Wemos Briefing Paper

Health workers on the move

Migration of health workers

The human resources for health (HRH) crisis is clearly reflected in a shortage of health workers in developed countries, especially in rural and poor areas. HRH shortages is one of the factors impeding the achievement of the Millennium Development Goals.

57 countries have been defined by the World Health Organization (WHO) as having a HRH crisis. Majority of these countries are located in sub-Saharan African, but some also in Asia, Latin America, the middle-East and the Pacific region. These countries have considerable internal migration of health workers from rural to urban areas and from the public to the private sector.[i]

A major threat for the sustainability of the health systems of these countries are the internal 'push'-factors that cause the emigration of its health workforce to more developed 'destination' countries. Although the relation between international migration and health worker shortages in low- and middle-income countries is complex, undoubtedly 'pull'-factors from richer countries facilitate the flow of health workers originating from developing countries and hence aggravates the shortage in these countries. Figures from the Organisation for Economic Co-operation and Development (OECD) are showing us that 23% of the doctors trained in sub-Saharan Africa are currently working in a number of OECD countries. In order to address these 'push'-factors in developing countries and limit the 'pull'-factors' in the West, there is a shared and global responsibility that requires joint action by a wide range of actors. This briefing paper presents several strategies to jointly work on.

Right to Health

International migration of health workers impinges upon the Universal Right to Health – as people in the 'source' countries are being deprived of access to health services. Migration however, also touches upon the freedom of individual movement. The right to health implies the obligation of states to respect, protect and fulfil access to health care for its citizens. At the same time there is the moral obligation by states to respect the integrity of the health system of other states, arguably even to provide financial and technical assistance to states in HRH crisis to strengthen an equitable and accessible health system with a skilled workforce. [ii] [iii]

The origins and scope of international migration of health workers

Improving socio-economic and career opportunities for individuals and their families are the major driving force for health workers' migration. Lack of those opportunities in the country of origin may drive health workers to migrate to developed 'destination' countries, that may offer them better opportunities and working conditions. The South-Eastern African civil society and research network *Equinet* describes the flow of health personnel as a 'conveyor-belt' of health personnel: illustrating the movement of health workers from rural to urban areas, from the public to the private sector, and from developing countries to the West. Migration of health workers from the 'source' country to a 'destination' country is generally the result of a variety of factors from within and outside the health system.

Conditions stimulating health workers to leave the public health system ('push'-factors), include low remunerations, unfavourable work environment (including safety at work), inadequate human resource planning resulting in high work load, poor infrastructure in health facilities, political and security environment of the area. The attractive situation in most 'destination' countries triggers the international movement of health workers even further. These so-called 'pull'-factors include among others, opportunities to study or specialise, active recruitment of foreign health personnel, improved living and working conditions.

Globally, the absolute number of migrants has more than doubled since 1960, though as a percentage of the world population the figure remained constant (between 2,5% and 3%). A vast majority of the migrants stay within the region, though the South-North migration has increased.[iv] Since the smallest, low-income countries tend to have the fewest skilled workers and weakest higher education systems, the overall pattern in the world is that skilled workers are departing precisely those places where they are scarcest.[v] According to figures from the The Global Health Workforce Alliance (GHWA) , African-born doctors and nurses migrated to more developed countries account for about 12% of the total estimated shortages in Africa. Data from OECD indicate that doctors and nurses trained abroad comprise a significant percentage of the total workforce in United States, United Kingdom, Germany, Canada, France and Australia.[vi] In the United States 1 out of 4 doctors was trained abroad. There is a huge disparity in health workforce between 'source' and

'destination' countries. Africa counts with 24% of the global disease burden, while it has only 3% of the global number of health workers.

The GHWA states that besides migration an important concern is that "*the massive shortfall in the production of health workers, at all levels, underpins every other problem. Doctors, nurses, midwives and other health workers are crucial to a functioning health system, but their training needs to be combined with improvements in working conditions and opportunities for professional development, as well as incentive packages and higher salaries to improve their retention*".[vii] Even if doctors and nurses are not leaving the country for greener pastures, countries in a human resource for health crisis could still experience health personnel shortages, because not enough health workers are trained, or the country does not have sufficient public space to cover the wage bill.

The complexity of global health workforce mobility requires us to establish manageable solutions to global shortages by finding strategies that simultaneously address 'push'-factors in developing countries and limit 'pull'-factors in the West. There is a responsibility for all actors in health.

This briefing paper presents several strategies that are divided into action to be undertaken THERE, meaning in developing countries with a HRH crisis, and HERE, referring to options for action in 'destination' countries.

Strategies for actions THERE to control 'push'-factors

Countries facing high migration of nurses and physicians are challenged to address the root causes of sustained understaffing of the health services. Below presented strategies may inspire policy makers, parliamentarians, civil society, labour unions, professional associations and international donors to adopt solutions that restrict 'push'-factors in countries with the highest HRH shortages.

Strategy to control 'push'-factors 1: Assist countries improving HRH via technical and sector support

The *EU Strategy for Action to tackle the critical shortage of health workers in developing countries*[viii] formulates action oriented decisions, health policy discussions and supporting and financing national human resources plans.[ix] The Strategy further emphasizes the importance of country leadership.

It urges the EU Member States to provide technical support to strengthen health workforce capacity through bilateral and multilateral programmes based on national workforce plans. It specifically calls for greater coordination and effective engagement of all the key actors at the country-level, including the private sector and civil society. In light of this, development partners should increase their support to the development of national strategies and policies in the South to increase the capacity, performance, research and career opportunities of the health workforce. An example is the retention scheme in Zambia where the Dutch government has played a role in the policy development towards retaining Zambian doctors for the health sector and prevent further brain drain. The initiative was effective with about 75 doctors becoming available for remote areas. It indicated the need to scale-up the health workforce as a whole because targeting specific professions could potentially destabilize the workforce.[x] More bilateral support from donor countries is required to improve the HRH situation in countries with a shortage.

Opportunity to control 'push'-factors 2: Increