. The third group in Australia was *'leavers'* that is, Pakistani physicians who obtained their primary medical qualification in Pakistan and at the time of the study were living and working in Australia.

In the absence of any publicly available listing of Pakistani physicians working in Pakistan or Australia, the recruitment of participants was done mainly through private invitation by

the Pakistan Medical Association (PMA) in Pakistan (Appendix 1) and the Association of Pakistani Doctors of Queensland (APDOQ) in Australia (Appendix 2). The contact details of these organisations were obtained from the internet. The researcher telephoned these organisations, explained the purpose and aims of the study and their support was sought for recruitment of participants for this study. Both organisations kindly agreed to provide the relevant support.

Where appropriate, if participants were not available through these associations, an indirect approach to some participants was made through former professional colleagues of the researcher in Pakistan. Some Pakistani physicians whom the researcher interviewed identified other physicians who they thought would be interested in the study. Two physicians nominated in this way participated in the study. Ultimately a combination of both purposeful and snowball sampling was utilised to achieve 'the most desirable sample for the research question' (Llewellyn, Sullivan & Minichiello 2004:228). A total of four Pakistani physicians, three *stayers* and one *resettler*, contacted in this way excluded themselves from the study after their initial agreement to participate in the study without providing any specific reason.

Following four interviews from each group of participants, that is *stayers*, *leavers* and *resettlers* making a total of twelve, it was decided with the researcher's supervisors that, as no new information was coming and data saturation had been reached, data collection should cease (Llewellyn, Sullivan & Minichiello 2004:223). However, as all the four participants in the '*leavers'* group were male, and in order to seek additional understanding and to add further value to the research, the researcher continued with a female '*leaver'*

who was a Pakistani physician working in Australia. The final study sample involved a total of thirteen physicians.

The recruitment process was ongoing and sampling decisions evolved during data collection and analysis (Llewellyn, Sullivan & Minichiello 2004:214) in meetings with the researcher and the supervisors after conducting and analysing data from two to three interviews. The purpose of these supervisory meetings was to compare the coding of the researcher and the supervisors and also to make ongoing sampling decisions. This step was also taken to ensure rigour and trustworthiness of the data which is discussed later in this chapter. For example, after interviewing the first *'stayer'* physician who was young and who had joined the medical profession recently, it was decided that the second *'stayer'* participant should be somebody who had worked as a physician for a longer time in Pakistan in order to ascertain any difference in responses between these two. Likewise, during the same interview, when it emerged that doctors usually do not like to work in rural areas in Pakistan, it was decided that the researcher should interview a Pakistani physician who was working in a rural area to obtain his/her perspective.

3.3.5 Interview schedule

A semi-structured interview schedule, together with a recursive model as the strategy for conducting in-depth interviewing, was used as the main source of data collection (Appendix 3). This strategy was adopted to ensure that the major emerging themes were discussed at each interview and to give freedom to each participant to discuss their individual experiences and opinions. This approach helped the researcher to treat each participant as unique and to modify the research technique in the light of information fed back during the research process (Schwartz & Jacobs 1979:45).

The interview schedule was developed in several stages. The researcher, based on his past experience as a physician in Pakistan and a review of the national and international literature pertaining to physicians' retention and migration, developed the first draft of the interview schedule. This first draft was reviewed by the researcher supervisors in a review meeting hold before submitting the interview schedule for ethical approval to the Human Research Ethics Committee of the University of the New England. Necessary changes were made for example, instead of directly starting the discussion by asking the participants about their reasons for staying, leaving or resettling into Pakistan, it was decided that the interview should commence by asking questions about the participant's background and their reasons for choosing medicine as a profession in order to develop a rapport and to set the interview in the context of the study. The revised version of the interview schedule was approved by the University of New England Human Research Ethics Committee (Appendix 3, 4, 5).

As the study progressed, additional questions emerged during the course of discussion with different participants and the interview schedule was revised accordingly. These were generally prompting questions to elicit a deeper response or to clarify responses to the questions contained in the schedule. For example, in the seventh interview, the participant raised some interesting points about the power hierarchy in medicine and the personal security issues within Pakistan. During the subsequent supervisory meeting, the researcher supervisors suggested prompting questions with the later participants to see if they also raised these issues. The researcher did not have to prompt all the participants because many of the questions were answered during the course of the interview. The prompts were only used if the participant did not elaborate on a point or became sidetracked.

Before commencing each formal interview, the researcher either reviewed the demographic data collected prior to the interview or collected it at the time of the interview using the Participant Demographic Data Sheet (Appendix 7, 8, 9). The data included gender, age, marital status, number of children qualifications obtained current position, name of countries other than Pakistan where participant had worked and duration stayed, and mode of practice. This information was important in terms of the purposive sampling objective of obtaining a range of participants representing diversity in gender, age, experience, position and mode of practice.

3.3.6 Pilot study

After obtaining ethical approval from the University of New England Human Research Ethics Committee in August 2008, two pilot interviews were conducted in September and October 2008. According to Schneider (2003:134), pilot studies can be used to ensure that the informants understand the intended meaning of the questions and the researcher understands the informant's answers, to identify problems and also to add to reliability through pre-testing (Silverman 2001:229). The two pilot participants were known to the researcher, a Pakistani physician who migrated to Australia and was working as a General Practitioner (GP) and the other, a Pakistani physician who first migrated to the United Kingdom (UK) and resettled in Pakistan and was working as a physician (Schneider 2003:134). These two participants were selected because of their appropriateness in meeting the sampling inclusion criteria and the convenience of access to them by the researcher. The pilot interviews were conducted to test the appropriateness of the interview questions and to refine the interview skills of the researcher (Roberts 2002a:259-260).

The researcher conducted the interviews over the telephone and they were recorded with the participant's permission using a portable digital voice recorder. The digital recordings

were downloaded to the researcher's computer as sound files and duplicated on a separate external hard drive to ensure the safety and security of the data. At the end of both pilot interviews, the researcher asked for feedback regarding the time allocated, whether the flow of the interview was appropriate, and if the participants believed that the questions were pertinent to the four study aims. The feedback indicated that the interview questions were relevant to the study aims and they allowed the participants to generate a discussion due to the open-ended nature of the questions.

Copies of the typed transcripts were sent to the participants and feedback sought. The nature of the feedback was encouraging and there were no requests for major changes or disagreement about the questions. The results of the pilot study were included in the final data analysis because of the richness of the information generated and the fact that there was little modification required in the interview questions between the pilot and subsequent interviews (Roberts 2002a:260).

3.3.7 Data collection procedure

Data were collected between September 2008 and July 2009. Those participants who initially agreed to participate were contacted by the researcher by telephone to confirm their participation. They were provided with either a 'hard copy' or electronic version of an Information Sheet for Participants (Appendix 6). The information sheet described the purpose, aims and significance of the study, the process of the study, the mode of participation for the physicians by telephone interviews and the approximate time required from each participant. The information sheet also described to the participant the researcher's intention to audiotape the interviews, their right to withdraw from the study at any time throughout the research process without prejudice or penalty and the measures to

provide confidentiality and further use of the data in journal articles, conferences and seminars. Details of the University of New England Human Research Ethics Committee approval and contact details of the researcher, the two supervisors and the Research Ethics Office were included. Once the participants were fully aware of the research project and their role as participants, they were provided with either a 'hard copy' or electronic version of a Participant Demographic Data Sheet (Appendix 7, 8, 9) and an Informed Consent Form (Appendix 10). The demographic data sheet and the two consent forms were completed by participants prior to the interviews. One copy of the consent form was either emailed or faxed to the researcher while the other copy was retained by the participant for their files. None of the participants requested a copy of the Interview Schedule prior to interviews.

All the participants who participated in this study were interviewed via telephone using the schedule. Before each interview was conducted, arrangements were made by either email or telephone for a convenient date and time for the interview to take place. The use of the telephone assisted in increasing the diversity of the sample by recruiting participants from all four provinces of Pakistan and across Australia (Chapple 1999:88). It also saved time and cost by providing an alternative to travel to meet the participants in person. Some researchers have shown concerns about telephone interviews due to the nature of rapport with faceless participants but other researchers have cited the advantage of being able to remain anonymous (Minichiello, Aroni & Hays 2008:55). The majority of the interviews were conducted at weekends and a few at evenings. The use of telephone interviews allowed the participants to choose the most suitable time and place for the interview (Chapple 1999:88). According to Minichiello, Aroni and Hays (2008:55), as opposed to face-to-face interviews, in telephone interviews the researcher is not able to observe body

language and other visual clues, but verbal signals were still recorded in the researcher's journal which is discussed further in this chapter.

Except for the participants in the pilot study all the remaining participants were unknown to the researcher. Therefore, before each interview the researcher aimed to develop a rapport with the participant. Once a participant was identified as willing to participate in the research project, the researcher would telephone the participant and introduce himself. He then explained the purpose of the research study, the data collection method and the use of the research findings. It was also emphasised that they were under no obligation to participate, that their identity would remain confidential and that they could withdraw from the study at any stage without penalty or prejudice. In addition, it was also made very clear to each participant that there were no incentives for participation in the study.

The Participant Information Sheet was then sent to the participant and after a few days the researcher again telephoned the participant to make sure that they had read and understood the information sheet and also to answer any questions from the participant. Then, either during the same conversation a suitable date and time for interview would be chosen or it would be left to the participant to communicate a convenient date and time to the researcher. Once the date and time of the interview was finalised, the researcher always telephoned the participant before the day of interview to reconfirm the arrangements. As previously mentioned, this approach of multiple contacts before the actual interview helped the researcher to develop a collegiate relationship and trust with the participant.

A digital voice recorder was used to record the interviews with the prior permission of the participants. All the interviews were transcribed by the researcher in person as soon as

possible after the interview took place. A copy of the relevant transcript was sent to each participant either via email or fax, with a request to let the researcher know if he has fairly captured what they had said during the interview. Other than English grammar and spelling mistakes, the participants were also requested to make corrections, and add or delete or clarify their interview transcripts. The participants were also advised that if they did not respond within two weeks, it would be assumed that they were satisfied with the transcript. Except for three participants, all the participants responded and were satisfied with their interview account.

According to G. Robinson (1977) and D. Robinson (2003), an appropriate translation of texts needs to reflect the cultural, social and specific knowledge of what is being translated and also a comprehensive knowledge of the languages used. In this study, some of the interviews were conducted in languages other than *English,* that is *Urdu* and *Pashto,* and transcribed directly into English. Therefore, there was a possibility that with English being the second language of the researcher, the translation might not convey the intended meanings of the respondent's constructions. This could have raised important quality and ethical issues. However, as the researcher is a native *Pashto* and *Urdu* speaker from Pakistan who undertook all his education, both in Pakistan and Australia, in *English*, there were no major problems in data translation. Furthermore, the translated transcripts were shared with the participants who were all medical doctors and were educated with *English* as their first language and were well versed with the *English* language, for validation and to confirm if the researcher has correctly captured their lived experiences.

At the commencement of each interview, the researcher thanked the participant for agreeing to take part in the study. The researcher gave a brief description of the study and

described his background as a physician and a doctoral candidate of Health Services Management Program at the University of New England, Australia, and that he was conducting this study as part of his doctoral degree requirements. The duration of all the interviews was approximately one hour. At the end of each interview, participants were specifically asked if there was anything else that they would like to add or discuss in relation to the research topic. In a few cases, the participants gave some additional information. The participants were thanked and advised that following transcription they would receive a copy of their transcript to review and were asked to feel free to add/delete the present text, add additional comments or approve the transcription.

3.3.8 Researcher's journal

A journal is a record of the researcher's impressions and insights of their research project experiences (Koch 2003:242). It 'includes a detailed examination of the research questions asked and ideas emerging as the study progresses' (Minichiello, Aroni & Timewell 1995:218). It provides valuable information for the development of ideas on the process and progress of the research study and allows the researcher to consider any issues that arise during data collection and make decisions for the next interviews. The journal also helps in facilitating the researcher's thinking about the analysis and interpretation of qualitative data (Liamputtong & Ezzy 2005:273).

The researcher maintained a journal throughout this study. This journal contained the record of the researcher's thoughts about the adopted research approach to study the experiences of Pakistani doctors, development of the interview schedule and its subsequent modification to suit individual participants. It also contained a record of issues that arose during the research journey and the decisions taken in consultation with the researcher

supervisors about issues and ideas development during the data analysis, interpretation and report writing phases. The recorded thoughts helped the researcher to reflect and learn, resulting in an increase in the quality of every subsequent phase of the research. Overall, the journal helped in enhancing the credibility of the study.

The journal was not a large book or diary but composed of folders with loose sheets of paper (Liamputtong & Ezzy 2005:273) consisting of hand written notes, tables and conceptual diagrams based on the researcher's thoughts, ideas and questions that developed during this study. The journal also consisted of some typed notes or memos (Liamputtong & Ezzy 2005:273) that were developed during themes generation, organisation and interpretation.

3.3.9 Data analysis technique

The data analysis technique employed in this research was thematic analysis and was done manually by the researcher. According to van Manen (1997:78), 'to do human science research is to be involved in the crafting of a text' and in order to grasp the meaning of the structure of the text 'it is helpful to think of the phenomena described in the text as approachable in terms of meaning units, structures of meaning, or themes'. To gain fuller understanding of the phenomenon, the researcher needs 'to go beyond literal meanings of the participants' words' and discover 'the fore-structures and thematic meanings' in the data (Mackey 2005:182). Thematic analysis aims to identify themes emerging from the data (Minichiello, Aroni & Hays 2008:280). In this type of analysis, while the general issues of interest are determined prior to the analysis, the specific nature of the categories and themes to be explored are not predetermined (Ezzy 2002:88). These categories are induced from the data. However, the researcher should be mindful of the fact that a

description of the phenomenon under study can be challenged by another description as multiple descriptions can be possible (Zalam & Bergum 2000:212) and that a full explanation of the phenomenon cannot be possible (Anderson 1991; Ezzy 2002:25). The thematic analysis approach utilised in this study was consistent with what is described by Pope, Ziebland and Mays (2000) and further informed by van Manen (1997) and Miles and Huberman (1994) and is described in the following section.

In this study, data analysis was conducted concurrently with the data collection, which allowed the researcher to refine and develop the interviewing approach, refine the interview schedule and to pursue emerging issues (Miles & Huberman 1994:50; Pope Ziebland & Mays 2000:114). This process of data collection, analysis, evaluation and interpretation continued until saturation was reached (Llewellyn, Sullivan & Minichiello 2004:223; Sarantakos 2005:349). According to Koch (1999:24), researchers utilising the interpretive approach need to accept and value the descriptions of their participants as their reality and understanding of the phenomenon. Therefore, before actual data analysis, the researcher made a personal approach to the qualitative data analysis by orienting himself for 'respect for people, their experiences and words' (Roberts 2002b:425). The researcher studied the research proposal to refresh the study purpose and four aims and kept them in mind throughout data analysis so that he knew what to look for in the data and to keep him from becoming sidetracked during data analysis.

After gaining a refreshed and refocused view of the research purpose and aims, the researcher studied the interview transcripts several times, along with the notes recorded in the researcher's journal to gain familiarisation with the raw data (Pope, Ziebland & Mays 2000:116). These transcripts were shared earlier with the participants for their feedback

and comments. At times the digital tapes of the interviews were re-played in order to gain an appreciation of the verbal expression as well as the words used. The researcher then read and re-read the transcripts highlighting those words, phrases or passages of interview content that he perceived to be meaningful and which addressed the study aims. A further reading of the transcript was done and a descriptive code was applied to the highlighted narrative and recorded in the margin of the transcript as described by Pope, Ziebland and Mays (2000:116).

According to Pope, Ziebland and Mays (2000:115), the improvement in consistency or reliability of the analysis can be achieved by the use of more than one analyst. Hansen (2006:150) has suggested using more than one analyst as a strategy to avoid possible bias on the part of the researcher. Therefore, after conducting the transcription and coding of each set of two to three interviews by the researcher, the transcripts were then read and coded individually by the researcher's supervisors. The results of the preliminary coding by the researcher and supervisors were compared in a review meeting and any differences were discussed until agreement was reached.

After reading each individual transcript, the main categories identified earlier were grouped into themes and subthemes that emerged from the data. Summaries of data from individual transcripts pertaining to each theme and subtheme were categorised by placing them into separate tables for the three different groups of study respondents based on the study aims to look for similarities and differences in individual participant responses (Miles & Huberman 1994). A list of all the themes was developed which was then reduced so that similar ideas were merged into respective groupings. This was done until the researcher was no longer able to 'move ideas without losing some of their specialness in

relation to the research' (Taylor 2002:430). Finally, the main themes were charted under three broad categories that emerged from the data (Pope, Ziebland & Mays 2000:115) and these will be discussed in the next chapter. This process of iteration of themes continued throughout data analysis and was also supported by the researcher's supervisors until data saturation was reached. Furthermore, to maintain the link between context and meaning, the researcher constantly referred back to the audiotaped files of the participants, interviews and the written transcripts.

Efforts were made to ensure so that the emergent themes represented the shared experiences that were constructed between the researcher and the individual study respondents. The validity of the emergent themes were verified based on their strong linkage to relevant theory and literature, their verification by the researcher's supervisors (Crotty 1996:23; van Manen 1997:100), both of whom were experienced researchers, and the public presentation of study results to colleagues, academics and health care professionals at two Australian conferences and one international conference.

In summary, the main steps involved in thematic analysis were as follows.

- Each interview was digitally taped and transcribed and translated into *English* by the researcher if the interview was conducted in *Urdu* or *Pashto* language.
- The transcribed and translated version of the interview was sent to participants with the request to provide feedback regarding accuracy and any errors in the transcription. Participants were also requested to add, delete or clarify any of the transcribed comments.
- Each transcript was read carefully while listening to the recorded interview of the participant for familiarisation and authentication.

- The transcripts were read multiple times, with the scope and aims of the study in mind, to highlight those words, sentences and sections that addressed those aims.
- A further reading of each transcript was done and an appropriate code was assigned to the highlighted sections.
- Transcripts of each set of two to three interviews were shared with the researcher's supervisors for verification of the emerging themes that were jointly reviewed in intermittent review meetings.
- The coded data were analysed thematically by placing them into tables and similarities and differences in the responses of the participants were noted.
- The results of this analysis were shared with researchers both nationally and internationally for feedback and verification.
- Following the thirteenth interview, the researcher, in consultation with the supervisors, was convinced that data saturation had occurred and data collection ceased.

3.4 Rigour and trustworthiness of the study

The aim of every good research project is to produce trustworthy data and that the research results it produces are taken seriously. Rigour is defined in terms of clear and strict process and 'attention to detail' (Taylor 2002:377). According to Lincoln and Guba (1985:290), in the conventional or quantitative paradigm, rigour and trustworthiness are achieved by following the criteria of 'internal validity', 'external validity', 'reliability' and 'objectivity'. In quantitative research, study designs that are valid and reliable are termed as 'rigorous' and this is achieved by applying strict rules relating to sampling, measurement instruments, statistical methods and the statistical power of the data analysis (Hansen 2006:48).

In contrast, Lincoln and Guba (1985:293) argue that criteria developed from the viewpoint of one perspective may not necessarily be appropriate for judging research actions taken from another perspective. Accordingly, the traditional meanings of rigour as previously described may not be suitable when conducting qualitative research. Therefore, Lincoln and Guba (1985:300) have described alternative criteria of credibility, transferability, dependability and confirmability for establishing rigour in qualitative research which are equivalent to the conventional terms of internal validity, external validity, reliability and objectivity in quantitative research.

Credibility relates to the concept of internal validity in conventional research (Hamberg et al. 1994:177). According to Hansen (2006:49), the credibility of a study is evaluated by assessing its findings and interpretations and if the reader is satisfied that they represent some form of 'truth', they are considered credible. According to Lincoln and Guba (1985:301), prolonged engagement, persistent observation, triangulation, peer debriefing and respondent validations are some of the activities that enhance the credibility of a study. Credibility in this study was addressed by 'prolonged engagement' with the study participants before and during interviews. After agreeing to participate, several telephone calls were made to the participants at different intervals clarifying their role and any concerns regarding the study and developing a degree of trust before the actual interviews. During the individual interviews, the engagement of the participants averaged approximately one hour.

The other activity conducted to increase the credibility of this study was respondent validation. This was addressed by providing the study participants with a copy of their respective interview transcript with an invitation to check whether the researcher had

accurately captured what they said during the interview and to make any clarification or change to the written transcript. This technique shows engagement, ‘persistent observation’ and respondent validation in ensuring credibility (Polit, Beck & Hungler 2001:313). Triangulation was achieved by using multiple interview respondents to obtain diverse views about the phenomenon. Rigour and trustworthiness of this study was further addressed by presenting the preliminary findings of this study at two conferences at the University of New England and at an international conference during the study to obtain peer review.

Transferability corresponds to the notion of external validity and generalisability of the research findings to other settings. According to Lincoln and Guba (1985:297-298), the reader of a research project can decide if the results of a study are relevant to other similar situations when the research context, methods, sampling and findings are clearly described. Results from qualitative research are rarely generalisable but they may be transferable (Hansen 2006:49). In this study, transferability was addressed by providing a detailed description of the literature relevant to the research purpose and aims and the theoretical framework in which to situate the research in Chapter Two. The research methodology together with the settings and data collection methods are described in detail in this chapter and data analysis and findings and conclusions in Chapters Five and Six. Furthermore, in this study, purposive and snowball sampling strategies were used which allowed the researcher to provide the most variable range of information to effectively address the aim of this study (Lincoln & Guba 1985:316).

Dependability is a criterion of trustworthiness of qualitative data which relates to ‘data stability over time and over conditions’ (Polit, Beck & Hungler 2001:315). Pope, Ziebland

and Mays (2000:115) have suggested using more than one analyst as a strategy for improving consistency or reliability of a study. This was ensured by an independent analysis of each set of two to three transcripts by the researcher and his supervisors. The results of this analysis by the researcher and supervisors were compared in review meetings and any differences were discussed until agreement was reached. Another technique suggested by Lincoln and Guba (1985:319-320) to establish the dependability of a research study is through ensuring the completeness and accuracy of the study records so that they are readily accessible. Copies of all the records of this study have been kept in both printed and electronic formats, with secondary storage of the latter in an external hard drive for enhanced security. Digital recordings of the interviews, coded interview transcripts, notes from respondent validation, iteration of the interview schedule and drafts of thesis chapters were retained. This systematic management of study records constitutes an audit trail (Lincoln & Guba 1985:319-320).

Confirmability refers to the objectivity or neutrality in research where it can be established that 'the researcher has tried to avoid distorting the reality they are describing' (Hansen 2006:49). This enables other independent researchers to agree about the data's relevance or meaning (Hamberg et al. 1994:179). In this research, confirmability was achieved by keeping an audit trail of the relevant records, triangulation of the study participants and by conducting a reflexive analysis. Reflexivity 'implies that the researcher understands that he or she is part of the social world that he or she investigates' (Berg quoted in Hansen 2006:59). In order to establish researcher credibility, which is considered as 'the instrument in qualitative inquiry', information about the researcher's background should be included in the research report (Patton 2002:472). Therefore, in Chapter One the researcher has clearly stated his role as a physician and health manager, his pre-understanding of the

topic and his relationship with the study participants, which is in line with hermeneutical phenomenology.

3.5 Methodological issues and limitations

Limitations refer to potential weaknesses in a study and these are invariably attached to the design of a research study. As with any study, there are a number of methodological issues and potential limitations that were considered in this study. These include the sample size, the issue of generalisability, the use of researcher's supervisors as a source of external validation, selection of *'leavers'* group from Australia, the role of the researcher and representation of stakeholders related to the phenomenon of retention, migration or resettlement of physicians in Pakistan.

In this research purposeful and snowball sampling strategies were utilised rather than randomisation. However, in this study, the probability sampling strategy was rejected because the study did not aim to obtain representativeness or generalisability of the findings. The criteria for selecting study participants were based on their experience of the phenomena and their ability to convey their experience and its meaning to them (Iaquinta & Larrabee 2004). Every possible effort was made to ensure variety through the sampling process to increase potential diversity and richness of the data. Keeping in mind the presence of large number of participants who had experienced the phenomena in question, the sample size was determined by both logistic considerations and by an attempt to achieve variation. The criteria used to achieve this diverse range of participants included age, gender, place and mode of practice and geographical representation.

As this study sought to understand the phenomena of decision-making regarding Pakistani physicians' decisions about staying, migrating or resettling into their country, the researcher believed that in this case the issue of generalisability is of less significance. The aim of phenomenological research is not to produce generalisable results, but to understand and interpret the experiences of the participants (O'Brien 2003:197). Thus, in summary, it is important to note that this research was not designed to predict or make inferences from the study results.

One important limitation of study design in this study is the use of the researcher's supervisors as the main source of external validation. The supervisors may have a conflict of interest in supervising the researcher on the one hand and independently assessing the researcher's analysis of the raw data on the other. However, the researcher did share the study results with colleagues, academics and researchers at two Australian conferences and one international conference for feedback and verification.

Another limitation of this study is that the *'leavers'* are limited to the Pakistani physicians living and working in Australia which represented only 1.46 percent of the Pakistani physicians working abroad. The views of Pakistani physicians working in other major destination countries such as USA (61.83 percent), UK (26.24 percent) and Ireland (6.14 percent) are not included in this study (Organisation for Economic Co-operation and Development:2007). Therefore, because of this limitation, the word 'exploratory' is added to the title of this thesis.

By training the researcher is a physician and has worked in this capacity for some time in Pakistan. The researcher has also worked in a health management position in different

national and international non-government organisations (NGOs) in Pakistan. This could be viewed as a limitation of this study. There was a possibility that the researcher's background could have led to bias in the selection and interpretation of the data. For this, every possible effort was made to reduce the likelihood of such distortion and, therefore, the experience of the researcher as a physician and health service manager was disclosed at the outset. However, this experience in the Pakistani health system helped the researcher to gain a much deeper understanding of the participants' perceptions and improved access and understanding of the participants' working environments.

A further potential limitation of this study was that it only focused on the views of the physicians. Other important stakeholders related to physician retention and migration issues in Pakistan, such as the Ministry of Health (MOH), the Pakistan Medical and Dental Council (PMDC), the College of Physicians and Surgeons Pakistan (CPSP), the Higher Education Commission (HEC) and the health consumers, were not included in this study. Therefore, the perceptions of these other important stakeholders regarding physicians' retention, migration and resettlement are not reflected in this study. These stakeholders' perceptions would be important and a future study could be conducted. This is discussed further in Chapter Five.

3.6 Ethical considerations

According to Fraser and Alexander (2006), before conducting any research the researchers must appropriately consult the relevant human research ethics bodies and must carefully evaluate all possible advantages to be gained from the research and any risks that may cause the participants discomfort or disadvantage. Therefore, before undertaking this research, ethical approval was obtained from the University of New England Human Research Ethics Committee Approval Number HE08/120, valid until 21/08/09 (Appendix

11). The researcher was also granted permission and assured of support in identification and recruitment of participants for this study by the Pakistan Medical Association in Pakistan (Appendix 1) and the Association of Pakistani Doctors, Queensland, in Australia (Appendix 2) before the actual commencement of data collection. Furthermore, before data collection, each participant was provided with a Participant Information Sheet (Appendix 6) and participants were advised they could withdraw from the study at any time without penalty or prejudice.

In the planning and implementation of this research, the researcher used the bioethical framework provided by Beauchamp and Childress (2001:12). Respect for autonomy, nonmaleficence, beneficence, and justice are the four main principles that underpin this framework. Autonomy is about the rights and freedom of choice of each participant to participate voluntarily in the study. Nonmaleficence means doing no harm to the participants. Beneficence refers to the fact that the research findings are good for the participants and their communities, while justice refers to fairness towards the participants in the distribution of benefits, risks and costs (Beauchamp & Childress 2001:12).

Keeping in view the above framework, every effort was made to ensure participants' confidentiality. Autonomy of the participants was ensured by requesting the participants sign a written informed consent to indicate their agreement to participate in the study and for their conversation to be audiotaped (Appendix 10). Participants kept a signed copy of the Informed Consent. According to the Australian National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (2007:59), 'researchers should identify and take steps to minimise potentially detrimental effects of an unequal or dependent relationship on the conduct of the research'. This was not an issue in

this study as the researcher does not have such a relationship with any of the participants nor does he hold any position of power in any health related organisation either in Pakistan or Australia.

During the transcription of data, each participant was allocated a pseudonym to de-identify the participant in the transcription from the original digital sound file. In addition, and to further enhance the confidentiality of the participants, the researcher obtained their demographic data on a separate Demographic Data Sheet (Appendix 7, 8, 9) and there was no mention of places of duty or any other potential information on the transcripts. The pseudonyms, the demographic profile sheets and the transcribed hard copies of the interviews were kept separate in a locked filing cabinet in the researcher's office. The audio files were kept on the researcher's personal computer with a secure password access and were backed up on an external hard drive kept in a locked office. Only the researcher had access to all the data while only the de-identified interview transcripts were shared with the supervisors. Consistent with the University of New England Ethics approval and the National Health and Medical Research Council Guidelines (NHMRC 2007), audio files and transcripts will be retained for five years and will then be destroyed.

3.7 Conclusion

This chapter commenced with a justification of the qualitative phenomenological approach as the research design. It then described the research methodology including the setting, study sample, interview schedule, data collection and the role of the researcher. Rigour and trustworthiness and ethical issues were then discussed followed by the study limitations including methodological issues. In the following chapter, analysis and results of the interviews are presented.

Chapter Four
Results

4.1 Introduction

The research design and methodology for this phenomenological study followed by the rigour, trustworthiness and limitations were described in the previous chapter. This chapter presents the study results. First, the profiles of the participants are presented and then the study findings are presented and discussed. The chapter concludes with the identification of the major findings. The presentation of findings is organised in relation to the four study aims that directed the study.

1. Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas.
2. Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad.
3. Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country.
4. Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time.

The factors that affected Pakistan physicians' career decisions are clustered into three categories as themes and subthemes: personal characteristics and family factors, health system factors and societal factors. Throughout this chapter the themes that emerged from the data are presented with supportive quotes specifically selected to describe the shared experiences and perceptions of the respondents in the study. These themes are not mutually

exclusive and each theme builds on the previous theme to describe the phenomenon under study, which is the perceptions of Pakistani physicians regarding their career decision to remain in Pakistan, migrate abroad or resettle back to their country after working abroad for some time.

This chapter provides an insight into how and why some Pakistani physicians decided to remain in their country, migrate abroad or resettle back after working in another country for some time. The complexity of the multiple factors involved in these decisions and its implications for health care provision in Pakistan are explored. The analysis of the findings is embedded in the experiences of those people who actually decided to remain, migrate abroad or resettle back into Pakistan for multiple reasons. Their viewpoints, usually not heard due to the scant research in this area in Pakistan, are valuable in the development of a global picture of health human resource development. The rich insights of the participants about their decisions to remain, migrate abroad or resettle will give new insights to policy planners and researchers to further refine both health human resource policy and practice in general and in Pakistan in particular.

4.2 Participant profile

This section provides a demographic profile of the participants who participated in this study. This information is important as it provides details about their gender, age categories in years, the province/state of the country in which they were working at the time of the study, their completed medical qualifications, their current role whether working as GP, specialist or doing specialist training, the mode of their practice whether public, private or both, countries in which they have worked other than Pakistan and their duration of work in those countries.

A total of thirteen respondents comprised of four *stayers*, five *leavers* and four *resettlers* were interviewed for this study using a combination of both purposeful and snowball sampling. Four Pakistani physicians, consisting of three *stayers* and one *resettler* excluded themselves from the study after their initial agreement to participate in the study without providing any specific reason. At the time of the study, the respondents worked in a variety of public/private healthcare facilities in four different provinces in Pakistan and three different states in Australia.

4.2.1 Stayers

Stayers were those Pakistani physicians who had obtained their primary medical qualification, that is, Bachelor of Medicine, Bachelor of Surgery (MBBS) in Pakistan, had never migrated to another country and were working in Pakistan at the time of this study. A total of four *stayers* were interviewed out of which two were females and two males. Table 4.1 provides demographic details of their background.

Table 4.1: Demographic profile of participants, stayers

Respondent code	Gender	Age (Yrs)	Province/ State	Qualifications	Current role	Mode of practice
PS1	F	< 35	Khyber Pakhtunkhwa	MBBS	Trainee (Pulmonology)	Public only
PS2	F	35-39	Balochistan	MBBS, MCPS, FCPS	Specialist (Gynaecology)	Public & private
PS3	M	35-39	Balochistan	MBBS, DMRD	Specialist (Radiology)	Public & private
PS4	M	45-49	Punjab	MBBS, DMRD	Specialist (Radiology)	Public & private

Note: PS = Participant stayer; MBBS = Bachelor of Medicine, Bachelor of Surgery; MCPS = Member College of Physicians & Surgeons, Pakistan; FCPS = Fellow College of Physicians & Surgeons, Pakistan; DMRD = Diploma in Medical Radio-Diagnosis (Pakistan); F = Female; M = Male.

4.2.2 Leavers

Leavers were those Pakistani physicians who had obtained their primary medical qualification (MBBS) in Pakistan and were working in Australia at the time of the study. A total of five *leavers* participated in the study of which one was female and four male. Table 4.2 provides details of the five Participant l*eavers* background.

Table 4.2: Demographic profile of participants, leavers

Respondent Code	Gender	Age (Yrs)	Province/ State	Qualifications	Current role	Mode of practice	Work outside Pakistan	Duration of work overseas (Yrs)
PL1	M	50-54	Western Australia	MBBS	GP	Private only	Australia	4
PL2	M	35-39	Queensland	MBBS	GP	Private only	Ireland	0.5
							Australia	5
PL3	M	< 35	Queensland	MBBS	Trainee (Medicine)	Public only	Saudi Arabia	4
							United Kingdom	3
							Australia	1
PL4	M	60 +	New South Wales	MBBS, DPM, MRCPsych, FRANZCP	Specialist (Psychiatry)	Public & private	United Kingdom	7
							Canada	2
							Australia	27
PL5	F	< 35	New South Wales	MBBS, MRCP	Trainee (Medicine)	Public only	UK	1
							Australia	2.5

Note: PL = Participant leaver; MBBS = Bachelor of Medicine, Bachelor of Surgery; DPM = Diploma in Psychological Medicine; MRCPsych = Member Royal College of Psychiatrists (UK); FRANZCP = Fellow Royal Australian & New Zealand College of Psychiatrists; MRCP = Member Royal College of Physicians (UK); F = Female; M = Male; GP = General Practitioner.

4.2.3 Resettlers

Resettlers were those Pakistani physicians who had obtained their primary medical qualification (MBBS) in Pakistan, migrated to another country and had resettled back and were working as physicians in Pakistan at the time of this study. A total of four *resettlers*

were interviewed of which one was female and three male. Table 4.3 provide details of the Participant *resettlers* background.

Table 4.3: Demographic profile of participants, resettlers

Respondent Code	Gender	Age (Yrs)	Province/ State	Qualifications	Current role	Mode of practice	Work outside Pakistan	Duration of work overseas (Yrs)
PR1	M	55-59	Khyber Pakhtunkhwa	MBBS, FRCS, Diploma (Urology)	Specialist (General surgery & Urology)	Public & private	United Kingdom	12
PR2	M	50-54	Punjab	MBBS, MCPS, FCPS, FRCS	Specialist (Surgery)	Public & private	United Kingdom	4
							Saudi Arabia	0.5
PR3	F	45-49	Sindh	MBBS, MCPS, MRCOG	Specialist (Gynaecology & Obstetrics)	Private only	United Kingdom	7
PR4	M	50-54	Punjab	MBBS, DMRD, FCPS	Specialist (Radiology)	Public & private	Saudi Arabia	6

Note: PR = Participant resettler; MBBS = Bachelor of Medicine, Bachelor of Surgery; MCPS = Member College of Physicians & Surgeons, Pakistan; FCPS = Fellow College of Physicians & Surgeons, Pakistan; DMRD = Diploma in Medical Radio-Diagnosis (Pakistan); FRCS = Fellow Royal College of Surgeons (UK); MRCOG = Member Royal College of Obstetricians & Gynaecologists (UK); F = Female; M = Male.

As stated above, the factors that influenced Pakistan physicians' career decision about staying, moving overseas or resettling back to their country are presented and described as themes under three categories (see Table 4.4). These categories are personal motives, perceptions and characteristics, health system factors and societal factors. In some of the categories, no factor was identified by the participants during their discussions.

Table 4.4: Factors influencing Pakistani physicians' career decisions

Category	Factor
Research Aim 1: Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas	
Personal characteristics and family factors	Identity and belonging Desire to serve own people Family attachment and support
Health system factors	Having a permanent job in Pakistan Less difference between local and overseas earnings
Societal factors	Perception of differentiation between locals and non-locals
Research Aim 2: Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad	
Personal characteristics and family factors	No factor was identified in this category by the participants
Health system factors	Lack of health human resource policy and planning Lack of good postgraduate medical training Lack of proper career structure and professional development Lower salaries Overseas demand
Societal factors	Health as a state priority Culture of valuing overseas training Personal insecurity and societal degradation
Research Aim 3: Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country	
Personal characteristics and family factors	*Quality of life versus standard of life
Health system factors	Having a permanent job in Pakistan
Societal factors	Feelings of differentiation between locals and non-locals
Research Aim 4: Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time	
Personal characteristics and family factors	No factor was identified in this category by the participants
Health system factors	Unwelcoming attitude Difficulty in finding suitable jobs Underpaid jobs
Societal factors	Personal insecurity and societal degradation

*A broad construct that includes both personal and family and societal factors as discussed further in this chapter.

4.3 Research Aim 1: Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas

The main reasons identified by the study participants for staying in Pakistan were identity and belonging, a desire to serve their own people, family attachment, having a permanent job in Pakistan, less difference between local and overseas earnings for specialists and a perception of differentiation between locals and non-locals abroad.

4.3.1 Personal characteristics and family factors

4.3.1.1 Identity and belonging

Almost all the respondents expressed a strong sense of identity and belonging to their country, culture and place of birth and this was one of the strongest reasons for not going abroad and remaining in their country or for resettling back into their country. Even those who migrated abroad were of the view that they would prefer to work in their country and culture if provided with the right opportunities and support. A female gynaecologist who went abroad for her postgraduate training and had resettled back into Pakistan expressed her feelings of attachment to her country in the following words:

> *So, these conditions of lawlessness, underpaid jobs etc, all these things bother you; otherwise everyone wants to come back to Pakistan. I can say this with conviction that everybody wants to go to their own home, their country. Nobody wants to live away from their own country, because here we have our roots.* (PR3)

This respondent approved of going abroad for obtaining further education but was of the strong opinion that those who go abroad for training should come back as we need to work collectively to bring improvement to the medical system. She further explained.

> *I will just tell them that you should definitely go abroad so that your vision becomes broad and you also know other ways of doing things. You also definitely seek knowledge from abroad and there is nothing bad about it. And I think everybody should go and learn from abroad but you should try to go back to your own country. There are a lot of problems*

but if we all try together then things will somewhat improve. If everyone runs away then things will not improve ... At least we should all come back and then collectively do a struggle. We have to make this system better. Our time has passed but at least our coming generations will get a better environment and a better country. Whatever we have suffered, at least the coming generation should get a better country. If all of us were running out for economic reasons then there will be no improvement in this country. This is our identity. (PR3)

This phenomenon of identity and belonging to their country and culture was also evident from the discussion of the Pakistani physicians who had migrated from Pakistan and were working in Australia. A female Pakistani physician who was undergoing postgraduate training in Australia, while describing her intentions of going back to Pakistan after completing her training cited raising her children in their country's cultural environment as the main reason for her re-settlement decision. She said.

Basically we want our kid's relationship with our culture and religion to remain intact. I mean we don't want them to spend their life in this environment and not know anything about their religion and culture. So this is our basic aim. (PL5)

A young radiologist informed me that after his graduation in Pakistan he did not have any intentions of going abroad especially to the Western countries, because of the cultural differences. He was of the opinion that one remains happier in his/her own country even if you earn much less than you earn in a different country and culture.

... from the very start I did not have any intention to go to Western countries because I don't feel very easy in that culture. (PS3)

If here I get two third or even a half of (what I earn) outside, then one remains more happy in his own country compared to abroad. (PS3)

These physicians were of the view that those who settle abroad permanently, especially in Western countries, become part of that culture and as a result lose their own culture and identity.

Our doctors who went abroad in the 50s and 60s and whom I meet while I am travelling, or sometimes when they come here; once they went abroad they could never came back, neither could they remain available

for any national service, nor did their kids have any relationship with their country. Within 2-3 generations they became a write-off from Pakistan. So, to me this is a tragedy for the people who settle abroad. (PS4)

... the civilisation of the West amalgamates them and incorporates them within itself and eventually engulfs them, and then their identity, their culture, their religion and the rest of their identity vanishes away. (PS4)

4.3.1.2 Desire to serve own people

For the majority of the respondents a desire to serve their own people was one of the main reasons for staying in their country. They all had a very strong desire to serve their own people and community. This theme was very prominent in the conversations of one male and one female *stayer*. They had never thought of going abroad and they wanted to provide services to their people and community. According to a female respondent who made the following comments when specifically asked about her decision to stay and not go abroad.

... we think that our people here need us more. I mean the professionals. (PS2)

Well, I want to give service to our people and our community here. I mean what I have learnt; I give service to our community. So, that's why. (PS2)

The majority of the study respondents approved of Pakistani physicians going abroad for training or to work for some time but were not in favour of settling abroad permanently. They were of the opinion that there is a need for qualified doctors in Pakistan and that they need to return a perceived obligation to their country by serving its people. A radiologist working in Pakistan put it in the following words:

... there are debts of your country. You have to give back to the community. If the nation is spending 6-7 million PKR to make a doctor, then if that doctor goes abroad and starts enjoying a luxurious life in the West and forgets that in his own country children are dying and there is a need of their skills, then he has to be accountable on the day of judgement in front of God. (PS4)

A female Pakistani physician who was undertaking her postgraduate medical training in Australia and was working as a trainee registrar also expressed similar views when asked about her views about Pakistani doctors going abroad for training or work. She was of the opinion that they need to go back to their country after completing their education or work as Pakistan and its people need their services. She explained.

> *I think that for every doctor in his life time there is the need for exposure of some other place because in Pakistan medicine is very limited. I mean for everyone this is needed but they should keep this at the back of their mind that they should come back because there is a huge need for doctors for our people. I mean they need us. So, because that country has served us, we should serve it too. Because all our life we have eaten from that soil so that [soil] has some obligation on us. I think they should all keep this in mind that they should go back and do something for their own people.* (PL5)

4.3.1.3 Family attachment and support

Another very important reason that had influenced staying Pakistani physicians to avoid going overseas was their intimate attachment with their families and the support that they received from their family members. For them, their attachment to their families was a strong tie to Pakistan. For example, a female participant decided not to go abroad because she had a very strong attachment with her family, especially with her parents. According to her, she could not live without her family. She explained that she had never thought of going abroad.

> *Well, I can't live without my family. I can't even imagine that I will go abroad. Especially for me leaving my parents is very difficult. It does not really matter whether your join your family or not on happy occasions but it is very difficult to reach home from abroad in events such as deaths. Therefore, I am not in favour of going abroad and especially if someone's parents or some other relative is sick. Thanks to God that my parents are healthy but I can't leave them even for short time.* (PS1)

The study respondents, especially the females, were very appreciative of the moral and material support available to them from their extended families in Pakistan. A female

gynaecologist with four children, a government job and doing an evening private practice explained it in the following words.

> *If I was not in a joint family [where all brothers, their children, unmarried sisters and parents live together in one house], then maybe I would not have done anything.* (PS2)

Another female trainee in the speciality of Medicine when asked about her views about her salary structure from a government job mentioned the financial support that she was getting from her family in the following words:

> *Personally, I get a lot of support from my home. Therefore, I don't have any such problem. And that's why I have not even thought whether this is more or less.* (PS1)

4.3.2 Health system factors

4.3.2.1 Having a permanent job in Pakistan

Having a permanent job in their home country was mentioned by most of the Pakistani physicians as one of the deterrents to migrating abroad. While elaborating on the reasons for his decision to stay in Pakistan, one of the respondents said that he was selected as a consultant when he was very young and that by staying in Pakistan he was assured of a promising career and other benefits.

> *For us, one of the reasons to stay in Pakistan was that we were selected as consultants very young, so we had a career in front of us and after some time we will become senior consultants and chief consultants. Then I will get a pension, and have health benefits. So, from government service I have many benefits. Although I am not heavily paid but still whatever I am paid and the practice that I have ... I have hands-on protection.* (PS4)

However, in the recent past, in order to improve efficiency in the government departments the government had introduced a contract employment policy in place of permanent jobs, mainly on the advice of the international lending/funding agencies. Now, because of this contract policy, the above mentioned benefits are withdrawn from government jobs leading

to job uncertainty. This in turn has led to a decrease in overall job satisfaction and, as a result, has meant more doctors start looking for other avenues including going abroad.

> *But now this thing is lacking. The chap who does his FCPS or does a fellowship from abroad, when we hire him we create a band of uncertainty around that. Because of that if he/she is doing a government job, he/she is doing it not very willingly and it is the same situation for our new entrants where we give them contractual jobs and this hurts their ego. That was the requirement of our funding agencies who suggested these things to improve efficiency in our departments that we should give people contractual jobs and do this and that. Those experiments were not successful. We changed those intact systems abruptly and now because of that we have problems.* (PS4)

4.3.2.2 Less difference between local and overseas earnings

The study participants were of the opinion that Pakistani doctors, especially the specialists with a good private practice (which most of the public sector doctors do in the evening), earns almost the same amount of money as their overseas counterparts. Therefore, after doing their postgraduate training and establishing their private practices, these doctors do not see much benefit economically in going abroad. One of the study respondents, after completing his postgraduate studies, commenced his private practice and was satisfied economically with his job. According to this young radiologist:

> *Well even abroad I will get the same package of PKR 100,000 to PKR 150,000 per month which with my private practice I am getting here too. So, I think one should not waste time abroad and instead give time to one's own private set up. You will remain abroad for five years but in those five years your own practice will be very well-established. Now, I am saying that I am satisfied economically with my job ... now economically there is not much difference for me. So that's why personally I don't think about going abroad.* (PS3)

A Pakistani physician who now works as a general practitioner in Australia was of the same opinion and mentioned that specialists earn almost the same amount of money compared to their counterparts in the developed world, if not more. Therefore, in his

opinion, this could be one of the reasons for some of the Pakistani doctors to remain in their country. He explained:

> *The specialist income is almost comparable with incomes in the western world. Dollar for dollar they are comparable but the incomes of general practitioners are very low. So, yeah that can be a reason for quite a few doctors if they stayed back. I can understand that.* (PL1)

4.3.3 Societal factors

4.3.3.1 Perception of differentiation between locals and non-locals

This study found that among those respondents who stayed in Pakistan there was a strong perception of differential treatment between immigrants compared to local born nationals in foreign countries. They mentioned this as one of their reasons for not going abroad. One respondent stated that one of the reasons for not going abroad was the general differentiation between locals and non-locals in the Middle East and the presence of negative perceptions of other cultures in Western countries. According to this respondent, these beliefs were based on their interactions with their friends and colleagues who were living in abroad.

> *Abroad, we are hearing from people that there is a difference between local and non-locals and even in Arab countries between Arabs and non-Arabs. And in European countries, I have heard from some doctors that when you are travelling in a bus, the English person will not sit with you on the same seat and instead will sit on another seat and your seat will remain empty. So, you feel very strange.* (PS3)

4.4 Research Aim 2: Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad

The factors that influenced Pakistani physicians' decisions to leave their country and move abroad either for further training or work were more or less the same for both *leavers* and *resettlers*. The main reasons identified by the physicians for leaving their country and going abroad was a lack of health human resource policy and planning, lack of good

postgraduate education, lack of proper career structure and professional development, lower salaries, overseas demand, a culture of valuing overseas training, personal security and general societal degradation, and health as a state priority.

4.4.1 Personal characteristics and family factors

Significantly, no factor was identified in this category as a reason for moving abroad by the respondents during their discussion. However, some Pakistani physicians did mention that, after they made up their mind to migrate abroad, their preference to migrate to a particular destination country was due to their friends having migrated there before.

A male Pakistani doctor now working as a GP in Australia first went to Ireland before coming to Australia due to the presence of his friends in Ireland. In Ireland, he was taking the Irish registration exam for doctors when he got a job offer in Australia and then he decided to go to Australia.

> *I was working in a hospital in psychiatry [in Pakistan]. Then I went to Ireland as my friends were there before me.* (PL2)
>
> *As I told you I went there [Ireland] for a job but there they only give you a job after passing an exam, their registration exam. I took part-one of that exam. At that stage I had family, kids and I had left my job as well [in Pakistan] and whatever money I had was running out. Then my priorities changed and I was looking for any job. Then luckily I got a job here [in Australia] and I decided that it's better to take this job and leave the part two of the registration exam [in Ireland], as a bird in the hand is better than two in the bush.* (PL2)

Another Pakistani psychiatrist now working in Australia did mention the presence of his colleague and friend who persuaded him to come to Australia. However, the primary factor for his decision to migrate abroad was his inability to find a job in Pakistan after completing his postgraduate training in the UK and Canada. He explained.

> *In 1980, there [Pakistan] I was looking for a job but it was all very uncertain. I tried but could not found any suitable position at that time.*

> *Then after that I had this friend in Australia who told me to come here and I came here. Here, I took this town specialist job.* (PL4).
>
> *I had a friend from India, a 'Sardar' [Sikh]. He is also a psychiatrist. I knew him from England. So, he told me to come here and he told me that there are a lot of opportunities [in Australia]. So, then I came here. He told me the process and how and what I should do. So, after that we settled here.* (PL4)

In contrast another Pakistani doctor who now works as a GP in Western Australia chose Australia for migration because of its people and environment, although he mentioned the presence of his family and friends in other countries such as Canada and the UK.

> *I always personally had a liking [for Australia] but, as I said, I had an opportunity to go to Canada because my uncle was there and he told me that he could sponsor me if I wanted to come and carry on my own medical speciality early… but I had no interest in Canada somehow. Then I went to the UK and stayed there. I loved the UK but I would have never able to choose it because it is very cold and I hate cold. So, Australia has a beautiful environment and ecology plus it's close to home. If you look at all the Anglophonic countries, Western Australia is only two hours from Pakistan. [2 hours time difference between Pakistan and Western Australia].* (PL1)

4.4.2 Health system factors

4.4.2.1 Lack of health human resource policy and planning

Almost all the respondents were unanimous in their assertions that there is a lack of health human resource policy and planning in Pakistan. They were of the opinion that in the absence of a viable health workforce policy in Pakistan the health system is in complete disarray, suffering from maldistribution of the health workforce. This maldistribution arises from geographical, gender, profession/speciality and institutional and services imbalances and influences.

The majority of the respondents were of the view that because of the government's misplaced priorities and the historical underfunding in health and other social sectors, the rural areas where the majority of the population reside remained underdeveloped with poor

health and other social infrastructure. Therefore, because of this overall underdevelopment and in the absence of any viable health human resource policy and planning where specific incentives can be incorporated for a rural workforce, doctors do not want to go and serve in these areas resulting in their concentration in major cities.

> *... as long as you have a proactive policy in Pakistan ... to push the health care facilities outwards towards remote areas, doctors will follow. The doctors need their basic facilities. I mean if you expect a doctor to go and sit in a God forsaken village where he is the only educated person and he has nothing to deliver what he has learnt, obviously he is not going to stay there.* (PL1)

A female Pakistani physician who is undergoing her postgraduate medical training in Australia expressed similar views and was of the opinion that due to lack of incentives and training opportunities in rural areas, doctors are reluctant to go and serve in these areas.

> *I think it's pointless to expect a person who does such tough studies for 5 years and after that do a difficult house job and go and sit in a village where he/she will get 6 thousands rupees per month and there are no other facilities. If I put myself in this situation, I would never do it. I also don't expect that my colleagues would also like it because the government is not giving any incentives. I mean they should make some attraction for people to go and work in rural areas.* (PL5)
>
> *Then in rural areas there is no training. Suppose if you want to work as a trainee you can't do that in a rural area. And mostly people want to do further training. Now there is no satisfaction to remain as a MBBS. Now even in rural areas people ask whether he/she is a specialist or not? Now, no one asks about a simple doctor. So, who will go to rural areas? I think if they think that someone will go to the rural areas they need to give some incentives.* (PL5)

The same respondent, when asked her opinion about the availability of doctors in Pakistan according to need immediately pointed out how the lack of a structured human resource policy has led to improper distribution of doctors and other health human resources. She explained.

> *Doctors, I think there are not more than we need it is the same as in Peshawar if you go to 'Dabgari' [a place where majority of doctors in Peshawar do their private practice], people say that this is a doctors' market. There, a doctor will be looking for a patient and will send a*

> *person to attract patients for him but people in the surrounding area of Peshawar, when they go to BHUs or the District Headquarter Hospital, it is lying vacant. There is no doctor there. There is no one there. People come to hospital and die. I think they are just not properly distributed. And this is because the government doesn't have any structured policy. There is no health system in which you distribute doctors in areas and post them everywhere and then provide them with proper facilities and incentives so that they can function there.* (PL5)

Another study participant, when asked the same question, was of the opinion that there are an adequate number of doctors but they are underutilised due to maldistribution. She said that because doctors are not offered good incentives they are reluctant to serve in rural areas, leading to a concentration of doctors in major cities which results in their unemployment and migration.

> *No, there are not more doctors produced but their utilisation is not done properly ... For example, people don't go to the peripheries. I am sitting in Quetta [provincial capital] and all my colleagues who have just done the FCPS have come to Quetta. So there is saturation here and the periphery is almost vacant...In cities how many doctors will sit? So, there is saturation and doctors get upset and think that they sit for whole day but don't see a single patient, and so they think about going abroad. This is the main reason.* (PS2)

Furthermore, the study revealed that because of the lack of basic facilities and other incentives from the government in rural areas, doctors want to work in major cities. This leads to increased competition and jobs saturation. Therefore, in order to stay in cities and also to augment their incomes, there is a general trend of specialisation among doctors, resulting in more specialised care at the expense of much needed primary care. A Pakistani radiologist who was initially posted to a rural area following his graduation, while narrating his story about doing his specialisation, stated that he did not have any specific interest in doing specialisation. This arose as he wanted to go into a major city and to ensure security in his career opted for specialisation.

> *Actually I wanted to come back to my city; therefore I preferred either DMRD or DMRT [Both major diplomas in radiology]. I thought by doing this that I will stay for at least two years in Lahore [metropolitan city].*

So, this was by chance and I decided to do this and got admission to DMRD. (PR4)

Another Pakistani physician also expressed identical views about the prevalent trend of specialisation among doctors in Pakistan and explained.

As I said, that if you want to live in a city, then being only a simple MBBS or medical officer no one even considers you as a doctor. So, in cities specialisation is dominant....The main reason for this is that...very less people specialise out of interest. I mean if someone says that someone is doing specialisation because of their interest, they are very rare. The main reason is that their aim is to specialise and then join a teaching position and get rid of transfers and postings, and secondly to establish a good clinic. (PS3)

A female Pakistani physician who was working as a trainee registrar in Australia was of the opinion that doctors do specialisation because of the demand from the public as now generally people prefer to go to specialists for their treatment.

Because, now the common man's psyche is that they ask whether this person is a specialist or not? Now the people's concept of an MBBS doctor is finished. If someone has done something [postgraduation], then people will go. So if you want people [patients] to come to you then you have to do it. (PL5)

In order to develop an evidence based health human resource strategy, there is a need for accurate and reliable data on the health human resource in a country. However, the respondents in this study were of the opinion that in Pakistan there is a lack of data on the available health human resource and the present and future needs of the country. This leads to vast geographical and intra-speciality imbalances in the availability of required health human resources. A study participant from the largest province of Pakistan, when asked about the widely prevalent perception that in Pakistan more doctors are produced than is needed, did not agree with this assumption and pointed out that due to the lack of an evidence based human resource policy we are experiencing both geographical and intra-speciality human resource imbalances. He explained.

> *Well, this may be the case in other areas but this is not the case at least in our Baluchistan [province]. Here there is need of even more ... if there are more [doctors] in surgery then there is no one in radiology and pathology. There is no one in psychiatry. If there are more in medicine, then there is no one in skin [dermatology].* (PS3)

Three of the study respondents specifically mentioned the recent feminisation of medicine and its implications regarding the availability of sufficient human resources for quality health care provision in Pakistan. They said that because of the open merit policy for males and females in medical schools, currently 70 to 75 percent of the students coming to these schools are females and only 25 percent are males. This increased trend of feminisation was attributed to the female students and their families' desire to find good matches while in medical school and get married.

> *Now in medical schools 75 - 80 percent are girl medical students, only 25 percent are boys. Now look, in those (boys) the majority of them go abroad ... And those girls get married and sit at home. After becoming doctors, they get married and also get good matches and the majority of people are making their girls doctors because of this.* (PS3)

However, a female physician expressed a slightly different opinion on the causes of feminisation of medicine and said that in her view this is because medicine and teaching are the only two professions which are considered acceptable for females in our society and therefore this might be the reason that people encourage their daughters to study medicine.

> *I think that in our society people don't like females in other office jobs but medicine is such a profession that has been accepted by the society as something acceptable for girls. I think that this might be the reason that people like to make their daughters doctor. Whereas, on the other hand, if someone would like to do accountancy, then their parents will not be proud that their daughter is becoming an accountant, work as an accountant or work in a bank or do a job in Business Administration or something like that. I think teaching and medicine are the two professions which are regarded as acceptable for females in our society. Probably this is the reason that females want to come into this profession as they do not have any hindrance from their family compared to other fields.* (PL5)

This respondent further pointed out that the increased feminisation of medicine might have a positive impact on the overall health status of the population, especially maternal and child health as, in her opinion, because of certain cultural issues females were reluctant to visit a male health care provider and therefore could not get the required treatment.

> *I think with this there should be a positive change because up till now it was a major problem that female patients were not willing to go to a male doctor and females would die in their homes with their diseases because a female physician or surgeon was not available. So I think in that respect it should be quite helpful that more females are coming... I think this should have a positive impact especially for female health because in Pakistan we know that mother and child health is a major issue. So, in my view it should have a positive impact.* (PL5)

However, another study respondent was of the opinion that following marriage some of the female doctors leave their profession completely while some think that they will start their professional career when their kids are grown-up. However, the majority of female doctors fail to return to their career after they leave for family reasons. Some of them leave abroad with their husbands while others join the private sector. Even those who did join the medical profession are experiencing problems in attending to late-night emergencies and doing evening and night shifts.

> *Now some females when they get married they do not continue their professional life. Some of them discontinue it for the time being and think that we will start when their kids are grown up. In this, too, some of them start again but many of them don't. Some of them leave abroad with their husbands. Those who did join their profession go to the private sector ... Even those who start working, again there are problems because they can't do night duties and evening duties as their families don't allow them to do night duties.* (PR4)

A female gynaecologist pointed out that some of the female doctors do not work after their marriages because of their dual responsibilities of work and family. She attributed this to the non availability of part-time training or part-time work opportunities in Pakistan.

> *They [females] don't work as, after marriage, they sit at home because their in-laws don't allow them to work because there are no part-time job facilities. There are no part-time job-sharing facilities or part-time*

training facilities so that girls can do their training for some time and then give the rest of their time to family and homes. We don't have any baby nurseries at work so where will they leave their babies? (PR3)

This respondent suggested to the government that these female doctors should be provided with women friendly work environments so that they can join their profession and prevent the loss of national resources used on their education.

You are making girls doctors, you have made the medical schools seats on open merit and 75 percent of students are girls but then give these girls facilities, make an environment for them so that they can work. (PR3)

4.4.2.2 Lack of good postgraduate medical training

The majority of the Pakistani physicians reported that the lack of good postgraduate medical training in Pakistan was one of their main reasons for leaving the country. For many leaving physicians this was the only reason for leaving their country. The responses of study participants concerning postgraduate training in Pakistan identified three main issues. These were insufficient number of postgraduate training positions, perceived poor quality of the available postgraduate education and a low renumerated salary structure during postgraduate training in Pakistan.

The first problem identified by the study participants with postgraduate education in Pakistan was an insufficient supply of enough training positions. This leads to many young doctors deciding to migrate abroad. According to one of the study participants who was working as a general practitioner in Australia, the capacity in Pakistan to produce doctors has almost doubled with time, however, the training positions for postgraduates are not being increased accordingly. He said:

... in the 70s there was a sudden expansion of the public sector capacity to produce doctors but then in the 80s, mid 90s the private sector took over. So, now you have almost double the capacity of doctors being produced in Pakistan and improvement in the production is only at basic

> *level. So you are only producing medical graduates. Capacity to train your specialists still remains minimal.* (PL1)

Another respondent, now working as a trainee registrar in Medicine in Australia, while describing his reasons for leaving Pakistan and coming to Australia explained:

> *There [Pakistan], when you start medicine you look for a brighter future. Then you look for training. So, there was no training. So keeping this in mind, we came out and then a cascade has started.* (PL3)

When this respondent's attention was drawn towards the availability of postgraduate training in Pakistan, his response was as follows.

> *Yes, I did try but the level of competition was very high, waiting lists and this and that. There was something, if you do unpaid then it was possible otherwise not.* (PL3)

According to the study participants, the other major issue with the postgraduate medical education in Pakistan is its quality. They were of the opinion that postgraduate training in Pakistan is mainly unstructured and is almost always based on the apprenticeship model. A female gynaecologist, now working in Pakistan and who did her postgraduate education both in Pakistan and the UK, explained the difference in the postgraduate training in both countries as follows:

> *There is a lot of difference. Our [Pakistani] training is not at all structured. Our training is just like an apprenticeship, like here you sit a child with a mechanic so that he will learn at least something. It is the same here ... There is no structured training.* (PR3)

A female Pakistani physician who did her eighteen months MRCP training in Pakistan and is now working as a trainee registrar in Australia was of the same opinion, that postgraduate training in Pakistan is not structured and the process of learning is entirely dependent on the individual efforts of the trainees themselves without much interest and effort from the trainers. She described her experience as below.

> *I think the training is altogether dependent on the trainee himself. Let's say those trainees, who are good and interested in learning and go after their consultants and are stuck with their books, they will learn*

> *something. Those who are interested but can't put that much effort in, then nobody else is bothered. So, the training is entirely dependent on the trainee himself. Although the senior doctors have vast knowledge and if you try to suck it out from them I think they will teach you something, but there is no such scheduled training. There is no structured training. They expect you to just come for duties and then leave.* (PL5)

Another Pakistani surgeon who did his fellowship both in Pakistan and the UK and is now working in Pakistan described the postgraduate training in Pakistan as 'punishment'. He pointed to the lack of research and training and development funds in the annual budgets of hospitals and other health care organisations.

> *Look, the training in Pakistan is a punishment. You are begging people and doing everything ... Our environment is not conducive to teachers and trainers then what to talk of trainees. Here the trainee is altogether an outsider... If you see the annual budget of a hospital and look for research funds there will not even be a single paisa [cent]. For education or training of teachers, there is not even a single paisa in the budget.* (PR2)

Another respondent drew my attention to the lack of government policy on postgraduate education in Pakistan. He was especially critical of the quality of university postgraduate medical education in Pakistan and described it in the following words:

> *... the government has no policy of its own for education ... The government has no organisation for postgraduation. The College of Physicians and Surgeons (CPSP) is a non-government body. The government only has these government supported universities and they don't do any postgraduate training and their programs of MD, MS, MPhil and other programs are very lousy and are still on the same old conventional grounds. They haven't got any curriculum, they haven't got any training, and they haven't got any examination system, standards, nothing.* (PS4)

Contrary to the views of the above participants, a young female physician who was in the first year of her postgraduate training in Pakistan was appreciative of her training. She was of the opinion that Pakistani qualified specialists are more competent than Western trained physicians and the reason that she gave was that locally trained doctors often work in

difficult conditions with limited resources while abroad the training environment is very standardised. In her own words:

> *Well, no one is comparable to the trainees of Pakistan. I don't say that those trained abroad know nothing or they have learnt nothing but mostly it is their name that they are foreign trained is what mostly considered.* (PS1)
>
> *The Pakistani-trained (doctors) are very competent because they work in different conditions and in foreign [countries] they get a very standard environment and everything is perfect.* (PS1)

The third major issue identified by the study participants regarding postgraduate medical education in Pakistan was the poor salary structure of these programs. The respondents were of the view that until and unless someone is financially well-off or being supported by his/her family, it is very difficult to survive on the salary being offered to the postgraduate students during their training. A Pakistani physician who now works as a general practitioner in Australia made the following comments.

> *If you want to do postgraduate training ... that is very difficult, unless you have factories or financially you are so well-off that for 5-7 years you can finance yourself. Because the pay that you will get will not be enough to make ends meet.* (PL2)

When this participant was asked about the available postgraduate training programs in Pakistan, the respondent replied that such opportunities are available but in order to avail yourself of such opportunities you need to have alternate sources of income to support your family because the salary that you get during your postgraduate training is not enough to meet your day-to-day expenses.

> *Yes, there are opportunities but how far you can go to avail yourself of those opportunities? For example I was in psychiatry and if you want to do the FCPS (Fellow of the College of Physicians and Surgeons, Pakistan), after doing part-1 and when you go for part-2 training you should have resources so that you can finance yourself. The 10 000 to 20 000 rupees that you will get from government will not be enough for you.* (PL2)

4.4.2.3 Lack of proper career structure and professional development

The study results show that due to the absence of a proper career structure and the absence of postgraduate training in family medicine and career pathways, doctors in Pakistan need to specialise and join the specialist cadre in order to move up their careers. Doing fellowship and joining a specialist cadre in Pakistan has its own problems such as an insufficient number of postgraduate training positions, perceived poor quality of the available postgraduate education and a low renumerated salary structure during postgraduate training. Therefore, most doctors who do not have an interest in specialisation or do not have the resources to specialise find themselves static in their career path. This finding reoccurred in the majority of interviews especially with those physicians who went abroad. All those who mentioned this as one of their reasons for moving abroad believed that they were not moving forward at some stage of their careers in Pakistan. The following physician who previously worked in a government hospital and had an evening private practice in Pakistan and was now working in Australia at the time of interview made the following comments on his decision to leave Pakistan:

> *The second problem was that professionally I was stagnant. I was not moving forward. At some stage I was stopped and I could not see how I could move forward.* (PL2)

Another physician who was previously working in a private hospital in Pakistan commented on his reasons for moving to Australia.

> *There is training and then there is career progression. So, that was not like that. That was just a job but that was not useful for career progression.* (PL3)

A female physician, while commenting on the unwillingness of doctors to work in rural areas, mentioned the lack of a doctor's career structure as an important reason for doctors not serving in rural areas leading to urban and international migration.

> *What will they do there? The Basic Health Units (BHU) are not functional. You should go and see the conditions of those health centres*

... Secondly, the doctor is so under-paid, he does not get incentives ... So, the same will happen he will leave his job and run away ... if you build a complete, proper structure then your doctors will go there and work. (PR3)

Furthermore, the respondents revealed that now the career structure for doctors in Pakistan is abolished and the government is offering medical jobs on contract with no promotion and other government job benefits, therefore, this is further encouragement for the younger doctors to migrate.

... as in the case of younger doctors their service structure is almost abolished in Punjab. On contract there is no service structure unless you are an Assistant, Associate or Professor. So, because of this a lot of boys are leaving. The younger generation is leaving because here the structure is all together finished. When your job is not secure, then how can you carry on? So, anybody who gets some opportunity runs away. (PR2)

According to another respondent, because of the lack of proper career structure there is no mechanism for doctors' service to a rural area to be recognised; for example, by serving in a rural area for certain amount of time enabling them to gain a position in a teaching hospital for further training. Therefore, due to the lack of the doctors' career structure and the lack of facilities in rural areas every graduate wants to go to cities and in order to stay in cities they need to specialise because of the intense competition.

There is no such system like if you have done 2 years rural service, after that you will be sent into a medical institute and then be sent for further training. There is no structure like this. So, everybody has to struggle for him or herself and they try on their own and there is no such system and so everyone wants to go to big cities and do specialisation. (PR4)

A Pakistani physician who did his postgraduate training in Pakistan and was working as a consultant radiologist said that he first wanted to go abroad for further studies after completing his basic medical qualification in Pakistan, but after a few unsuccessful attempts he gave up this idea as he was promoted to a consultant position in Pakistan and had a career in front of him.

> *But after that I just gave up because I was working here and so I did not see too much attraction in that. Even if I go there, then on return I have to become a consultant and I am already a consultant. So then, in that I could not feel much charm.* (PS4)

It was also revealed that, due to the lack of career structure, Pakistani doctors are facing problems in their service promotions and they serve in the same grades for years. This not only creates frustration and resentment in the already employed doctors but is also a cause of physician unemployment as no new job vacancies are being created.

> *Unemployment is high because the government has so many jobs lying vacant and they are not taking people in those jobs. Doctors are working in the same grades for 17-18 years. I know so many doctors who are my friends ... in 1996 they had their last promotions. Now some are stuck in grade 19, some 18 and 17 and they are not moving up ... When you take them upward, follow the four-tier system, then you will get empty positions at the bottom.* (PR3)

4.4.2.4 Lower salaries

Another very important reason mentioned for going abroad by almost all the participants was lower salaries, especially in the public sector in Pakistan. Due to the lower salaries, most doctors in the public sector either do private practice in the evening or take another job to increase their earnings. This not only puts an increased workload on these physicians leading to a much compromised social and family life and ultimately frustration but it also leads to decreased quality of patient care. Because of this, they look for other options including migration abroad, as one participant explained.

> *... the doctor who does postgraduate qualification can't do anything for him/herself because they become so busy that they have no social life. So he/she can do something for their family but individually their social life is almost finished. They are in the government hospital in the morning, then they remain in their private clinics till 9-10 o'clock in the night. He/she does not know when the sun is rising and going down. Their only contacts remain with their patients, otherwise socially they don't have anything.* (PS3)

A female gynaecologist who did her postgraduate training in the UK and was working in Pakistan at the time of this study expressed similar views. She gave some very depressing statistics about doctors' salaries in Pakistan and compared those with people in similar professions such as business administration who get almost three to four times more salary than doctors.

> *The problem is that you underpay the doctor so much, e.g. when a doctor graduates after completing his house-job then he gets only 6,200 rupees. But on the same level, when an MBA graduates, he gets 30,000 rupees plus perks. That doctor may become a professor or assistant professor in future and how much do you pay him? You give him 35,000 rupees in government service. What will happen to him? With 35,000 rupees you can't even manage your car's petrol. Then what will he do. He will leave his job and will engage in private jobs. He will run from one clinic to another and then another. His life will be spent running. That doctor becomes tired, exhausted and finished. So that's why doctors are going abroad in such a number.* (PR3)

A male Pakistani postgraduate medical trainee in Australia, while comparing patient care in Australia and Pakistan, described lower salaries leading to increased physician workload due to dual jobs as one of the reasons for decreased quality of patient care in Pakistan.

> *Some people do two jobs because the government pay is not sufficient to meet their expenditures. So, I have seen people who do their government job in the day and private practice in the evening. So, when you overwork yourself then you can't provide that level of care.* (PL3)

Another Pakistani female physician who did her Royal College of Physicians membership training in Pakistan and is now working as a trainee registrar in Australia described low salaries as one of the main reasons for low job satisfaction among the employees of the health department and also a major reason for people going abroad. She was of the opinion that the salary is not enough for yourself nor for your family and expressed the following views:

> *... in Pakistan you do medicine in 7/8 years and then you do house job and training after doing graduation, and when you have not reached the consultant level you can't support your family. And especially for males where they are the only earning member, they can't support their families*

> *on their salary. They were giving 10 000 PKR to TMOs [Trainee Medical Officers] when we were there in Pakistan. So with 10 000 what can you do these days and in that, too, sometimes it was delayed and sometime, something else. So, I think one major factor is this.* (PL5)

> *Income wise there is no satisfaction. Most doctors in the public sector are not satisfied and they start private practice. I was content with the salary, that's fine now I am doing training, but I could not fulfil all my requirements myself nor could I support my family. So, obviously it was not enough for that. So that satisfaction is not there.* (PL5)

One of the participants spent six years in a Middle Eastern country specifically to augment his earnings. He then planned to go there for a further one year to pay for his daughter's medical education and again when his son commences his professional education. His reason for going abroad was expensive children's education, especially professional education, which he was unable to afford on his salary.

> *The salaries are less here and on this salary you can't afford to live. The education of children has become very expensive especially professional education.* (PR4)

4.4.2.5 Overseas demand

Apart from the above mentioned issues and problems regarding the lack of quality postgraduate training, a lack of service structure and career progression and lower salaries faced by doctors in Pakistan, some of the study participants also mentioned the overseas demand for doctors as one of the reasons influencing Pakistani physicians' decisions to migrate abroad. They were of the opinion that there is still an overseas demand for doctors but previously there were more opportunities for Pakistani doctors especially in the Western countries such as the UK and USA. A Pakistani psychiatrist who went to the UK for his fellowship in the early seventies and was working in Australia explained this as follows.

> *Then after that [graduation and internship] I was unsure whether to go to America or England. That was the time when you had a lot of choice. You could go anywhere. In England at that time you could get full registration ... so for postgraduation I went to England.* (PS4)

Another Pakistani physician also shared the same opinion and added that due to the problems in finding the intended speciality for training and problems in getting a visa for going to Western countries, many young Pakistani medical graduates, after completing their fellowships, are now opting for countries in the Middle East and South East Asia like Malaysia. He said that:

> *Things are getting very difficult and even after getting very high scores they can't go into their residency of choice. They can't find their match. If they found their match, then due to non-availability of visas they couldn't go. So, there are a lot of problems. So, because of that they then stay here and do their fellowship in 4-5 years and then go to the Gulf and other places where their fellowship is accepted and then they earn good money.* (PS4)

Another Pakistani radiologist who went to a Middle Eastern country, when asked about his reason for going to that country replied that it was simpler as you did not need to take any examination before going there.

> *... it was easy. Job vacancies used to come and I did not need to take any exam to be able to go.* (PR4)

4.4.3 Societal factors

4.4.3.1 Health as a state priority

The respondents were unanimous in their assertions that health is not on our list of top priorities of government. Because of this, the participants perceived the Pakistani health care system to be in total disarray, leading to tremendous disparities between the heath care provision in major cities and rural areas.

> *... you know in Pakistan the disparity between your major cities and rural areas is tremendous. Your health care in Peshawar [provincial capital of NWFP] is 21st century while your healthcare in Data Khel village which is 200 miles [from Peshawar] is Stone Age. So, the disparity is tremendous and that needs investment and in a country that is struggling for all sorts of economic development, health is a fourth/fifth priority. It should be first but it is a fourth and fifth priority.* (PL1)

A female participant who now works in Australia was critical of the lack of a proper health system in Pakistan and was of the opinion that the government does not take any responsibility for its people's health and that every individual is responsible for their own health. She recalled how she felt frustrated when she could not help her patients while in hospital and used to ask them to purchase basic medicines from private pharmacies.

> *We don't have any health system. Every individual has its own health system. When someone gets a disease, it's his own headache. There is no government support or any such system. Of course it is very frustrating when you ask patients to buy medicines which they cannot afford. Ask to arrange blood and etc. which they could not. So in that sense you also know how shocking that system is. System, I don't think that it exists, any health system at all. Individuals are responsible for their own health. Nobody takes any responsibility for them.* (PL5)

The respondents further pointed out that the country's health budget is almost negligible and suggested that the Pakistan government needs to increase its health funding so that Pakistan's health care system can be modernised and made sustainable.

> *I think you need a proactive policy to find more dollars from your systems to sustain your health care, modernise your systems to sustain health care and go for development of infrastructure and services.* (PL1)

Another participant also suggested an increase in health funding for maximising health facilities so that the quality of care is improved in government hospitals. He argued:

> *In government hospitals, the level of care can be improved if you increase funding in health and provide every kind of facility ... basic facilities.* (PL3)

The study participants further said that although the overall health sector as a whole is neglected in Pakistan, even in health the most neglected area is that of training and development of health professionals.

> *... health and the social sector is not our priority. And so because of this we lack in health services and when we lack in health services we lack even more in training and other things.* (PS4)

A female gynaecologist, when asked about her views about the possibility of increasing the health budget keeping in view the prevailing poor economic conditions in Pakistan, she replied that 60 percent of the country's budget is being spent on defence. She said that this can be decreased and the additional resources generated from this saving can be spent on social sectors like health and education. She also argued for more transparency in the utilisation of existing health funds so that maximum benefits can reach the most disadvantaged people at the lower end of the health delivery system.

> *... the reason is that your 60 percent budget is being spent on the army. In the health sector, you are spending only 0.5 percent of your GDP and in that, too, only 10 percent reaches down. So from where will you spend money? There should be proper transparency of the funds. You should increase your budget in education and health, decrease your budget in defence, and then you will be able to do that.* (PR3)

Another issue identified by the study participants was the political nature of decision-making in the health sector in Pakistan without any consideration to any evidence and logic. This, they felt, is due to an apparent lack of focus on health and misplaced national priorities. Furthermore, they pointed out that there is a lack of consistency in national policies and the system is being run on political influence rather than long term strategic planning to address need.

> *When a person comes [in power] then it comes to his mind that, oh there should be dialysis, and then millions get spent on dialysis. They don't know that people are not getting safe drinking water, there are no basic services, and here there is no immunisation, no polio eradication, so, how can we go on dialysis.* (PS4)

Another respondent also confirmed this view that decision-making in health care is mostly political in nature without any research basis and planning. It is based on valuing of technology and tertiary based care at the expense of equity of access to primary health care. He gave the examples of unnecessary installation of costly diagnostic machines such as CT scan and MRI without consideration of their need and utility. He said:

... if in areas where there are no doctors on the curative side and you install these machines and post doctors on the investigative and diagnostic side, then I think it is useless. So if you don't have surgeons and other people in a facility and you have been given the diagnostic facility, then for what purpose will that diagnostic facility be? (PR4)

4.4.3.2 Culture of valuing overseas training

The majority of the respondents interviewed valued overseas training and work. They were of the opinion that overseas training is very structured and methodical. There is more stress on communication and other skill development. They have large budgets for training and professional development and other facilities such as well resourced libraries. A Pakistan surgeon who did his fellowship from the UK described his experience as follows:

There [UK] it was real business, real training. They used to take work from you. There [UK] it was proper training. They teach you how to communicate with your patients, communicate with GPs, and community communication, how to prepare for your exam etc. You know it was a proper training in every respect. (PR1)

Another Pakistani radiologist working in Pakistan who went abroad for short courses placed a high value on overseas training and wished for his daughter also to get an opportunity to go abroad for her postgraduate training. He explained his point of view as follows:

... for my daughter it will be my endeavour that once she graduates, at least for training and not for the purpose of staying, I wish that she goes abroad ... Their [abroad] medical training is quite methodical and the budgetary allocation on their medical training is very high. And they have a lot of facilities. (PS4)

The study participants were also of the opinion that even the Pakistani general public places a high value on training and working overseas especially in developed countries. Therefore, this overseas experience not only increases their earnings by attracting more patients but it also gives them more respect and prestige in the society.

In Pakistan there is a general perception that the superior degree is the FRCS (UK fellowship) ... I am talking with respect to the name. The general public don't know whether this person has spent time over there

> *[UK] or just went there for exams. Its name is recognised ... if FRCP is written on your name board outside, then naturally it will fetch you some extra patients and get some extra respect as well.* (PR2)

A female Pakistani physician now working in Australia described lower salaries and the culture of valuing overseas qualifications as two major reasons for Pakistani doctors to train abroad.

> *Our people have this psyche that when someone does something abroad it has a good impression on the people in Pakistan. So, then people are interested in doing their degrees abroad.* (PL5)

Another Pakistani doctor who was undergoing postgraduate training in Pakistan confirmed this assertion. She explained her observations that locally trained doctors are equally competent clinically, if not more, compared to the foreign trained physicians. Yet, despite this fact, in her opinion, doctors are more valued because of their overseas qualifications.

> *... no one is comparable to the trainees of Pakistan. I don't say that they [overseas trained] know nothing or they have learnt nothing but mostly it is their name that they are foreign trained which is generally considered ... They get their posts because of the name and degree that they are foreign trained.* (PS1)

Because of this valuing of overseas qualification by the physicians themselves and also by the general public and the lack of good local postgraduate training in Pakistan, most physicians prefer to go abroad for their postgraduate qualifications. This finding indicates a paradox between the study themes as most Pakistani doctors, due to their attachment with their families and their identity and belonging with their culture and country, want to remain in their country; however, due to the valuing of overseas training they go abroad. This is despite local doctors having comparable expertise to their foreign trained colleagues.

4.4.3.3 Personal insecurity and societal degradation

Almost all the study participants were unanimous in their assertions that there is a gradual societal degradation occurring in Pakistan. By societal degradation they meant the issues of corruption and bad governance. Two physicians specifically mentioned this as one of their main reasons for migrating abroad. They were of the opinion that the general state of society in Pakistan is not merit based and because of that they felt uncomfortable in that society and therefore decided to go overseas. One of them said that:

> *... I had never ever liked societies not merit based and my biggest problem in Pakistan as a doctor or as an individual was that there was no merit, no recognition of merit. There was no justice and things are going from bad to worse rather than improving, they are deteriorating.* (PL1)

Another Pakistani physician, now living in Australia with his family, expressed similar views when asked about the reasons for his decision to leave his country and move overseas. He said:

> *First reason is that as I always felt that I was a misfit in that society, generally. For example, something that I did not want to do, sometimes I was forced to do ... so, in the prevalent culture and the values of the society I was totally a misfit.* (PL2)

The majority of participant Pakistani doctors, regardless of whether they were a *stayer*, *leaver* or *resettler* expressed similar feelings of overall societal degradation and increasing insecurity in Pakistan. This caused *stayers* to consider to go abroad, reinforced *leavers* to stay abroad and in the case of *resettlers* to reconsider going abroad. A Pakistani physician who went to the UK and Saudi Arabia for training and work and is now working as a consultant surgeon in Pakistan said that initially he wanted to go abroad for better quality of life. He had since changed his views and the reasons for renewed considerations about leaving Pakistan again focused around the overall deterioration and insecurity in Pakistan.

> *As I told you, at that time I wanted to have that quality of life as it is there or like you see it (in Australia) but if you ask me now, I will say that it is due to the overall deterioration in Pakistan. Although I am settled, I am*

> *happy as I am at the maximum level of achievement that a doctor can have in his life. But, due to the overall insecurity and fear that one wants to run away from Pakistan ... Now it is because of the overall fear that people want to run away from here.* (PR2)

The study results show that even those Pakistani specialist doctors who have reached senior positions and were satisfied financially with their jobs in Pakistan were also considering moving abroad because of the recent wave of lawlessness and insecurity. A Pakistani radiologist who stayed in Pakistan because, after doing his postgraduate training he did not see much difference between his earnings in Pakistan and overseas, expressed his plan of exploring migration as an option due to the deteriorated state of security in Pakistan.

> *Now, I am saying that I am satisfied economically with my job. So, it is sometimes because of the security situation that I think about going abroad, otherwise, now economically there is not much difference for me.* (PS3)

The study participants revealed that this gradual deterioration in country's socioeconomic conditions with the recent decline in law and order and security conditions are not only compelling those who are working in Pakistan but it is also deterring those Pakistani doctors working abroad from returning to their country.

> *... for the last 5 to 10 years, the conditions of the country have gradually deteriorated. Law and order, security and other things make them get frightened and then they don't want to come here.* (PR4)

Apart from the general law and order issues and gradual degradation in the general state of the society, the study participants pointed out the increasing trend towards corruption and other professional malpractices within the medical profession leading to the devaluing of a once respectable and noble profession. A Pakistani radiologist who was working in Pakistan was of the view that doctors are losing their respect because of the bad impression that they have in the society.

> *You know when a 'Sepahi' [police constable] introduces himself to someone he feels important because of his background in administration, people don't give that much importance to a doctor and they think that they are just doing 'loot-marr' [robbing people].* (PS3)

Another respondent who migrated from Pakistan and was working as a GP in Australia, while commenting on his experience of working as a doctor in Pakistan, explained that in medicine you will encounter the same problems as you witness generally in the society.

> *And secondly, the same problems that are in the society are reflected in medicine. The people sometimes are not as much honest as they are supposed to be.* (PL2)

Another Pakistani physician who left Pakistan and was working in Australia as a GP commented on the decline in respect for the medical profession and the prevalent professional jealousy among doctors and other cadres of health care providers leading to a decrease in their job satisfaction.

> *... the level of respect that previously the doctors had in the society has been tremendously declining. There were internal pressures within the profession. Doctor eats doctor..... You know. Doctors versus nurses, nurses versus paramedics. All those things have been continuously breaking down rather than remaining steady or improving. So the job satisfaction or the societal satisfaction was at a very low point...* (PL1)

A female Pakistani physician who was working in Australia at the time of the study agreed with the involvement of some doctors in monetary corruption. However, she was of the opinion that this was due to the frustration that these people went through before reaching a consultant level when they start earning money. She explained.

> *I think there are some doctors who contribute in bringing a bad name to their profession but I think this is all out of frustration. I think most doctors reach to such a stage where they become so much frustrated that when they reach the stage that they can charge money, then they try to earn as much as they can and they are ready to accept it from whatever way it is coming.* (PL5)

Those Pakistani doctors who managed to return to their country and joined either their previous jobs or were able to find other suitable jobs experienced resistance by seniors in

their departments. This resistance centred on the introduction of advanced medical procedures or innovations into the health delivery system from abroad. A Pakistani surgeon trained in liver transplant surgery from the UK had returned to Pakistan but was again planning to move abroad because of professional jealousy from his senior colleagues. He explained his experience in the following words:

> *In Pakistan, the biggest problem is that if you want to do something new, then people will resist you, even the seniors of your own department. So, this is a big flaw in medicine here.* (PR2)

When this respondent was asked about the reasons behind this intense resistance by his colleagues, his response was very straight forward as explained below:

> *It has a commercial reason, what else? They want to earn money out of that. One group thinks that if this project is started, so naturally it will be 2-4 billion rupees and if they get 10 percent as commission, then it is around 20-25 crore [200-250 million rupees] income. And one group thinks that when they establish this unit, their practice will increase.* (PR2)

Another Pakistani physician, while commenting on the reasons for physician's migration, described resistance to innovation by seniors as a factor for motivation for migration.

> *Here if a junior wants to do something, seniors will say don't do that.* (PS3)

4.5 Research Aim 3: Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country

The respondents' identified and discussed three important factors that influenced their decision to return to their country after staying overseas for a varied length of time either for their postgraduate studies or work. These were having a permanent job in Pakistan, quality of life versus standard of living and the perceived difference experienced between locals and non-locals abroad.

4.5.1 Personal characteristics and family factors

4.5.1.1 Quality of life versus standard of life

This was an interesting finding in which the respondents made a distinction and comparison between the quality of life and standard of life abroad and in their country. One Pakistani surgeon who spent around twelve years in the UK and is now working in Pakistan, while giving his reason for resettling in Pakistan, stated that the standard of life was good abroad but the quality of life is good here. By standard of life this participant meant having a good house, a good car and other material things and by quality of life he meant the overall satisfaction and fulfilment that you receive in your life. For example, according to this participant, he has family, friends and his community in Pakistan whereas, being abroad those things that gave him satisfaction were not there.

> *You know the standard of life was good abroad but the quality of life was good here. Even now the standard of life may be very good over there but the quality of life is good over here.* (PR1)

When this respondent was asked about the differentiation between quality of life and standard of life, he replied that standard of life means the material part of life such as a car and a house, while quality of life represents the social aspect of life such as family, friends, culture and language.

> *Standard of life means that you have every facility in life, like there [UK] we had a good house with a garden and we used to travel in a Mercedes and here [Pakistan] we travel in a Baleno [Suzuki car]. So, this was the difference. Quality of life means the satisfaction that you get. I mean here we used to chat with our friends. Here we have job satisfaction. Then here you can help your friends or the help that you get from friends. Those things are not there. There is individualism over there. The things that give you satisfaction are not there. So, the quality of life is better here.* (PR1)

Furthermore, the same respondent was of the view that quality of life depends on many things such as friends, family, environment, city and government and that it is difficult to achieve quality in your life on your own. It is something which is present there.

> *... quality is something different. It depends on many things which you cannot achieve yourself. It depends on your environment, relatives, friends, city, government ... many things. So, all these things combine to make a quality life.* (PR1)

Quality of life was also mentioned as a reason for coming back to Pakistan by another female Pakistani physician. According to her, when she was abroad she missed her home, brothers and sisters and parents. She gave birth to her twins while abroad and experienced feelings of loneliness and lack of family support while she was abroad.

> *Then you miss your home, your brothers and sisters are here [Pakistan], your parents are here ... my kids' birth took place there in loneliness. Nobody was there with me. There was no one ... I am lying alone all day, having vomiting with twins, lying in hospital for one month on drips. So there was no one who could make something for you, feed you something. Then two kids together. Then when they grow up a bit, you have family support like your mother, your aunt or your sister has arrived to help you. Both my kids were crying and I went into post-natal depression and there was nobody to look after my kids ... There was no family support at that time and that was my critical time.* (PR3)

She further explained that abroad she used to miss her family when she could not unite with them on important occasions such as religious festivals or family emergencies such as at the time of her sister's surgery. She explained.

> *Then there are occasions of happiness and sorrow, there is Eid [Muslims religious festivals twice a year]. They were all being spent there. Over there, there are people but you do not enjoy it like when you have family, your sisters and brothers. Then, when you have a problem back home, like my sister's operation (surgery), you can't come on leave immediately. So, all these things were very painful for me. So because of that I thought that, no, I have to go to Pakistan and I will raise my kids there and will work in Pakistan.* (PR3)

This phenomenon of better quality of life in their home countries was also evident from the discussion of those Pakistani physicians who had migrated from Pakistan and were working in Australia. A Pakistani physician who had recently migrated to Australia, while commenting on his experience about working in Pakistan and Australia, replied in the following words:

> *... it's [Australia] ok, because you don't get everything [in life] that you require, so yeah it's fine. There [Pakistan] when you just make a circle of family and friends, then you start leaving. It [in Australia] is also life but totally different from Pakistan life ... there [Pakistan] you have family members, you have relatives and close friends. Time also passes here [Australia]. That's fine but it's totally different.* (PL3)

Another respondent who is also now working in Australia, when asked about his advice to the new Pakistani medical graduates regarding migration to other countries replied that migration is a give and take decision. He explained that abroad you may find a good career and financial prospects but on the other hand you leave your family, friends and culture. In his own words:

> *Obviously this is a give and take situation. If you go to some other place where you find a lot of good things, where you have much better chances for career and professional development, where you are financially well-off, but by the same token you leave your family, your brothers and sisters and friends and culture. You have to sacrifice everything and compromise. So, you have to think about how far you can go. How much you can sacrifice and leave.* (PL2)

The above finding shows that quality of life is a broad and complex construct that includes personal characteristics and family factors such as family, relatives and friends and also wider societal elements such as one's surroundings, language, culture, city and government. This is discussed further in Chapter Five of this thesis. However, a Pakistani physician who had returned to Pakistan for family reasons, particularly his parents insistence, was again trying to go abroad as he was facing resistance from his seniors to the introduction of liver transplant surgery in his department, did not agree with this notion of better quality of life in Pakistan as compared to overseas. He was also facing problems in his career promotion to the position of professorship. He was of the opinion that people go overseas with pre-conceived ideas and start doing things which they have never done in their own country. He agreed that in your own country you have your own culture, language, family and friends and that overseas these may be lacking. However, he did not

value these elements to the same extent and felt otherwise. He said that there is not much difference between Pakistan and overseas. He explained.

> *I don't know what he means by quality of life. We ourselves put restrictions on us when we go there ... things that we have never done in Pakistan we start doing there e.g. not to talk to other people, not allow kids to meet other people, etc ... The rest, you have your language, family, brothers and sisters and relatives, childhood class fellows which you can say are a bit more here compared to abroad, otherwise nothing. So, here is a minor difference.* (PR2)

4.5.2 Health system factors

4.5.2.1 Having a permanent job in Pakistan

The study participants perceived that if a physician has a permanent job in Pakistan and then goes overseas for training or work, there are more chances that he/she will come back to his country. In Pakistan those doctors who have a permanent job are more likely to return to Pakistan. This shows that having a permanent job in their country acts as an incentive for resettlement in Pakistan. A Pakistani doctor who spent six years in a Middle Eastern country stated that he came back because of his family and job in Pakistan.

> *Alhamdulillah (thanks God), I spent 6 years there and in the last year my salary was almost doubled but I had to come back for my family and to continue my service here. I thought that if I continue in Saudi Arabia then maybe I will have to discontinue my service in Pakistan. So, there was no more choice for me to stay in Saudi Arabia and I had to come back. So that's why I decided to come back and continue my service.* (PR4)

This participant further explained that because of changed policy in recent years, the government has made most of the medical jobs on contract only and no permanent jobs are being offered to young doctors. He therefore felt that in recent years young doctors who go abroad will try to settle there permanently. In contrast, he said that those having a permanent job were more likely to resettle in Pakistan.

> *As I told you, if someone goes there at a young age, then they will try to settle and they become settled there. And those people who go late or especially if they have some service [job] here or have family here, then they come back. Especially those who have some service, then they*

> *definitely come back and the other people rarely come back because they think what will we do there [Pakistan]? They rarely come back and if they do, they go back [leave] again.* (PR4)

4.5.3 Societal factors

4.5.3.1 Feeling of differentiation between locals and non-locals

This was another theme commonly mentioned by the study respondents which influenced their decision to resettle back into their country. According to a female respondent who went overseas for her fellowship and is now working in Pakistan, she developed a strong perception of differentiation between locals and non-locals based on her experience while living abroad. She said that while living abroad no matter what you do, you are not treated as a first class citizen. She acknowledged the good environment that she had been working in over there, but even then, based on her experience, she was of the opinion that she could not became their first class citizen. As a result of these negative feelings, she decided to return to her country. She explained this in the following words.

> *Um ... I had to come to Pakistan. Whatever we do over there, we are still a second class citizen. So there is no such thing. Like, I went for my IVF training from Manchester to St. Mary and my consultant recommended me and I was chosen as one of the candidates. So, I was one of the candidates and the other was English. So, in that there was a paid job and one unpaid job. His and my qualifications were equal and my experience was more than him and I had worked more in infertility but he was given the paid job. So, I asked them, 'why didn't you give me this paid job?' They told me that it was 'because you are not a British'. So this is too much, no matter what you do, you are not treated as a first class citizen. Yes we do work over there and we work in a very good environment but even then we can't become a first class citizen.* (PR3)

Another Pakistani female physician who came to Australia for her postgraduate training and was working as a trainee registrar narrated few instances of differentiation due to her cultural outfit both in the hospital and in the market place. This, she said made her quite depressed and she decided to go back to her country after completing her postgraduate education.

> *Sometimes patients criticise us because I wear a hijab [head scarf], not very often but in the last 2 1/2 to 3 years at least 3 or 4 times it happened. Twice patients were involved and two times the general public. I mean they ask why do you cover up like this? What have you made of yourself [by wearing head scarf]?* (PL5)

A male Pakistani surgeon who spent some time in a Middle Eastern country and returned back to Pakistan described his experience as 'very bad'. He pointed out the differentiation among locals and foreigners and even among expatriates based on colour and country of origin.

> *Their system is almost totally rotten especially if you are living as an expatriate. Over there, injustice is at its limit. Are you local or an expatriate? If you are an expatriate, then is your colour is white or black? Your passport is of which category? There is a difference in salary and attitude and how they allocate your duties. It makes a lot of difference. Then in the general population, especially the Arabs, they look down upon you.* (PR2)

Another Pakistani radiologist who spent six years in the Middle East expressed somewhat similar views and complained against the lack of insurance for doctors, unnecessary investigations over patient's complaints and its lengthy disposal procedures in courts against expatriate doctors. According to this respondent, these issues keep you under constant tension and stress.

> *The problem is that in Saudi Arabia there was no such thing as doctor's [indemnity] insurance ... Because of that everybody was afraid, doctors were very scared. I mean if something minor happened, for example if you wrote that the liver was 2 cm high by mistake [in the radiologist report], he will go to someone else [another doctor] and will then say that this doctor does not know anything and will then complain against you and then an investigation will start and you would be stressed because of that.* (PS4)

4.6 Research Aim 4: Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time

During their discussions, the study respondents elaborated on the problems encountered by them while resettling in Pakistan. These included experiencing an unwelcoming attitude on returning, difficulty in finding suitable jobs and underpaid jobs. The study participants also complained that the government does not have any resettlement plan for utilising those doctors who are trained overseas and want to return to Pakistan.

> *... if someone new is going out to learn something and then come back, then that can benefit their people. But the main thing is that they should be treated in a proper way when they return ... I mean the main reason is that the government do not utilise their people properly.* (PS4)

They were of the opinion that most of the overseas Pakistani doctors want to return after completing their postgraduate training or working there for some years but they could not do so because of the above mentioned problems.

4.6.1 Personal characteristics and family factors

No personal or family problem was identified by the respondents during the process of their resettlement into Pakistan.

4.6.2 Health system factors

4.6.2.1 Unwelcoming attitude

A female gynaecologist who went to the UK for her postgraduate qualification and then returned complained about the unwelcoming attitude especially on the part of the government hospital management. Following a few initial failed attempts to find a job in both the public and private sectors due to the unwelcoming attitude on the part of her

employers, she gave up looking for a job and then started her own private practice. She described her experience in the following words:

> *There was no welcoming attitude in government hospitals that a person has returned after so much learning. There were no such opportunities apply apply somewhere ... that you should take such people in your system so that they teach something more to our future students ... They created so many hurdles that I decided to leave it.* (PR3)

4.6.2.2 Difficulty in finding a suitable job

Difficulty in finding a suitable job was another problem faced by Pakistani doctors who wanted to return to their country. One of the respondents, a senior Pakistani psychiatrist now working in Australia, had to leave his country as he could not find a suitable job in Pakistan upon his return from abroad after completing his postgraduate training in the UK and Canada. Initially, he left his country because of the non-availability of postgraduate training positions in his chosen speciality. When he was asked about his reasons for leaving Pakistan before and after his postgraduate training, he replied in the following words:

> *In the beginning, the reasons were that the FCPS [Fellowship of the College of Physicians and Surgeons, Pakistan] was new at that time and I applied there, but for six months I did not receive any reply. The application was laying there and then our professor of psychiatry in Lahore said to me why don't you go abroad instead of waiting here ... Then I applied in England and I went there for postgraduation. Then, after that on returning back I could not find any suitable job.* (PL4)

Another Pakistani surgeon, while commenting on his decision to return to his country after staying in the UK for some years for his postgraduate training and work, mentioned the availability of a suitable job in Pakistan as one of the reasons for his resettlement.

> *And then I got a good job here as well. That was one factor.* (PR1)

4.6.2.3 Underpaid jobs

Underpaid jobs were another reason mentioned by these respondents that was hampering Pakistani physicians' resettlement back into their country. A female gynaecologist who returned from the UK after her postgraduate training worked for three months in a private sector hospital but left this job because of the unwelcoming attitude on the part of management and the lower salary. She explained:

> *I worked for three months but there [private hospital] it was too much of a one-man show. And then I left that. And these are very under-paid jobs. That was 1998-99 and they were giving me 42,000 rupees at that level. You should pay a good salary to a doctor who has done so much. Pay him to such an extent that he remains satisfied with his job and work. So that was a very under-paid job.* (PR3)

4.6.3 Societal factors

Personal insecurity and the law and order situation in Pakistan was also mentioned as a potential problem that discourages overseas Pakistani doctors from resettling back into their country. According to the study participants, this issue of the recent surge in insecurity in Pakistan is not only encouraging Pakistani doctors to leave their country but it also acts as a deterrent for Pakistani doctors' resettlement decisions. This is discussed further above in this chapter under 4.4.3.3.

4.7 Conclusion

Three significant findings emerge from the data analysis. First, the study shows the dynamic nature of the physicians' career decision-making which depends on the constant weighing of complex personal, family, professional and societal factors. Second, those physicians who decided to stay in Pakistan or resettled back into Pakistan did that because of their personal and family reasons or because of societal factors. Health system factors played a minimal role in the decisions of these physicians, except for the availability of permanent jobs. The third major finding that emerged from the study is that the factors

affecting Pakistani physicians' decisions to move overseas or barring those from coming back into their country after training or working abroad for some time are mostly health system problems with the addition of a recent societal problem of personal insecurity and general societal degradation. The next chapter provides a discussion of the findings of this study and its implications for health human resource reforms in Pakistan.

Chapter Five
Discussion and Conclusions

5.1 Introduction

The preceding chapter presented the results and described the major themes that emerged from the interview data with the Pakistani physicians working in Australia and Pakistan at the time of the study. The respondents described their perceived reality about the factors that affected their career decision regarding whether to remain in Pakistan, migrate abroad, or resettle back into their country after training or working abroad for some time. The participants also discussed the problems that they faced during the process of resettling back into Pakistan.

The findings of this study have important implications for policy and practice in relation to health human resource development generally and the medical workforce particularly in Pakistan and also other similar developing countries. It is important to note that Pakistan is not the only country facing problems with health human resource recruitment, retention and migration. Globally, countries in both the developed and the developing world are struggling with efficient and effective use of its human resources for health. These implications will be discussed later in this chapter after discussing the major findings.

This chapter presents the conclusions and discussion of the findings relating to the purpose and four research aims of this study. The purpose of this study was to explore the perceptions of Pakistani physicians regarding their career decisions to remain in their

country, migrate abroad or resettle back to their country after working abroad for some time. The four research aims were to:

1. Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas.
2. Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad.
3. Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country.
4. Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time.

First, the major findings and the conclusions of the study are discussed from the researcher's perspective and in the context of the available literature on physicians' retention, migration and resettlement in Pakistan and other developing countries. This is followed by a discussion of implications of the study for policy and practice in Pakistan and other similar developing countries. Finally, the chapter concludes with recommendations for further research arising from the findings of this study.

5.2 Major conclusions

This phenomenological study has explored the factors that affected a group of Pakistani physicians' career decision regarding their retention, migration and resettlement and the problems that one group faced during the process of resettling back into Pakistan from overseas. To date, limited research has been carried out to explore the factors that encourage individual doctors to migrate and scant attention has been paid regarding

retention and resettlement decisions. This study adds to the literature and extends our knowledge regarding career decision-making for Pakistani doctors as it is one of the few qualitative studies that has looked into physicians' migration decisions. Furthermore, it contributes to our understanding of why doctors remain in their countries and do not migrate and why they resettle back into their countries after remaining abroad for some time. This latter aspect is less often addressed, even in the existing qualitative literature.

Furthermore, while this study validates the results of other studies that show health system factors, especially economic concerns, contributing to the retention and migration decisions of health workers, it also explores other factors, such as personal, family and societal factors, that are equally if not more important than just the professional and economic aspects of health workers retention, migration and resettlement decisions. This study adds a number of new perspectives to our current knowledge about physicians' retention, migration and resettlement decisions. These new dimensions are as follows and will be discussed later in this chapter.

- The dynamic nature of the physicians' career decision-making which depends on the constant weighing of complex personal, family, professional and societal factors.
- The importance of quality of life versus standard of life in career decisions.
- The role of personal insecurity and societal degradation in career decisions.
- The feminisation of the Pakistani medical workforce and its related problems.

From the findings of this study three major conclusions were drawn. First, the study indicated a dynamic nature of the physicians' career decision-making which depends on

the constant weighing of complex personal, family, professional and societal factors. Second, the main factors that contributed to Pakistani physicians' career decisions in this study for those who preferred to stay in their county or resettle back into Pakistan after working abroad for some time were mainly personal, family or societal factors and there was a minimal role for professional or health system related attractions, except for the availability of permanent jobs. Third, the factors that affected those Pakistani physicians who decided to move overseas for training and work or discouraged those physicians who wanted to come back to their country were mostly health system related problems with the recent addition of the general societal issue of personal insecurity and societal degradation. These major conclusions are discussed in this chapter in the context of the available literature from Pakistan and other developing countries on physicians' retention, migration and resettlement which was previously discussed in Chapter Two of this thesis.

5.3 Discussion of major conclusions in the context of available literature

5.3.1 The dynamic nature of physicians' career decision-making

The first major conclusion from this study which addresses the overall purpose of this study suggests that the three groups of respondents, *stayers*, *leavers* and *resettlers*, interviewed for this study are not static and mutually exclusive entities, as during the course of their career journeys these physicians continuously evaluated their personal, professional and social circumstances and made their career decisions based on these different conditions. Based on these multiple and complex factors, those physicians that are happy with their life, work and family balance stay, while those that are unhappy with the balance and have different priorities, move abroad. Likewise, those who go overseas and achieved their predominantly professional goals, such as postgraduate training or increased

monetary benefits, tend to stay overseas. In the meantime, if their priorities change, such as their perceived better quality of life in their home country as compared to overseas, then they resettle back into their country of origin. Likewise, those physicians who resettle back into their country can leave again depending on their analysis of the available conditions in their home country. Therefore, based on this constant weighing up of these multiple circumstances a *stayer* physician can become a *leaver* and a *leaver* can become a *resettler* and, depending on the prevailing conditions, even a *resettler* physician can become a *leaver* again.

This finding about Pakistani physicians' evaluation of multiple personal, family, professional and societal factors during their career decisions has similarities with decision-making behavioural models proposed by Wolpert and Crawford and Tolhurst (2008) 'Landscape of Fulfilment' model. According to behavioural models, migration decisions are a sort of individual cost-benefit analysis that not only includes economic factors but other non-economic societal factors such as security and self-fulfilment (Hangen-Zanker 2008). According to this model, a person will only migrate if his/her values and expectations are met at the destination.

Similarly, according to Tolhurst's (2008) model of 'Landscape of Fulfilment', individual doctors seek the balance between the notion of the 'self' that encompasses their internal inspirations and values with the other domains that relate to aspects of life and work. Therefore, this model argues that, based on this balance between self, life and work expectations, doctors make decisions about staying or leaving their practice locations.

5.3.2 Factors influencing Pakistani physicians' retention and resettlement decisions

The second major conclusion from this study is that the main factors that contributed to Pakistani physicians' retention and resettlement decisions after training or working abroad were mostly personal and family or societal factors and there was a minimal role for professional or health system related factors in their career decisions, except for the availability of permanent jobs to these physicians in Pakistan. This conclusion addresses the purpose and the first and third aims of the study which are discussed below in the context of the study results and previous research discussed in Chapter Two of this thesis. These aims were to: i) Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas, and iii) Explore the perceptions of Pakistani physicians regarding their career decisions to initially go abroad and then to resettle back into their country.

5.3.2.1 Quality of life versus standard of life

A key finding of this study is that the motivation for Pakistani physicians to remain or resettle back into their country is the perceived better quality of life in Pakistan compared to the better standard of life overseas. The study results indicate that quality of life is a broad and complex construct that relates to inner self fulfilment. It depends on both personal and family factors and also societal factors. The personal and family factors that improve quality of life include factors such as identity and belonging to country and culture, a sense of attachment with family and friends and a desire to serve one's own community. Likewise, the societal elements that enhance quality of life are factors such as living in one's own city, government and people. Furthermore, the study participants believed that the factors that enhance quality of life cannot be achieved on their own and it is something that is present in your environment and place of origin. On the other hand

they were of the opinion that the standard of life pertains to the material part of life, including factors such as a good salary, a house, a car and so on. Contrary to quality of life, the study respondents argued that standard of life can be improved by increasing one's material achievements.

Overall there is lack of research that looks at quality of life in migrant and non-migrant physicians both in Pakistan and in other countries. However, there is some literature that supports the results from this current study. This finding in this thesis is consistent with the results from a survey about final year medical students' retention and migration intentions in Karachi, Pakistan (Syed et al. 2008). The survey found that the major factors in the medical students' intentions to stay in Pakistan included their family ties, the desire to serve their nation and the desire to settle in Pakistan. Gadit (2008b:343) is of the view that 'a person remains happy in the environment of upbringing and birth and develops emotional attachment and identification'. Similarly Taj and Aly (2008) is of the opinion that some Pakistani doctors who initially go overseas for their personal ambitions and family obligations return to their country in search of self satisfaction and contribute in the development of medicine in Pakistan. Furthermore, according to Gadit (2008b:343), anecdotal evidence suggests that the bond of migrant Pakistani doctors remains intact with their country of origin and that there is a lifetime urge to go back and settle in Pakistan. However, there are certain factors as identified in this thesis and further discussed in this chapter that compel Pakistani doctors to leave their country and go overseas and also discourage them from resettling back into their country. These factors are lack of health human resource policy and planning, lower salaries, lack of proper career structure and professional development, lack of good postgraduate training and personal insecurity and societal degradation.

Similar findings were also reported in the literature from other developing countries, for example, Makasa (2005:780) described his reasons for staying in his country Zambia and not moving abroad. This author described living with his family and friends with the accompanying social and cultural benefits and the support that he received from them, the joy of serving his own poor people and community and the gratitude that he received from them as the main reasons for staying. Similarly, Akl et al. (2007:1282), with their study with final year medical students in Lebanon, found similar personal and family reasons for not going overseas but remaining in their country. Likewise, Oman, Moulds and Usher (2009b) studied Fijian specialist doctors who stayed in their country and did not migrate overseas. Despite facing work related problems, they mentioned a desire to serve their own people, their strong belief in God that kept them going, their commitment to their families and friends and a strong attachment to their country and culture as the reason for their retention in their country.

5.3.2.2 Perception of differentiation between locals and non-locals

The data from this study suggest that a perception of differentiation between locals and foreigners and even among expatriates based on their country of origin and their passport in some countries was found to be a factor that affected Pakistani physicians' staying and resettlement decisions. This perception amongst the study participants who were staying in Pakistan and did not go overseas was based on their interactions with their colleagues working abroad. Among the repatriated physicians this feeling of differentiation was the result of their actual experience when they were living abroad. Furthermore, the study also showed that this feeling of differentiation was reported by doctors who worked in both the Anglo-Saxon and Middle Eastern countries alike. While no such data that supports this finding are available in the Pakistani context, literature from other developing countries such as Makasa (2005:780) in Africa and Akl et al. (2007:1282) in Lebanon has found a

perception of differentiation among locals and non-locals abroad as a reason for physicians to stay in their countries and not going abroad.

Furthermore, this current study revealed that this differentiation could be related to professional issues such as difficulty in finding a suitable training position or post-training employment or to the everyday life situations where people are discriminated and treated differently based on their complexion and the way they are dressed. Gadit (2008b:343) is also of the view that, despite Pakistani doctors who migrate to the Middle East receiving much higher salaries compared to their salaries in Pakistan, they are not treated equally with their colleagues from Western countries who have comparable qualifications but receive much higher remunerations and other incentives. This finding is consistent with studies from other countries which have reported on differentiation between local and non-local medical graduates in Western countries (Moore & Rhodenbaugh 2002; Woods et al. 2006). Nasir (1994:625) found that international medical graduates (IMGs) in family practice residences in the US received fewer responses to requests for residency information than their local counterparts. Similarly, Miller et al. (1998:779) reported that, compared to the US medical graduates, foreign graduates reported more difficulty in finding a clinical position after completing their residencies. It is important to note that these other studies (Miller et al. 1998:779; Moore & Rhodenbaugh 2002; Nasir 1994:625; Woods et al. 2006) have found the presence of differentiation between local and non-local doctors abroad. However, they have not explored this issue as it relates to physicians' retention and resettlement decisions as is done in this current study.

5.3.2.3 Having a permanent job in Pakistan

In addition to the above discussed personal and family or societal factors that contributed to the Pakistani physicians' retention and resettlement decisions, Pakistani physicians interviewed for this study also perceived that having a permanent job in Pakistan acted as an incentive for them to remain in their country rather than go abroad and it also acted as a major resettlement attraction for those who returned to Pakistan after working abroad for some time. Importantly, this was the only health system factor identified in this study which contributed to Pakistani physicians' retention and resettlement decisions. However, as indicated by some of the respondents in this present study, since the early 1990s the government has abolished the provision of a permanent jobs policy and medical appointments are made on a contract basis, thereby removing the only heath system incentive available to these physicians for remaining or resettling in Pakistan.

This finding is supported by Shafqat and Zaidi (2007:442), who indicated that the main reasons for resettlement of around forty graduates of the Aga Khan Medical College, Karachi, who went abroad for further studies included their family ties, a desire to raise children in a familiar culture and an emotional need to be at home. However, these authors are of the opinion that the key factor that affected these physicians' resettlement decision was the availability of attractive career prospects with their former institution in Pakistan with salaries which permitted a comfortable lifestyle.

5.3.3 Factors influencing Pakistani physicians' retention decisions and problems in their resettlement

The third major conclusion from this study is that the majority of the Pakistani physicians preferred to stay in their country or return to Pakistan for personal and family reasons in addition to some societal factors. However, there are certain health system related issues

and problems, coupled with the recent general societal issue of the insecurity situation in Pakistan, that compelled them to leave the comforts of their home and culture. These factors also discouraged them from resettling. This conclusion addresses the purpose and the second and fourth aims of the study which are discussed below in the context of the study results and previous literature critically discussed in Chapter Two of this thesis. These aims were to: ii) explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad, and iv) identify the problems encountered by Pakistani physicians during the process of resettlement back to their country after working abroad for some time. These factors are discussed in the following sections.

5.3.3.1 Health as a state priority

According to the WHO (2002:7), health is regarded 'as a form of human capital and therefore an input in the growth process'. It is a recognised fact that countries with healthy and educated populations are more likely to prosper. However, the results of this study indicate that Pakistani physicians perceive that health is not, and has never been, a priority issue on the political agenda of Pakistan. This is an important finding that shows the perceived historical neglect of health and other social sectors such as education in Pakistan. The study respondents argued that because health did not get its due attention human resources for health have also suffered, leading to various issues that negatively affect the Pakistani health workforce. These issues are lack of health human resource policy and planning, lower salaries, lack of proper career structure and professional development opportunities and lack of good postgraduate medical training in Pakistan.

This finding about health as a state priority in Pakistan is a long-term issue which is frequently discussed in the Pakistani literature. For example, Islam and Tahir (2002:163), while discussing the challenges and constraints to the health sector reforms in South Asia,

have pointed out that Pakistan, like most other developing countries, has traditionally made little investment in the social sector areas of education and health. As a result, it is still suffering from a high level of illiteracy, particularly among women, even after six decades of independence (see Table 5.1).

Table 5.1: Literacy rate, 2006 – 2008, Pakistan

Year	**Literacy rate**	
	Male	Female
2006	65	42
2007	67	42
2008	69	44

Source: Farooq (2009:159)

Moreover, despite the fact that Pakistan is investing less in education and health, its defence/military expenditure is quite high (see Table 5.2). Therefore, in the words of Islam and Tahir (2002:163), Pakistan, like other developing countries in South Asia is 'reaping the 'benefits' of their long history of neglecting the social sector'. Shafqat and Zaidi (2007:443) have pointed out that because of the 'inadequate and inappropriate investment in local health care systems', Pakistan, like most developing countries, is facing 'both severe shortages of health care professionals and a high level of unemployment among physicians'.

Table 5.2: Public expenditure on health and the military, Pakistan

Year	**Public expenditure (as % of GDP) on**	
	Health	**Military**
2000	0.58	4.0
2005	0.57	4.0
2007	0.57	3.5
2008	0.57	3.2

Source: Khan (2009:170-171) and World Bank (2009b)

The perceived low priority given to the health sector by successive governments in Pakistan is believed to be due to the political instability and the frequent changes in

successive regimes. Since the creation of Pakistan in 1947, the government has changed hands twenty-three times. During this time the military has directly ruled the country longer than the elected governments (Pappas et al. 2009). Even during the so-called democratically elected civilian governments, the military retained the upper hand in the decision-making. Khan and Heuvel (2007:282) claimed that no civilian government in Pakistan remained in power for more than three years. This has meant that successive governments have had little time to concentrate on social development issues. Furthermore, as stated by Khan and Heuvel (2007:282), military regimes have tended 'to propagate topics that concern national enemies or perceived threats to security' in order to increase defence budgets at the cost of social welfare.

Furthermore, the study respondents were of the opinion that the health sector in Pakistan does not remain a priority at the political level and as a result minimal resources are allocated to the health sector. This finding suggests that extra resourcing for implementing the health workforce reforms suggested in this current study would be required. This view is also supported by the latest State Bank of Pakistan (SBP) Annual Report (2009:233-234) which says that 'in FY09 public expenditure as a percentage of GDP declined to 0.55 percent from 0.57 percent in FY08'. For the last two years, the report also claimed a decreasing trend in the financial allocation for the implementation of the Poverty Reduction Strategy Paper (PRSP). According to the data, total expenditure in the health sector through the PRSP allocations declined to Rs 26 819 million in the 2009 Financial Year from 61 127 million in the 2008 Financial Year. The report further reveals that existing health infrastructure is not sufficient to meet the needs of over 160 million people living in the country. The report witnessed a minimal increase in health centres during 1998 to 2007 (see Table 5.3).

Table 5.3: Health facilities and beds by province, 1998 and 2007, Pakistan

Province/ state	Health centres*		No. of beds		Population (Million)
	1998	**2007**	**1998**	**2007**	**2007**
Punjab	2265	2317	42305	45775	87.7
Sind	2302	2556	26522	28606	36.5
Khyber Pakhtunkhwa	847	902	13257	16691	21.9
Balochistan	773	742	4575	5983	8.2

*Includes hospitals, dispensaries and maternal and child welfare centres
Source: Federal Bureau of Statistics (2008:225)

Pakistani physicians interviewed for this study perceived that even the distribution of the available meagre resources for health is done on political expediency and based on the misplaced priorities of the rulers. According to Pappas et al. (2009), the constitution of Pakistan provides health care to all its citizens and the country is a signatory to all international conventions that call for equity. However, there are visible health inequalities in Pakistan as the distribution of health resources is done to benefit only the powerful and privileged in the country. For example, according to Pappas et al. (2009), the Government of Pakistan spent US$ 1.06 million on the overseas treatment of eleven members of the Pakistani elite which is more than the annual budget of a tertiary care hospital and is thirteen times more than the government expenditure on the control and prevention of non-communicable diseases. In another example of the political nature of decision-making and misplaced priorities in health, in October 2006, the Government of Pakistan approved the construction of two 'medical towers' to cater for medical tourism for high tech medicine at a cost of approximately Rs. 6.5 billion in the absence of any feasibility study or business plan (Pappas et al. 2009). In a study in which Islam (2004) looked at Pakistan's ability to achieve the health related MDGs by 2015, this author concluded that, while Pakistan needs additional resources for health, it also needs to review and reprioritise the use of available resources to achieve maximum health gains.

As mentioned above, the constitution of Pakistan envisions the provision of health care to all its citizens and it is the responsibility of the state to take care of the health of its people; however, Pakistani physicians have revealed that the government is not taking any responsibility for the provision of health care to its people. This view is supported by Pappas et al. (2009) who argues that, in Pakistan, more than 75 percent of health care is being provided by the private sector leading to a serious problem of access and quality of care (Pappas et al. 2009). As a result, health is increasingly becoming a private commodity which is available only to those who can afford the price, leaving 'the vast majority of the poor and the disadvantaged at the mercy of the market forces' (Islam & Tahir 2002:165).

Furthermore, this current study also revealed that, due to the lack of attention that health has received over the years, the health system has difficulty in creating equity of access to services, creating vast rural/urban disparities in the provision of healthcare. There are two main reasons for this disparity. First, because the private sector is the main provider of healthcare in Pakistan, by its very nature a private sector investor would aim to maximise its return on investments would prefer by building and running a for-profit hospital in a major city rather than a Basic Health Unit (BHU) in a rural area (Islam & Tahir 2002:165). Second, and as argued by Zaidi (1985:481), the other important reason for the urban concentration of health facilities in Pakistan because the ruling and elite class of Pakistan who govern the distribution of resources in the health sector and the economy in general reside in cities. Priorities are given to programs and projects that suit their own interests and benefits. This maldistribution of health and other social infrastructure has led to the urban concentration of the health workforce. This leads to medical jobs saturation in the larger cities with the potential for unemployment, frustration and overseas migration.

5.3.3.2 Lack of health human resource policy and planning

A key health system related finding of this study is the lack of comprehensive health human resource policy and planning. This contributes to the Pakistani physicians' migration, discourages their resettlement into Pakistan and creates an imbalance in the health workforce of Pakistan. The study participants were of the opinion that overall health is a neglected sector in Pakistan and, within the health sector, human resources is the most neglected component.

Health workforce policies are considered a pre-requisite for successful implementation of overall health policies and health reforms in the health workforce literature. For example, Dussault and Dubois (2003) described developing countries' inability to implement sustainable health reforms even though they have access to new resources from international development partners. They described the loss of the health workforce and their productivity due to public to private sector migration as well as migration to developed and more stable countries. These authors are of the view that these problems are due to the lack of, or inadequate, human resource policies and practices at all levels of training and development, performance management and definition of working conditions (Dussault & Dubois 2003). Furthermore, according to Dovlo (2001), developing countries have done little to frame coherent policy to retain their health human resources. Overall, as rightly pointed out by Islam (2003), without comprehensive and proactive policy framework and planning, it would be extremely difficult for developing countries to address their health human resource issues in an effective manner.

This study's perceived lack of comprehensive and dynamic health human resource policy and planning in Pakistan is also identified by other studies and reports in the Pakistani context. This lack of human resource policy pertains not only to physicians but also the

different categories of health professionals in Pakistan. A report by a joint mission of the World Health Organization (WHO), United Nations Children's Fund (UNICEF), Department For International Development (DFID), United Kingdom and the World Bank (2007:11) to review the health system of Pakistan has pointed out that 'there is a lack of a clear long-term vision of human resource development' and that there is an absence of any specialised section or unit both at the federal and provincial/state levels for such an important health system function. Nishtar (2006:120) viewed the absence of a comprehensive and functional policy on human resource development as a major constraint for maintaining both individual and institutional capacity for health system development in Pakistan.

Doctors' reluctance to serve in rural areas

The respondent Pakistani physicians perceive that, because of the government's misplaced priorities and the historical underfunding in health and other social sectors, the rural areas where the majority of the Pakistani population reside remain underdeveloped with poor health and a lack of social infrastructure. Therefore, because of this overall underdevelopment and in the absence of any viable health human resource policy and planning where specific incentives can be incorporated for a rural workforce, doctors are reluctant to serve in these areas. This creates severe geographical imbalances in the supply of the medical workforce. This finding confirms previous research findings that the available career structure of the doctors is such that there are no incentives for them to work in rural areas, rather there are disadvantages that affect their family, social and professional lives (Farooq et al. 2004). The respondents in the current study also suggest that a reluctance of doctors to serve in rural areas leads to a concentration of physicians in urban centres. A consequence of this is their unemployment and migration to other countries in huge numbers. This view of the study respondents is consistent with other

international literature on human resources for health (Dussault & Franceschini 2006; Bundred & Levitt 2000:245). It is termed the 'medical carousel' effect as prosperous countries recruit foreign health workers to fill positions in rural and remote areas and, in effect, professionals in source countries leave rural areas to fill in the gaps in cities and major towns (Bundred & Levitt 2000:245).

Interestingly, this problem of physicians' reluctance to serve in rural areas and their concentration in urban centres is not unique to the Pakistani context and other developing and developed countries are also experiencing a similar problem which is widely discussed in the international literature (Chomitz et al. 1998; Dussault & Franceschini 2006; Nigenda & Machado 2000:315; WHO 1997). According to Dussault and Franceschini (2006), geographical imbalance of health personnel is a universal, longstanding and serious problem. These authors further state that both developing and developed countries have experienced a higher concentration of health personnel in urban and wealthier regions. In Nicaragua, around half of the total health workforce is concentrated in the capital, Managua, where only one fifth of the population resides (Nigenda & Machado 2000:315). In Ghana, it was reported that in 1997, out of 1247 general physicians 1087 (87.2 percent) worked in the urban areas; however, 66 percent of the country's population resides in the rural areas (WHO 1997). Likewise, in Indonesia, it is reported that doctors and nurses do not like to work in rural and remote areas due to poor communications with other parts of the country and negligible amenities for health workers and their families (Chomitz et al. 1998). In 2002, in a meeting of the Organization of Economic Cooperation and Development (OECD) attended by experts on human resources planning, there were universal reports of maldistribution problems across the twenty countries represented. However, unlike developing countries, the developed countries can mitigate the effects of

maldistribution by employing strategies such as transfer by air, telemedicine (Dussault & Franceschini 2006) and even overseas recruitment.

In this study the respondents believed that due to the overall underdevelopment of rural areas and the absence of specific incentive programs for rural doctors, the majority of doctors want to stay in the city. This leads to increased competition and jobs saturation. Furthermore, they argued that the majority of the doctors do not want to specialise out of interest, but stay in the cities to complete postgraduate training. The need to increase their earnings leads to increasing specialisation. Talati and Syed (2008:2158) are of similar views and state that 'while [post] graduates are willing to seek employment in Pakistan, they are generally unwilling to serve in rural areas'. The other plausible reason put forward by the study respondents for this increased trend towards specialisation is the absence of a family physician or primary care physician career option available to these physicians. This perspective of the respondents confirms similar views expressed by Ansari (2008:2) and Biggs (2008:59). Furthermore, similar problems were also reported by Mullan (2006:383) in India where the healthcare system is similar to Pakistan's system.

Feminisation of the Pakistani medical workforce

A key finding of this current study is the increased feminisation of the Pakistani medical workforce which has important policy and practice implications for future health human resource management in Pakistan. The study participants in this study reported that around 70-75 percent of new medical school entrants are females. This increase in the number of recent female medical graduates is also reported by Ansari (2008:2) who quoted an example of the Karachi Medical and Dental College where, in 2008, in a class of fifty there were only five to seven male students. Similarly, according to Biggs (2008:61), in 2006 at Dow Medical University of Health Sciences, 'females made up to 60% of each medical

year'. Furthermore, the respondents in this study believed that this increase in female intake is due to several interrelated reasons. First, for the last couple of years as the result of a Supreme Court of Pakistan verdict, the admissions to medical schools are being made on an open merit policy instead of fixed quota for males and females as was done previously (Ansari 2008:2). The other reason put forward by one Pakistani physician respondent for the increased number of female entrants into the medical schools was the traditional acceptability of medicine as a working profession for females in Pakistan. Some other participants in this study were of the opinion that this increased trend towards feminisation of medicine is due to these students and their families' desire to find good matches for their daughters while in medical schools and get married. This perception of the respondents in this study supports the view of Ansari (2008:2) that 'for many females [in Pakistan] the only purpose of becoming doctors is to find proper suitors'.

The participants in this present study perceived that this increase in the feminisation of medicine could be due to multiple factors; however, they were of the opinion that it has important policy implications for future medical workforce policy and planning in Pakistan. This finding is consistent with the recent debate about feminisation of the medical workforce and its implications in Pakistan. For example, in 2008, during the International Surgical Conference (SURGICON) in Pakistan, it was highlighted that the majority of students enrolling in medical schools are females and historically women have had less inclination to join the field of surgery, thus the fear of a future decreased availability of surgeons in Pakistan (*News* 15 Nov. 2008). Talati and Pappas (2006:57) are also of the opinion that as more females are entering the medical profession, there is a greater need to understand gender related differences with respect to specialty preference, preference for location and hours of work and other characteristics.

There was a difference of perceptions among the study respondents about the effects of feminisation of the medical workforce on the accessibility of medical services in Pakistan. As indicated by one study participant, the increase in the number of female doctors could have a positive effect on the overall availability of doctors especially to the female population. This respondent believed that cultural issues for women, especially in rural areas, can mean that many are reluctant to see male doctors and therefore are not able to get the required treatment. Therefore, this increased feminisation could help in improving maternal and child health which is a major health issue in Pakistan.

However, the majority of the study respondents did not agree with this contention that more female doctors will help in increasing Pakistani women's accessibility to doctors, especially in rural areas. They were of the opinion that this may not be the case unless the workforce is properly managed because they believed that some of the female doctors leave their profession permanently after getting married and others think that they will start their professional careers after completing their families. However, according to the study respondents, even in this latter group, the majority could not rejoin their profession and some even move overseas with their spouses. Ansari (2008:2) and Biggs (2008:61) have also confirmed this belief and quoted a dropout rate of 70-80 percent for graduating female physicians, which is a huge economic and human resource loss for Pakistan. Furthermore, the respondents in this study argued that in the absence of part-time training or work facilities in Pakistan, even those females who start their careers experience problems in attending evening and night duties due to their work and family responsibilities (Ansari 2008:2; Pal 2007:276). The literature from neighbouring countries such as Bangladesh also show that female doctors are less likely to stay in rural areas compared to their male

counterparts (Chaudhury & Hammer 2004:430). This makes rural women further disadvantaged even with an increased feminisation of the medical workforce.

Lack of policy for physicians' resettlement

According to Shafqat and Zaidi (2005:493), although resettlement requires a lot of motivation and resources, those physicians who do return to Pakistan contribute heavily in becoming trend-setters in clinical excellence. They can become leaders in education and research and also contribute to the country's health policy and public health. Dussault and Franceschini (2006) have also expressed similar views that returning migrant physicians transfer updated scientific knowledge and share this new knowledge, technological know-how and techniques with their peers and students. In contrast, despite valuing overseas training, many study participants mentioned that there is a reluctance from within the medical community, especially by their senior colleagues, to incorporate new techniques on their return to Pakistan. This practice fails to optimally use the skills of the returning medical workforce in a country already experiencing a workforce shortage.

Furthermore, Pakistani physicians interviewed in this study pointed out the lack of any policy framework for Pakistani physician resettlement from overseas, leading to the loss of this well educated and well trained health human resource for Pakistan. The participants complained that in the absence of a well planned resettlement strategy they faced an overall unwelcoming attitude both in the public and private sector and there is no system where they can look and apply for available jobs. This finding complements Pal's (2007:276) view that 'now fewer and fewer foreign trained obstetricians and gynaecologists return to Pakistan …' This finding also supports data gathered from medical schools in Pakistan which show that only approximately 300 out of 10 000 Pakistani physicians trained in the United States have resettled back into their country

(Shafqat & Zaidi 2007:442). Furthermore, Shafqat and Zaidi (2007:442) stated that many overseas Pakistani physicians wish to return but they could not do so due to the non-availability of suitable jobs. According to the results of another study in Pakistan by Hyder, Akhter and Qayyum (2003:341), fifty-four researchers funded through public finances for doctoral training in health sciences reported problems in getting appropriate jobs, lack of facilities and absence of incentives to perform.

Need for data and research

The respondents in this present study agreed that in order to develop an evidence-based human resource strategy, there is a need for accurate and reliable data on the health human resource in the country. However, they argued that there is a general lack of data on the available health human resource and future needs of the country. This limits the capacity to develop improved medical workforce policies and planning in Pakistan. Similar findings were found by Biggs (2008) and Talati and Pappas (2006). According to Biggs (2008:61), currently the only up-to-date data regarding Pakistani physicians are available from the Pakistan Medical and Dental Council (PMDC) which is the national body for physician registration. However, this data only identifies the approximate total number of physicians registered every five to ten years with the PMDC since its inception (Biggs 2008:61). It does not provide any information regarding the number of physicians actually available in the country and working in the system, or physicians leaving or working abroad or those returning. Talati and Pappas (2006:58) are also of the view that data on physician migration are scarce and patchy in Pakistan. Furthermore, there is a lack of information on the quantum of doctors' medical work, that is, whether they are working full-time, part-time or not working at all (Biggs 2008:61). Therefore, this current study suggests that, without this vital information, it is very difficult to develop a viable health human resource

strategy, leading to imbalances in the Pakistani health workforce in terms of number, distribution, speciality and cadre.

Furthermore, the study respondents were of the opinion that in the absence of such data, the government is unable to develop a viable health human resource strategy for adequate planning of the health workforce. This finding is supported by recent newspaper reports in Pakistan that point towards inadequate human resource decision-making in the absence of vital data and research. For example, in April 2009, the Minister for Labour and Manpower in response to a question in the National Assembly of Pakistan reported that Pakistan exported 500 doctors to Oman while 500 doctors were being sent to Saudi Arabia in the coming few months (*News* 17 April 2009). On the contrary, two weeks later during the same month of April in 2009, the Prime Minister of Pakistan gave approval to establish two new medical colleges in Loralai and Khuzdar districts of Balochistan province (*News* 27 April 2009) to increase the number of doctors to meet their increasing need in the country. Similarly, a month later in May 2009, the Prime Minister of Pakistan, while speaking at the inaugural ceremony of Sheikh Khalifa-bin-Zayed Al-Nahyan Medical and Dental College in Lahore, announced that the government was opening new medical colleges to cater for the shortage of doctors in the country in proportion to its growing population (Malik 2009).

The results of this study clearly indicate that the historical neglect and underinvestment in the health sector together with the lack of viable health human resource policy and planning in Pakistan has led to the creation of specific health system problems. This plays a major role in physicians' career decisions to migrate abroad and defer resettling to Pakistan. Training more doctors is unlikely to address the shortage of medical

professionals in Pakistan unless reform of the health system and its workforce policy is undertaken. These health systems issues identified in this study are discussed in the following sections.

5.3.3.3 Lower salaries

The first major health system constraint identified by Pakistani physicians in this study is lower salaries and other monetary incentives, especially in the public sector. This forces physicians to remain in the urban areas or seek employment overseas. The respondents believed that due to the lower salaries, most doctors in the public sector do either private practice in the evening or take another job to increase their earnings. This not only puts an increased workload on these physicians leading to their much compromised social and family life and ultimately frustration, but it also lead to decreased quality of patient care. Because of this, they look for other options including migration abroad.

The barrier of lower salaries was also found by other studies conducted in Pakistan to contribute towards physicians' decreased job satisfaction, decreased patient care and to their overseas migration. In a survey conducted by Khuwaja et al. (2004:24) to compare job satisfaction and stress among male and female doctors in three teaching hospitals in Karachi, Pakistan, it was found that salary and benefits was the most dissatisfying characteristic for 182 doctors who participated in the study. In another study with doctors in a tertiary hospital in Karachi, Pakistan, Saeed and Ibrahim (2005) found that 84 percent of the respondents mentioned inadequate salaries for doctors and paramedical staff from the government as one of the reasons for not being able to provide quality care to their patients. Furthermore, it was also found that doctors, especially senior doctors, in order to augment their earnings, engage in evening private practice and this affects their patients' care and the mentorship of their postgraduate trainees (Biggs 2008:60; Saeed & Ibrahim

2005:45). Shahid (2007:429), while discussing stress among Emergency Physicians (EPs) in Pakistan, stated that 'EPs do not earn enough money in Pakistan to support their families and go overseas to work'. Lower salaries are a generalised health system issue and are not only specific to the physician profession but affect other cadres of the health workforce such as nurses and paramedics. Nishtar (2006:124), in her gateway paper *Health Systems in Pakistan – a Way Forward*, states:

> *It is well-established that lack of incentives prompt providers – specialist clinicians, nurses and other paramedics – to serve in the private sector or to seek employment overseas where better incentives are offered ... Medical officers compete for postings in health facilities in busier towns where they are more likely to have profitable private practice on the side.*

Lower salaries and underpaid jobs were also mentioned as a problem that discourages expatriate Pakistani doctors who want to resettle to their country. The study participants were of the view that developing countries such as Pakistan may not be able to offer salaries to its doctors comparable to those received in developed countries; however, they suggested that the government should pay them a reasonable salary so that they can have a comfortable living. The example of Aga Khan Medical College, a private medical institution, is quite instructive in this regard. According to Shafqat and Zaidi (2007:442), the motives for resettlement of around forty graduates of the Aga Khan Medical College, Karachi, who are now staff in its faculty were mainly personal and societal such as ageing parents and family ties, a desire to raise children in a familiar culture and an emotional need to be at home. However, the key factor that affected their resettlement decision was the availability of attractive career prospects with their former institution in Pakistan with salaries permitting a comfortable lifestyle.

Similarly, Astor et al. (2005:2494), in a survey conducted in Colombia, Nigeria, India Pakistan and the Philippines, have found that 90.8 percent of the respondents rated a desire

for a higher income or more buying power as a highly significant motivating factor for migration. Furthermore, according to this study by Astor et al. (2008), the only policy option recommended by the study respondents was to increase professional salaries and improve working conditions. Studies in other developing countries having comparable socioeconomic conditions to Pakistan have also found lower salaries as one of the major factors for health workers' overseas migration (Awases et al. 2004; Brown & Connell 2004; Hagopian et al. 2005). However, as argued by (Vujicic et al. 2004), wage differentials between poor and rich countries are so large that by increasing income alone it is unlikely to affect the extent of migration and resettlement. This suggests that other factors such as the availability of quality postgraduate education, stable career structures and safe and secure working environments, as identified in this current study, will play a significant role in influencing Pakistani physicians' decisions to remain in their country and not to migrate abroad. This will also help in attracting overseas Pakistani physicians who want to resettle and serve in their country. This is consistent with the finding of this current study where better quality of life in Pakistan is a major motivating factor for doctors to return to Pakistan. Furthermore, another recent qualitative study by Alonso-Garbayo and Maben (2009) concluded that 'economic incentives may be just part of the solution' and that improving working conditions, offering professional development opportunities, improving material supplies and providing better monitoring and supervision are equally important in the retention of health workers in their countries. This is consistent with the finding of this thesis where a perceived better quality of life is a major motivating factor for doctors to return to Pakistan.

5.3.3.4 Lack of proper career structure and professional development

Lack of career structure was another major health system issue identified by this study that motivated Pakistani physicians to migrate abroad. The study respondents believed that in

the absence of a proper career structure and other career options such as a system of general practice or family medicine training, doctors are not willing to serve in rural areas, leading to massive geographical imbalances in the distribution of physicians. These doctors, in order to progress in their career and to increase their earnings, want to specialise so they can remain in major cities. This thus leads to jobs saturation, competition and migration.

This finding is consistent with other studies conducted in Pakistan that found that the majority of Pakistani doctors are not satisfied with their service structure and career progression. However, none of these studies explored this as a factor for retention or overseas migration. Farooq et al. (2004), in their study with doctors in the Abbottabad district of Pakistan, found the lack of professional growth and delay in postgraduate training as the main reasons for doctors not working in a rural health facility. In another study by Ghazali et al. (2007:43) with doctors in a teaching hospital of Bahawalpur, Pakistan, it was found that 92 percent of the respondents were not satisfied with their career progression and the available service structure in Pakistan. Biggs (2008:61) has also noted the lack of a clear career path and prospects for postgraduate doctors in Pakistan.

Furthermore, this thesis found that during the early 1990s when, in order to bring efficiency into the public sector organisations in Pakistan, the government started offering jobs on a contract basis instead of permanent positions with no promotions and other fringe benefits available to the permanent employees. This further deteriorated the already fragile career structure for doctors and created more career uncertainties leading more doctors to move overseas. This finding is supported by Malik (2008) who reported that in the absence of a permanent service structure for doctors in Pakistan, a massive overseas migration of

recent medical graduates is going on which is estimated at almost 60 percent only in the province of Punjab, which is population-wise the largest province of Pakistan.

This study also indicated that due to the lack of a proper career structure, Pakistani doctors are facing problems in promotions and they often serve in the same grades for years. This not only creates frustration and job dissatisfaction but is also a cause of doctors' unemployment as no new job vacancies are being created. This situation can be gauged from the fact that in December 2009, 14 seats of professors, 62 positions of associate professors and 70 assistant professor positions were lying vacant in five public medical colleges of Lahore, Punjab due to delays in promotions, thereby facing the threat of the colleges having their recognition withdrawn by the Pakistan Medical and Dental Council (*News* 20 Dec. 2009). This is due to the much delayed processes for recruitment and promotions. The situation is similar in other provinces and it is commonplace in Pakistan for doctors to protest on roads for regularisation of their services and promotion to higher grades (*News* 1 Oct. 2009).

Furthermore, the study respondents complained about the lack of continuous professional development for doctors in Pakistan as opposed to many countries around the globe that make continuous efforts to provide their doctors with enough opportunities to keep their knowledge and skills up to date. This belief expressed by the respondents is supported in a survey conducted by Siddiqui, Secombe and Peterson (2003) that argued that, in Pakistan, a doctor once qualified and registered is allowed to practice for life. According to the results of this survey in which a total of 329 doctors participated, a unanimous need for structured and organised professional development programs was expressed by all the participants and even 67.3 percent of the respondents were in favour of a mandatory

program. The finding from this study also supports evidence from the international literature wherein lack of clear career pathways, delays and lack of transparency in promotions to senior positions and continuous professional development were found to be major sources of dissatisfaction for doctors and an important source of motivation for health workers' overseas migration (Awases et al. 2004; Brown & Connell 2004; Hagopian et al. 2005; Oman, Moulds & Usher 2009a).

5.3.3.5 Lack of good postgraduate medical training

The results of this current study suggests that the majority of the Pakistani physicians leave their country and go abroad, especially to the developed countries, to pursue their postgraduate training due to the perceived lack of good postgraduate medical training in Pakistan. Lack of good medical training in Pakistan as a cause for Pakistani physicians' overseas migration was also found by Syed et al. (2008) in a survey conducted with the final year students of two private medical universities in Pakistan. These survey results showed that 95 percent of students from the Aga Khan University (AKU) and 65 percent from Baqai University (BU) intended to proceed abroad for training. Furthermore, the study respondents identified three major issues with postgraduate medical training in Pakistan. These issues are the non-availability of enough postgraduate training positions, the salary structure and the quality of postgraduate training in Pakistan.

The first issue with postgraduate medical training in Pakistan, as identified in this study, is the non-availability of enough postgraduate training positions which prompts many young doctors to go abroad. The study respondents were of the view that although the number of graduating doctors in Pakistan has increased many fold due to the increase in the number of medical schools both in the public and private sectors, there is no corresponding increase in the number of postgraduate training positions. Because of the lack of facilities

in rural areas, lack of career structure, lower salaries and the absence of any formal system or designated practitioners for primary care, every doctor in Pakistan tries to undertake postgraduate education and this leads to a general trend of specialisation. This view is supported by a recent newspaper report (*News* 18 Dec. 2009), which reported that, in 2009, in the province of Khyber Pakhtunkhwa (formerly North West Frontier Province [NWFP]), hundreds of doctors qualified in the Part-1 examination (theoretical part) of the fellowship of College of Physicians and Surgeons Pakistan (CPSP), which has an average pass rate of 20 percent (Biggs 2008:59), but only thirty-five candidates were offered training positions in the public hospitals. Now this problem has reached such a crisis point that doctors have started agitating on roads and observing strikes to increase the paid training positions (*News* 6 Jan. 2009). Furthermore, as identified by the study participants in this study and reported by Syed et al. (2008:66), in the absence of paid training positions, in order to save their time, doctors are compelled to do their training without salary. This is not possible for all doctors and in the process they become frustrated and look for other avenues including overseas migration.

The other issue identified in this current study with regard to postgraduate medical training in Pakistan is the poor salary structure of the postgraduate training programs. According to the study respondents, on the one hand doctors are compelled to do their postgraduate training on an unpaid basis as there are not enough paid postgraduate training positions available, but on the other hand even the salary which is offered for those limited paid positions is not enough for normal life expenses. Syed et al. (2008:66) has reported a salary of around USD 110-180 per month which is barely enough to meet the basic needs of these trainees. Biggs (2008:60), while conducting an assessment of postgraduate medical training in Pakistan, has also reported this issue of low payment of trainees, or the lack of

it, and noted that ‘the responsibility trainees carry for patient care is significant and the need to address the matter of payment for services is urgent’. Similarly, Shiwani (2007:472) is also of the same view that ‘… training of doctors in some of the public funded postgraduate medical institutes without any remuneration and exploitation of postgraduate doctors is a well known fact’. This is a long lasting demand of postgraduate doctors for which they are observing strikes and holding protest demonstrations in public in recent times (*News* 22 Sept. 2008, 8 May 2010).

Another area with regard to postgraduate training in Pakistan that needs immediate attention and was widely discussed by the study participants in this thesis is the quality of training on Postgraduate Medical Education (PGME) programs. Traditionally, in Pakistan, postgraduate medical qualifications, mainly fellowships and some diplomas, are awarded by the College of Physicians and Surgeons Pakistan (CPSP). In recent years, some medical colleges have been upgraded to Medical University status and have started alternative postgraduate qualifications of Master of Surgery (MS) and Doctor of Medicine (MD). There are widely different opinions about the quality of these new qualifications of MS and MD (Biggs 2008:59), and the respondents in this study were of the opinion that these qualifications are not of very high quality (Ansari 2008:2). Furthermore, although the efforts made by the College of Physicians and Surgeons Pakistan (CPSP) for improving the quality of its degrees were appreciated, there was a general consensus among the study participants that there is a need for greater improvement in this regard. Pal (2007:276) is of the opinion that ‘trainees in most teaching hospitals, express dissatisfaction with their training’. The study results by Syed et al. (2008:63) also show that the majority of the students at the Aga Khan University (93 percent) and Baqai University (65 percent) cited poor quality PGME in Pakistan as the most important factor motivating them to train

abroad. The study respondents termed the postgraduate medical training in Pakistan as ‘unstructured’, ‘apprenticeship’ and ‘punishment’. Biggs (2008:59) is also of the view that postgraduate medical training in Pakistan is ‘generally based on supervised apprenticeship in a teaching hospital …’.

The main reason identified in this current study and also reported by others (Biggs 2008:60; Saeed & Ibrahim 2004:47; Talati & Syed 2008:2159) that affects the quality of postgraduate education in Pakistan is the lack of time and drive by senior doctors and professors to mentor medical trainees. This in part can be attributed to low morale and their involvement in evening practice which they need to do because of the lower salaries they receive in public health institutions. In some institutions, especially the public hospitals, this deficient supervision is also the result of too many trainees for the available staff. This lack of time for positive supervision and the high supervisor to trainee ratio results in strained relations between the postgraduate students and their teachers. This view is consistent with the results of a survey conducted by Avan et al. (2006) in which 341 registered residents of various specialties from four teaching hospitals in Pakistan were asked about how they perceived their work environment. Besides long working hours and perceptions of mistreatment, mostly at the hands of patients, the study found the lowest scores were for the faculty members’ contribution to postgraduate education. Therefore this suggests that senior faculty members’ lack of interest in the teaching of residents. Similarly, another survey by Ahmer et al. (2009) conducted with postgraduate trainees registered in psychiatry with CPSP in 2007 showed that 80 percent of trainees reported having experienced at least one bullying behaviour in the preceding twelve months and 73.3 percent of the trainees reported being bullied by their consultants.

This current study also pointed out the lack of research and training and development funds in the budgets of the medical training organisations which is also one of the incentives for doctors preferring to train abroad. Lack of funding for conducting research was also mentioned as a constraint for not producing optimum research outputs by fifty-four PhD researchers upon their return who were trained overseas by the funds of the Government of Pakistan (Hyder, Akhter & Qayyum 2003:340) as discussed previously in Chapter Two of this thesis. Similarly, another recent study in Pakistan found that lack of research allotted time, research training, statistical support, mentorship and financial incentives are the main barriers towards research in Pakistani universities (Sabzwari, Kauser & Khuwaja 2009). However, it is heartening to note that a higher number of physicians in public institutions were involved in research compared to doctors in private universities. This may be the result of recent provision of finances and support from the Higher Education Commission (HEC) of Pakistan to the public sector universities (Sabzwari, Kauser & Khuwaja 2009). Similar problems were found by other studies conducted with medical students and postgraduate medical trainees in Pakistan (Aslam et al. 2004; Khan et al. 2006; Khan, Khan & Iqbal 2009). Lack of good postgraduate medical training with its different issues and problems as discussed in this current study as a reason for medical migration is also reported in other studies from developing countries settings in Lebanon (Akl et al. 2007), West Africa (Hagopian et al. 2005), Fiji (Oman, Moulds & Usher 2009b) and Libya (Benamer, Bredan & Bakoush 2009) which were discussed in Chapter Two of this thesis.

Culture of valuing overseas training

Together with the lack of opportunities for quality postgraduate medical training in Pakistan, this study found that there is a prevalent culture of valuing overseas training in Pakistan both in the medical fraternity and the society in general. This is another factor contributing towards Pakistani physicians' decisions to migrate abroad. The physician

respondents viewed foreign training in the developed countries as more organised and structured, having more emphasis on skills as opposed to theory and more resources for research and development. They also reported that generally in society, people who do not have much understanding of the difference between the quality of local and overseas training would still prefer to go for their treatment to someone who has an overseas qualification. This culture of valuing overseas qualifications is an important factor motivating physicians to consider overseas migration to Western countries. This pattern of migration is also reported by other studies conducted in developing countries (Akl et al. 2007:1281-2; Hagopian et al. 2005:1755). Aly and Taj (2008:6) have argued that one of the reasons for Pakistani medical graduates going to the West is 'the long-standing belief of young doctors and their parents that training outside their home is superior and a mark of achievement'. Similarly, Gadit and Mugford (2008:465), while discussing the trend of questioning credentials among psychiatrists in Pakistan, has reported that:

> *There is the perception of a general sense of superiority among the holders of MRCPsych [Member Royal College of Psychiatrists, UK], who are bent upon nullifying all other qualifications. Although there is propagation by some senior psychiatrists that preference should be given to locally qualified psychiatrists, foreign qualifications still carry weight and are respected.*

5.3.3.6 Personal insecurity and societal degradation

Together with the above discussed health system issues and problems, the study participants witnessed a gradual downfall in the general state of society which is reflected within the medical profession. This gradual deterioration in social values, coupled with the recent surge in insecurity in Pakistan, is described as another major reason for Pakistani physicians' job dissatisfaction, frustration and for seeking overseas employment. Personal insecurity is also described as a major discouraging factor for overseas Pakistani physicians' resettling decisions when they otherwise value their better quality of like in

Pakistan. According to Burnham, Lafta and Doocy (2009), this important factor affecting physicians' migration decisions is rarely discussed in the literature. However, a literature review conducted for this thesis found that recent studies conducted in other developing countries like Fiji (Oman, Moulds and Usher (2009b), Iraq (Burnham, Lafta & Doocy 2009) and Lebanon (Akl et al. 2007) have identified violence, political instability and personal insecurity as reasons for physicians' overseas migration.

Pakistani physicians, regardless of their groups, whether *stayer*, *leaver* or *resettler*, mentioned insecurity as a major problem currently faced by them in Pakistan. In Pakistan, the law and order situation has never been satisfactory but during the last few years personal insecurity has become the biggest problem for Pakistani citizens. Gadit (2008b:342) is also of the view that 'with the rising law and order situation in Pakistan, many doctors are eager to leave the country for a better life structure'. According to the latest report of the Human Rights Commission of Pakistan (HRCP), *State of Human Rights in Pakistan* (2009:6), terrorism posed the greatest threat to fundamental rights of the citizen throughout the year 2009. The report mentioned that according to unofficial estimates, there were 2568 incidents of terrorism in the country in which 3021 people were killed and 7334 were injured.

Unfortunately, because of the recent deterioration in the law and order situation during the last couple of years in Pakistan, even those Pakistani doctors in this study who were economically content and were staying in their country due to their intense desire to live close to their families and culture and to serve their people and country, have started thinking about going overseas. There is lack of previous research that has looked into violence and insecurity as a reason for Pakistani physicians' overseas migration, however,

Gadit (2006:465) argues that in Pakistan in recent years, personal insecurity, violence, robberies and kidnapping have increased and doctors have been kidnapped for ransoms and killed. In another study by Khuwaja et al. (2004:24), safety and security was found to be a major source of job dissatisfaction among the doctors of three tertiary care hospitals in Karachi, the largest port city of Pakistan. This increased insecurity has not only affected the medical profession but other highly educated and skilled professionals are leaving Pakistan in large numbers.

Furthermore, apart from the recently deteriorated law and order situation in Pakistan, this study found a strong perception of a gradual societal degradation in Pakistan which is reflected in the medical profession, mainly in the shape of corruption. This view is supported by a recent newspaper report in which the Chief Justice of Peshawar High Court, while hearing a case, observed that 'it is regrettable that no one is doing his/her duty rightly, owing to which our society is declining day by day' (Dastageer 2009). Similarly, Israr and Islam (2006:323-324) described lack of good governance and a conducive organisational culture as the main reason for the failure of sustainability of the Family Health Project (FHP), funded by the World Bank during 1992-1999.

The study participants had an intense perception of corruption and professional malpractice within the medical profession in Pakistan which led to low job satisfaction and frustration. This has resulted in a tremendous devaluing of a once noble and respectable profession. Overall, corruption is on the rise in Pakistan and it seems that corruption has been accepted as a norm by the society (Abbasi 2009). Even in health care, corruption is very commonplace in Pakistan. According to the National Corruption Perception Survey (Transparency International Pakistan 2009:19), health was ranked as the third most corrupt

department in Pakistan and according to a survey respondent 'there is no difference between a *daco* [robber] and a doctor'. Similarly, according to Shiwani and Gadit (2010:75), absenteeism of health personnel from their place of work while receiving salaries, reluctance to see patients in government hospitals and referring them to private clinics, overuse of diagnostic tests, charging illegal user fees from poor patients, over-prescription, writing false medical bills and certificates, and indulgence in unethical pharmaceutical marketing strategies and promotion of medicines are some of the prevalent practices in medicine in Pakistan that are now considered to be normal.

Furthermore, this current study also revealed a worrying trend of professional jealousy among doctors and health care providers in Pakistan which, according to the study participants, has reached an alarming level. This trend was attributed by the participants to doctors' reluctance to serve in rural areas leading to job saturation in cities and increased professional competition. This view is consistent with previous literature in Pakistan. According to Gadit and Mugford (2008:464), 'human rights violations are rampant in Pakistan at all levels but there is a sad irony in the fact that they occur among medical professionals …'. This study by Gadit and Mugford (2008) found that 95 percent of the sixty randomly selected psychiatrists in Pakistan experienced bullying and harassment. Similarly, Gadit (2007:425-426) has reported that professional jealousy and subsequent harassment is more prevalent among the specialists doctors and is one of the main hurdles in medical practice advancement in Pakistan. This situation is similar to the current general environment in Pakistan where human rights violations and lawlessness is common (Gadit & Mugford 2008:465).

Because of this practice competition and pursuit of personal fame and wealth, the results of this study reveal that those Pakistani physicians who returned from overseas after completing their postgraduate education were facing intense resistance from their fellow colleagues, especially their seniors, whenever they tried to introduce new procedures and innovations in their professional work. These physicians were so pressurised that they were considering moving overseas again. This finding supports the views expressed in the above section that professional jealously is a major obstacle in the development of medicine in Pakistan (Gadit (2007:425-426). This finding also shows a paradox that overseas training and qualifications is valued yet there is resistance to those who wish to return and apply new skills. Gadit (2007:426) has expressed similar views that 'doctors who came to serve their country were discouraged, abused, defamed and subjected to such a level of mental torture that had compelled them to leave the country'. In another study by Hyder, Akhter and Qayum (2003:340) in which fifty-four Pakistani researchers in health who returned to Pakistan after completing their doctoral studies, reported similar findings and complained that a 'research culture cannot be inculcated in a developing country like ours when the research institutions are governed by unqualified chairs'.

5.4 How the aims of the thesis were met

The four aims of this thesis were to:

1. Explore the perceptions of Pakistani physicians regarding their career decision to remain in their country and not move overseas.
2. Explore the perceptions of Pakistani physicians regarding their career decision to migrate abroad.
3. Explore the perceptions of Pakistani physicians regarding their career decision to initially go abroad and then resettle back to their country.

4. Identify the problems encountered by Pakistani physicians during the process of resettlement back into their country after working abroad for some time.

This thesis presents an in-depth analysis of the qualitative data collected from three groups of Pakistani physicians, that is, *stayers*, *leavers* and *resettlers,* about their perceptions regarding retention, migration and resettlement decisions and the factors that influenced these decisions. This thesis also identified the problems faced by Pakistani physicians during the process of resettlement in Pakistan. The analysis of the data found that the main factors that influence Pakistani physicians' career decisions were personal and family factors, health system factors and societal factors.

The study results showed that the main personal and family factors that influence Pakistani physicians' decision to stay in their country were their identity and belonging to their country and culture, a desire to serve their own people, their family attachment and the availability of family support in Pakistan. The health system factor that influenced their retention decision was having a permanent job in Pakistan and a societal factor of their perception of differentiation between locals and non-locals abroad. These findings addressed the first aim of the thesis.

Those Pakistani physicians who left their country and went overseas did so mainly because of health system problems and a few societal factors. The health system factors identified were lack of health human resource policy and planning, lack of availability of good postgraduate medical training, a poor career structure and less professional development opportunities and the availability of lower salaries to these doctors in Pakistan. The societal factors that compelled these physicians to leave their country were the non-recognition of

health as a state priority, a culture of valuing overseas training and increasing personal insecurity and societal degradation in Pakistan. These findings addressed the second aim of the thesis.

Similarly, the results of this thesis also revealed several factors that encouraged Pakistani physicians who had gone abroad for further studies or work to resettle into their country. These factors included a perception of a better quality of life in Pakistan as compared to overseas, the availability of a permanent job in Pakistan and feelings of differentiation between locals and non-local abroad. These findings addressed the third aim of the thesis.

Furthermore, the study results also identified the problems faced by Pakistani physicians during the process of resettlement in Pakistan which addressed the fourth aim of the thesis. These problems were mainly health system problems such as an unwelcoming attitude on the part of hospital management both in the public and private sectors, difficulty in finding suitable jobs and the availability of underpaid jobs. Recently, the increasing personal insecurity and societal degradation was also identified as a potential problem that discourages Pakistani physicians from resettling.

It is hoped that the findings of this study will alert policy makers to the human resource problems encountered within the medical profession in Pakistan. The following section describes the implications for policy and practice arising from this study.

5.5 Implications for policy and practice

In this current study, the perceptions of Pakistani physicians regarding their retention, migration and resettlement decisions provided new information on the medical workforce situation and raised issues and questions that provide directions for further intervention. Participants complained about the lack of career progression particularly suited to the feminised medical workforce which is being trained. This has implications for policy in order to achieve equitable access to a sustainable health workforce for all of Pakistan.

From the findings of this study, it is clear that physician migration, retention and resettlement is a complex issue and there are multiple personal, social, political and economic factors that affect their decisions to stay, move abroad or resettle back into their country. This study found that the majority of the Pakistani physicians would stay in Pakistan or resettle back into Pakistan if provided with the right conditions and opportunities. There is a need for workforce policy to be preventative and address the factors that motivate or compel these physicians to migrate abroad. There is also a need to rectify the problems and issues identified by those physicians in their course of resettlement back into their country. Policy also needs to address the needs of career and family of the feminised workforce. This approach is preferable to legislation or punitive measures which have not succeeded in limiting migration (Stilwell et al. 2004:598). The following implications arise from this study.

5.5.1 Need to recognise health as a state priority

As a first step the government needs to place health as the highest priority on their agenda. According to Nishtar (2010:75), to reform mixed health systems such as Pakistan 'the first priority is to address broader constraints of the political and economic systems that are manifest in inequities of power, money and resources …' This requires developing a

continuous democratic political system that can ensure that health policies and strategies reflect the actual healthcare needs and well-being of the people of Pakistan (Khan & Heuvel 2007). This democratic and participative policy and planning context will help in developing a strong sense of ownership among the people of their health and other social welfare programs. This will also help in avoiding the unnecessary influence of political instability upon health and will ensure the much needed sustainability of health policies when the government is changed. It can compel the government to consider the health sector as a priority in allocating resources and will help in increasing the much needed government health expenditure (Khan & Heuvel 2007).

According to Nishtar (2010:75), in most low and low middle-income countries such as Pakistan, an increase in public sources of financing for health is critical for meaningful health reforms. However, some workforce reforms can be implemented at a relatively little costs such as part-time training and more flexible work hours, especially for female doctors. The history of the healthcare sector in Pakistan shows that it has never received its true allocation of funds in the budget. From 2002 to 2009, the highest public sector health expenditure as a percent of gross domestic product (GDP) was 0.59 percent and in 2009 it was 0.55 percent (Khan 2009:170-171). Furthermore, Pakistan annually spends less than US$ 34 per capita on health, the amount which the WHO considers essential for the provision of basic health services (Nishtar 2010:74).

The marked underinvestment in healthcare contributes to poor morale and staffing at government health facilities. Increasing health expenditure and modernising health infrastructure would help in creating opportunities by offering more career options for physicians to remain in Pakistan and work in public sector hospitals. This study also

recommends a number of improvements that will mean increased health expenditure: creating incentives for physicians' recruitment and retention in rural areas, increasing the salaries of doctors, designing courses for family/general care physicians, and generating regular data about the present and future medical workforce. All these recommendations call for present health expenditure to be assessed.

The government needs to invest heavily to improve the healthcare sector especially in rural areas. To persuade doctors to work in rural areas there is a need for the implementation of a rural friendly policy that cater for Continuous Medical Education (CME) requirements and a well designed career pathway for rural doctors. There is a need for a well calculated package of incentives such as provision of housing and transport, specifying the number of years that they will spend in a rural area rather than expecting them to remain there indefinitely, offering financial incentives and further training after completing their agreed tenure in the area (Korte et al. cited in Stilwell et al. 2004:598). These strategies will help to increase doctors' motivation, which in turn will increase their retention in rural areas leading to less concentration in cities and eventually overseas migration. This will also help in the provision of quality healthcare services to the majority of Pakistanis living in rural areas. Another area that will help in doctors' willingness to serve in rural areas is to bring educational reforms to the structure and content of the undergraduate curriculum, the adaptation of new pedagogical methods and the students' exposure to medicine outside of teaching hospitals including attachment to rural hospitals (Dussault & Franceschini 2006).

While this current study recommends more investment in healthcare, it also calls for better management of the existing clinical and educational resources and better human resource management to reduce wastage in medical education system. This study recommends

better health management practices to introduce innovations that can potentially save costs. Likewise, this study also recognises the need for a better primary care system to reduce the use of the already burdened tertiary care system in Pakistan.

5.5.2 A viable health human resource policy and planning

The second most important policy recommendation of this study which has implications for practice is the need for viable and comprehensive health human resource policy and planning that can address the training and working needs of a feminised workforce in Pakistan. Talati and Syed (2008:2160), while discussing the challenges faced by the surgical training programs in Pakistan have aptly underscored the need for such a strategic human resource policy in the following words.

> *To achieve the number, quality and distributions of surgeons required to improve the situation, we need visionary strategic planning that searches for innovations that accelerate the rate of progression in surgical training, address teachers education, and distribute health services equitably to the population. Such planning will require the engagement of surgeons in a dialogue with society and government.*

For effective workforce planning, there is a need to generate reliable data about the healthcare workforce. Establishing and maintaining appropriate databases on human resources, including information on migration and resettlement should be the first step. The available data are scarce and patchy and only gives an overall picture of the total physicians registered without providing any information about the number of physicians actually present in the country and working in the system. For such planning, developments like annual surveys of practice and annual physician registration should be given thought in Pakistan (Biggs 2008:61). Furthermore, Pakistan needs to consider the physician loss due to overseas migration in any future workforce planning. According to Mullen (2005:1815), 11.7 percent of Pakistani doctors are working in Australia, Canada,

the UK and USA. This percentage could be higher if data for other countries were available.

While data on present and future physician needs is not available and a proactive workforce policy is not in place, this study recommends a temporary moratorium on any future growth of both public and private medical colleges in Pakistan. This is important because this study suggests that current health workforce decisions are made on political grounds and not on the basis of actual health needs of the country. Contrary to the popular belief that Pakistan is producing more doctors than it needs, Talati and Pappas (2006) are of the view that due to its rapid population growth, Pakistan needs more doctors than its current production level. They have estimated future physician workforce shortages in the range of 57 900 and 451 102 physicians in 2020 (using 1 physician/1000 population and 2.93 physicians/1000 population) for Pakistan (Talati & Pappas 2006:58). Therefore, keeping in view these uncertainties a temporary moratorium on the opening of new medical colleges would be a sensible line of course until a system approach of mapping the training places/colleges of undergraduate and postgraduate medical students is undertaken. If mapping demonstrates that there is physician overproduction and maldistribution is occurring extra resources spent on producing more doctors can be diverted to the production of other less costly and equally needed health human resources such as nurses, technicians, health managers and administrators.

Another important area that needs to be considered in any future workforce reforms is the feminisation of the medical profession in Pakistan. It has the potential to affect the availability of doctors especially in rural areas, and also to alter the impact of strategies designed to correct imbalances (Dussault & Franceschini 2006). Any sustainable

workforce policy will require catering for the needs of the future feminised medical workforce in Pakistan such as the availability of family friendly work environments and part-time trainings and jobs, so that they can balance their work and family requirements (Oman, Usher & Moulds 2009). This will help the female doctors who left their profession due their dual work and family responsibilities to rejoin their profession and prevent the loss of national resources spent on their education. It will also help in the provision of quality healthcare services especially to the women and children of this country.

Another area that begs attention and will help in physician retention and resettlement is the abolishment of the contract employment policy and provision of a permanent employment career structure for the doctors. According to the results of this study, the availability of a permanent physician position was a major incentive for those who preferred to stay in Pakistan.

5.5.3 Reengineering of a specialist family/primary care physician career pathway

The findings in this current study suggest that there is a need for an emphasis on family medicine in Pakistan. Therefore, this study recommends development of a career option and a tailor-made training course in family medicine. This would offer generalist skills to deliver treatment and preventative services necessary for the operation of the district hospitals and primary care services in the community. This combination of skills is consistent with recommendations of the World Health Organization for training health professionals into the 21st century (WHO 2005). Health professionals require five core competencies: patient-centred care, partnering (working with patients, health professionals and communities), quality improvement, information and communication technology, and public health perspective. This recommendation has important implications for medical

practice in Pakistan. Other studies (Ansari 2008:1; Biggs 2008:59) have also recommended a general practice career pathway in Pakistan; however, this will not be an easy task due to the devaluing of the term GP to indicate a junior doctor and its successful implementation will need a Pakistan-specific solution. This would improve career opportunities and would help in decreasing patient load on the overburdened tertiary care hospitals. It can also help in improving healthcare services in the rural and remote areas of the country. It is also hoped that it would provide some balance to the current fragmented and hi-tech specialised medicine in Pakistan.

5.5.4 Development and implementation of legal and regulatory reforms

Another important area that causes much job dissatisfaction among Pakistani doctors is the recent surge in personal insecurity and gradual societal degradation with its concomitant effects in medicine. It is hoped that the present deteriorated law and order situation will not remain too long and will subside within the coming years due to the successful military operations against the anti-government militants in the troubled regions of the country.

However, the lack of transparency in health governance and increasing corruption are worrying problems for the health sector in Pakistan. The magnitude of the problem can be gauged from an example by Ansari (2008:1), wherein he mentioned a large public sector hospital in Karachi where a Multidetector CT scanner and MRI scanner was not purchased because a suitable ‘percentage’ of kickback could not be worked out of the allocated sum. Therefore, building a professional environment that discourages unethical practices and profiteering and emphasises high quality practices would do a great deal to improve medical care in Pakistan. Laws governing hospital accreditation, setting practice standards, the credentialing of health professionals and their prescriptive practices need to be

regularised and enforced. Professional ethics and professional discipline in medicine needs urgent attention and determination at the highest level.

5.5.5 Improvement in postgraduate medical education

Another area of potential intervention that has far reaching implications for practice and requires special attention is the quality and salary structure of the postgraduate medical education programs in Pakistan, including the recognition of family medicine as a specialised discipline. There is a strong need for the development of quality control mechanisms to ensure that institutions offering postgraduate training are of a high standard. In addition, the salary structure for postgraduate trainees in Pakistan is poorly developed. Several training institutions offer an initial salary equivalent to US$110-180 per month (Syed et al. 2008:66). This amount hardly caters for the basic needs of the postgraduate trainees. It is argued that this low salary is also due to the fact that there are more medical graduates available for the limited training positions in Pakistan which forces some doctors to work in institutions without receiving any salary.

Similarly Avan et al. (2006) argue that there is a critical need to improve the work environment for postgraduate residents in Pakistan. This includes reforms for rationalising their work hours, strategies to increase senior faculty members' contribution to the teaching of residents and allying the perceived mistreatment of trainees at the hands of their mentors, colleagues, nurses and patients during their training.

Furthermore, with the international geopolitical changes, overseas avenues for postgraduate training especially in the UK and USA are decreasing (Pal 2007:276). This is due to the formation of the European Union (EU) which has resulted in decreased training

posts for non-EU doctors and increasing visa restrictions for Pakistanis to work in the USA and other developed countries after 9/11. This means that more doctors will try to obtain their postgraduate qualifications in the country. Therefore, attention needs to be paid to developing postgraduate medical education opportunities at home (Pal 2007:276). It is therefore high time that Pakistan starts to develop standardised and structured training systems with continuous assessment at the local level to meet the national needs (Shiwani 2007:473). The valuing of overseas training needs to be changed to a viewpoint of growing our own graduates for our own needs. A vertically integrated pipeline training model for rural areas, similar to the USA and Australia, needs to be modified to train GP proceduralists for rural areas in addition to the specialised training programs.

5.5.6 An Action plan for effective utilisation of overseas Pakistani physicians'

In Pakistan, the returning of physicians, although small in number, plays a critical role in boosting research and education in key institutions in the country (Talati & Pappas 2006:56). Therefore, to develop a local sustainable healthcare system, action is needed for the resettlement of overseas Pakistani doctors to their country or at least involving them in the development of the local health system. This will lead to knowledge translation to improve quality of care by bringing in new innovations if the system supports this change. As the results of this study and other literature show, physicians who left their countries for several reasons can resettle back and play an important role in developing scientific and technological opportunities at home (Dodani & LaPorte 2005:490). However, the main challenges are a decreased local capacity to absorb highly trained physicians (Shafqat & Zaidi 2007:442; Pal 2007:276), underpaid jobs, lack of a welcoming attitude, especially on the part of government, and facing resistance for medical innovations especially by their

senior colleagues. Any future policy initiative in this regard will have to solve these problems before achieving success.

Properly done, the resettlement of Pakistani physicians 'can help diminish vast disparities in health care' (Shafqat & Zaidi 2007:443). Aluwihare (2005:20), while commenting on prevention and amelioration of physician migration in the developing countries, suggested making physician resettlement easier by involving the private sector. One way could be the involvement of the private sector in establishment and management of health facilities especially in rural areas. This will create more job opportunities for doctors and other health workers and will also help in improving the provision of much needed health services in these areas. However, most importantly the government needs to develop strict oversight mechanisms to ensure access to these services by those who can least afford them, and also to maintain the quality of services provided by the private sector. It is further suggested that donor countries need to develop research infrastructure that will help in attracting physicians to these countries so that they can continue their academic careers. This is evidenced by the experience of Singapore, South Korea, Taiwan and which is now perhaps commencing in China and India (Aluwihare 2005:20).

5.5.7 Bilateral agreements

Another very important strategic option that the government needs to explore with the major recipient countries of Pakistani migrating physicians such as the UK and USA is the development of a bilateral agreement for developing professional training programs on the condition of return. It will help Pakistani health workers by increasing their earnings and also by getting trained by working for some years in an advanced healthcare system under supervision. On the other hand, the recipient country will get much needed healthcare

workers that will provide healthcare to their people. Therefore, such type of agreements could be beneficial for both Pakistan and the recipient country.

5.6 New directions for further research

This study has paved the way for further research into this important area of health human resources in Pakistan. As a result of the findings of this study, four recommendations for new research areas are proposed. The first important area of investigation would be to conduct a qualitative study to explore the perceptions of other important stakeholders on physician retention and migration issues in Pakistan, such as the Ministry of Health (MOH) and the provincial departments of health, the Pakistan Medical and Dental Council (PMDC), the College of Physicians and Surgeons Pakistan (CPSP) and the health consumers, as this study only focused on the views of the physicians. Such research would further help in developing evidence based health human resource policy and planning in Pakistan.

The second potential area of future research that would build on the findings of this study would be to conduct a study regarding the feasibility of establishing a general practitioner/family practitioner cadre for Pakistan. This study has revealed that in the absence of such a system there is an overwhelming trend towards specialisation of medicine and a specialty dominated system. The establishment of such a system would not only help in stemming the tide of migration for postgraduate medical education but it would also help in the provision of affordable and accessible healthcare to the people of Pakistan.

Third, a study that could also be conducted to build on the findings of this research would be an evaluation of the current postgraduate medical education programs offered both in the universities and the CPSP in Pakistan and the development of quality control mechanisms to ensure that institutions offering postgraduate training perform well. This present study has revealed that currently these programs are not structured and learning and training is the sole responsibility of the trainee alone with limited involvement from the trainers. Therefore, this proposed multi-methods research study could specifically look into the role of the trainer in postgraduate training.

Fourth, given the feminisation of Pakistani medical workforce, as revealed in this study, further research is needed to evaluate the effects of more female doctors on the availability health care services especially to women in rural areas. Furthermore, there is a greater need to understand gender related differences with respect to specialty preference, preference for location and hours of work and other characteristics of female doctors.

Finally, further research is needed to better understand the working of health labour market in Pakistan, the production of Pakistani health workers and improve their distribution and performance using econometric tools and methodology.

5.7 Conclusion

This chapter has identified and discussed the two major conclusions of this study. The results of the study have shown that the majority of Pakistani physicians would rather stay or resettle back to their country because of their strong sense of identity and belonging and the overall satisfaction and fulfilment that they receive in their country. However, the respondents identified certain systemic factors that compel them to go abroad and

discourage those who go abroad and want to return. These factors are a lack of government commitment to health and lack of viable health human resource policy and planning, a lack of quality postgraduate training and career structure, lower salaries, and the recent surge of personal insecurity and the gradual societal degradation with its negative reflections of corruption and professional misconduct in medicine.

Following a discussion of the major conclusions, implications for policy and practice were identified and discussed followed by new directions for further research in this area. After identifying the major issues and problems faced by physicians in Pakistan, this study recommended changes to policy and practice at both macro and micro levels. It is hoped that these changes will help in retaining and utilising this well trained and highly motivated health human resource to the benefits of the people of Pakistan.

A unique contribution of this study is that it has attempted to look holistically at physician retention, migration and resettlement issues using qualitative methodology. The factors that influence physicians to remain in their country and factors that compel them to go overseas or hinder their resettlement can now be further tested and refined using a larger and more representative sample of physicians in Pakistan as well as overseas. It is hoped that the findings of this study will help in the design of future health human resource reforms in Pakistan and other developing countries that have similar socioeconomic and health system conditions to Pakistan.

Finally, the results of this study show that in order to develop a sustainable healthcare system, Pakistan needs to invest in health and other social sectors as a priority. In addition, there is an urgent need for the development of an effective health human resource strategy

that provides for the right opportunities and support for its medical workforce especially in rural areas and those wishing to return back to their country. While health improvements in Pakistan will require a broad agenda of development activities, access to an educated and motivated workforce of health professionals is also critical for this purpose.

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Appendix 1: Pakistan Medical Association approval

24th July 2008

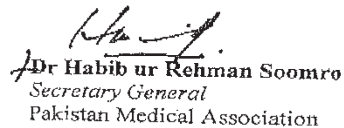
Muhammed Arif
Doctor of Health Services Management Program
School of Health
Faculty of Professionals
University of New England
Arimidal NSW 2351
Australia

Dear Mr. Arif

With reference to our initial communication, I wish to inform you that Pakistan Medical Association fully support the study you are doing titled 'An investigation of the reasons why Pakistani physicians decide to migrate abroad or remain in their country'.

In this regard PMA will help you in identification and recruitment of participation in this study.

Sincerely yours,



Dr Habib ur Rehman Soomro
Secretary General
Pakistan Medical Association

FROM : CYBER WAVES FAX NO. : 9221 5675953 Jul. 24 2008 05:21PM P3

Appendix 2: Association of Pakistani Doctors, Queensland, Australia approval

ASSOCIATION OF PAKISTANI DOCTORS ,QUEENSLAND
(APDOQ) - AUSTRALIA

Muhammad Arif
Student
Doctor of Health Services Management Program
School of Health
Faculty of the Professions
University of New England
Armidale NSW 2351.

Dear Dr. Arif,

I am pleased to inform you that Association of Pakistani Doctors of Queensland (APDOQ) – Australia supports your study titled

'To migrate abroad or remain: A study of Pakistani physician's decision-making'.

Furthermore, APDOQ will also help you in identification and recruitment of study participants for this study.

Best regards,

Dr. Muhammad Arshad Hussain
President APDOQ
46 Staghorn Parade
North Lakes Qld 4509

Phone: (07) 32048899
Mobile: 0402805549

Appendix 3: Interview schedule for stayers

(Pakistani physicians who have obtained their primary medical qualification in Pakistan, never migrated to another country and are now working and living in Pakistan)

Introduction by interviewer
I am Dr Muhammad Arif and I am conducting this study as part of my Doctor of Health Services Management degree at the University of New England, Armidale, NSW, Australia. The purpose of this study is to explore the perceptions of Pakistani physicians' regarding their career decisions to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. It is hoped that what is learned from this study will contribute to knowledge and will also help in better informing future health human resource policy and planning in Pakistan.

With your permission this interview would be tape recorded so that I can ensure that I make an accurate record of what you say. A summary of the transcript will be provided to you so that you can verify that the information is correct. I estimate that the time commitment required of you as for the interview and reading the transcript summary would not exceed three hours.

The information that you provide will be de-identified and will be kept in a locked filing cabinet for five years following thesis submission and then destroyed. Your participation is completely voluntary. You will be free to withdraw at any stage throughout the process without penalty or prejudice.

Q1. Could you please tell me something about your background?
Prompt:
- Why did you choose to do medicine?

Q2. Could you please tell me about your medical career following your graduation?
Prompts:
- How long did you work in Pakistan?
- What is your opinion about your experience of working in Pakistan?

Q3. In your opinion what were the reasons for staying in Pakistan?
Prompts:
- What was the deciding factor that made you stay in Pakistan?
- Had you ever considered leaving Pakistan?

Q4. What would be your advice to medical graduates today regarding working/migrating to another country?

Q5. Is there any other issue that you would like to raise?

Appendix 4: Interview schedule for leavers

(*Pakistani physicians who have obtained their primary medical qualification in Pakistan and now are working and living in Australia)*

Introduction by interviewer
I am Dr Muhammad Arif and I am conducting this study as part of my Doctor of Health Services Management degree at the University of New England, Armidale, NSW, Australia. The purpose of this study is to explore the perceptions of Pakistani physicians' regarding their career decisions to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. It is hoped that what is learned from this study will contribute to knowledge and will also help in better informing future health human resource policy and planning in Pakistan.

With your permission this interview would be tape recorded so that I can ensure that I make an accurate record of what you say. A summary of the transcript will be provided to you so that you can verify that the information is correct. I estimate that the time commitment required of you as for the interview and reading the transcript summary would not exceed three hours.

The information that you provide will be de-identified and will be kept in a locked filing cabinet for five years following thesis submission and then destroyed. Your participation is completely voluntary. You will be free to withdraw at any stage throughout the process without any penalty or prejudice.

Q1. Could you please tell me something about your background?
Prompt:

- Why did you choose to do medicine?

Q2. Could you please tell me about your medical career following your graduation?
Prompts:

- How long did you work in Pakistan?
- Where did you relocate to Australia?
- How long have you been in Australia?
- What is your opinion about your experience of working in Pakistan?
- What is your opinion about your experience of working in Australia?
- Why you did specifically came to Australia?

Q3. In your opinion what were the reasons for leaving Pakistan?
Prompt:

- What was the main reason that made you leave Pakistan?

Q4. What would be your advice to medical graduates today regarding working/migrating to another country?

Appendix 5: Interview schedule for resettlers

(Pakistani physicians who have obtained their primary medical qualification in Pakistan first migrated to another country and are now again working and living in Pakistan)

Introduction by interviewer
I am Dr Muhammad Arif and I am conducting this study as part of my Doctor of Health Services Management degree at the University of New England, Armidale, NSW, Australia. The purpose of this study is to explore the perceptions of Pakistani physicians' regarding their career decisions to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. It is hoped that what is learned from this study will contribute to knowledge and will also help in better informing future health human resource policy and planning in Pakistan.

With your permission this interview would be tape recorded so that I can ensure that I make an accurate record of what you say. A summary of the transcript will be provided to you so that you can verify that the information is correct. I estimate that the time commitment required of you as for the interview and reading the transcript summary would not exceed three hours.

The information that you provide will be de-identified and will be kept in a locked filing cabinet for five years following thesis submission and then destroyed. Your participation is completely voluntary. You will be free to withdraw at any stage throughout the process without penalty or prejudice.

Q1. Could you please tell me something about your background?
Prompt:

- Why did you choose to do medicine?

Q2. Could you please tell me about your medical career following your graduation?
Prompts:

- How long did you work in Pakistan?
- Where did you relocate to your country of migration?
- How long did you work in your country of migration?
- How long have you been in Pakistan?
- What is your opinion about your experience of working in Pakistan before leaving?
- What is your opinion about your experience of working in your country of migration?
- What is your opinion about your experience of working in Pakistan after re-settling?

Q3. In your opinion what were the reasons for leaving Pakistan?
Prompt:

- What was the main reason that made you leave Pakistan?

Q4. In your opinion what were the reasons for going back to Pakistan?
Prompt:

- What was the main reason that made you to go back to Pakistan?

Q5. What would be your advice to medical graduates today regarding working/migrating to another country?

Q6. Is there any other issue that you would like to raise?

Appendix 6: Information sheet for study participants

School of Rural Medicine
A Partner of the Joint Medical Program

University of New England
Armidale NSW 2351
Australia
Phone 61 2 6773 3322
Fax 61 2 6773 2388
ruralmed@une.edu.au
www.une.edu.au/ruralmed/

Research project: To remain, migrate abroad or resettle: A study of Pakistani physicians' career decisions.

I wish to invite you to participate in my research on the above topic. The details of the study follow and I hope you will consider being involved. I am conducting this research project for my Doctor of Health Services Management (DHSM) degree at the University of New England. My supervisors are Professor John Fraser at the University of New England and Professor Mary Cruickshank at Charles Darwin University. Professor John Fraser can be contacted by email at jfrase22@une.edu.au or by phone on (+61) 02 6773 2751 and Professor Mary Cruickshank can be contacted by email at Mary.Cruickshank@cdu.edu.au or by phone on (+61) 08 8946 6246. I can be contacted by email marif2@une.edu.au or by phone on (+61) 02 6773 3590.

Purpose of the study

The purpose of the study is to explore the perceptions of Pakistani physicians' regarding their career decisions to remain in their country, migrate abroad or resettle back into their country after working abroad for some time. This will be an in-depth analysis of the reasons why some Pakistani physicians decide to migrate abroad from the perspective of those Pakistani physicians who have migrated and working in Australia and the reasons why some Pakistani physicians decide to stay in their country from the perspective of those physicians who are working in Pakistan. It is hoped that what is learned from this study will contribute to knowledge and will also help in better informing future health human resource policy and planning in Pakistan.

Time requirements

A telephone interview lasting approximately 60 minutes (at my expense) that will be audio taped.

Methodology

The study will be qualitative in nature consisting of interviews. The interview will last for approximately 60 minutes. There will be a series of open-ended questions that allows you to explore your views and experiences about your decision to either migrate abroad or remain in your country. Following the interview, the transcript of the interview will be provided to you if you wish to read it. Participation is completely voluntary. You will be free to withdraw at any time throughout the process without penalty or prejudice.

It is unlikely that this research will raise any personal or upsetting issues but if it does you may wish to contact your family doctor or Lifeline Australia on 13 11 14 for free counselling service if you are in Australia.

According to the Australian Government, National Health and Medical Research Council (NHMRC) guidelines, the audiotapes and the transcripts will be kept in a locked cabinet in the researcher's office for five years following thesis submission and then destroyed.

Research process

It is anticipated that this research will be completed by the end of July 2010. The results may be presented at conferences and written up in journals without any identifying information.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE08/120, Valid to 21/08/2009).

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following Address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (+61) 02 6773 3449 Facsimile (+61) 02 6773 3543
Email: ethics@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Best regards,

Dr Muhammad Arif

School of Rural Medicine

Appendix 7: Participant's demographic data sheet for stayers

(Pakistani physicians who have obtained their primary medical qualification in Pakistan, never migrated to another country and are now working and living in Pakistan)

Informant code………….

Research project: To remain, migrate abroad or resettle: A study of Pakistani physicians' career decisions.

1. Gender: □ Male □ Female

2. Age in years: □ < 35 □ 35 – 39 □ 40 – 44 □ 45 – 49

□ 50 – 54 □ 55 – 59 □ 60+

3. Place: ……………………. □ Urban □ Rural

4. Marital status: □ Single □ Married

5. No. of Children: …………………………….

6. What is your completed medical qualification including degree/ diploma/ certificate/ other? (Please write full name of the qualification obtained).

No.	Qualification	Country	Year

7. How would you describe your current position?

□ General practitioner (GP) □ Specialist (Specify) ………………………………….

□ Other (Specify)…………………………………..

8. Have you ever worked as a physician in a country other than Pakistan?

□ No □ Yes (name) ……………………....... □ Duration ……………

9. What is your current mode of medical practice?

□ Public only □ Private only □ Public & private

Thank you for your participation in this study

Dr Muhammad Arif
UNE

Appendix 8: Participant's demographic data sheet for leavers

(Pakistani physicians who have obtained their primary medical qualification in Pakistan and now are working and livingin Australia)

Informant code………….

Research project: To remain, migrate abroad or resettle: A study of Pakistani physicians' career decisions.

1. Gender: ◻ Male ◻ Female

2. Age in years: ◻ < 35 ◻ 35 – 39 ◻ 40 – 44 ◻ 45 – 49

◻ 50 – 54 ◻ 55 – 59 ◻ 60+

3. Post code: ……………..

4. Marital status: ◻ Single ◻ Married

5. No. of Children …………………………….

6. What is your completed medical qualification including degree/ diploma/ certificate/ other? (Please write full name of the qualification obtained).

No.	Qualification	Country	Year

7. How would you describe your current position?

□ General practitioner (GP) □ Specialist (Specify) ………………………………….

□ Other (Specify)…………………………………

8. Have you ever worked as a physician in a country other than Pakistan?

□ No □ Yes (name) …………………....... □ Duration ……………

9. What is your current mode of medical practice?

□ Public only □ Private only □ Public & private both

Thank you for your participation in this study

Dr Muhammad Arif
UNE

Appendix 9: Participant's demographic data sheet for resettlers

(Pakistani physicians who have obtained their primary medical qualification in Pakistan first migrated to another country and are now again working and living in Pakistan)

Informant code…………

Research project: To remain, migrate abroad or resettle: A study of Pakistani physicians' career decisions.

1. Gender: □ Male □ Female

2. Age in years: □ < 35 □ 35 – 39 □ 40 – 44 □ 45 – 49

□ 50 – 54 □ 55 – 59 □ 60+

3. Place: ……………………. □ Urban □ Rural

4. Marital status: □ Single □ Married

5. No. of Children: …………………………….

6. What is your completed medical qualification including degree/ diploma/ certificate/ other? (Please write full name of the qualification obtained).

No.	Qualification	Country	Year

7. How would you describe your current position?

□ General practitioner (GP) □ Specialist (Specify) ………………………………….

□ Other (Specify)…………………………………..

8. Have you ever worked as a physician in a country other than Pakistan?

□ No □ Yes (name) ……………………....... □ Duration ……………

9. What is your current mode of medical practice?

□ Public only □ Private only □ Public & private

Thank you for your participation in this study

Dr Muhammad Arif
UNE

Appendix 10: Consent form for study participants

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University of New England
Armidale NSW 2351
Australia
Phone 61 2 6773 3322
Fax 61 2 6773 2388
ruralmed@une.edu.au
www.une.edu.au/ruralmed/

I, ……………………………………………, have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction. Yes/No

I agree to participate in this activity, realizing that I may withdraw at any time. Yes/No

I agree that research data gathered for the study may be published using a pseudonym.
Yes/No

I agree to the interview being audiotape recorded and transcribed.
Yes/No

……………………………….. ……………………………
Participant Date

……………………………….. ……………………………
Researcher Date

Appendix 11: UNE Human research ethics committee approval

Ethics Office, Research Services
Armidale, NSW 2351, Australia
Telephone: 02 6773 3449
Facsimile: 02 6773 3543
http://www.une.edu.au/research-services\ethics
E-mail: jo-ann.sozou@une.edu.au

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: A/Prof M Cruickshank, Prof J Fraser & Dr M Arif
School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE:	To migrate abroad or remain: A study of Pakistani physician's decision-making.
COMMENCEMENT DATE:	21/08/2008
COMMITTEE APPROVAL No.:	HE08/120
APPROVAL VALID TO:	21/08/2009
COMMENTS:	Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.
For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address: http://www.une.edu.au/research-services/forms/hrecfinalreport.doc

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.

Jo Sozou

21/08/2008

Jo-Ann Sozou
Secretary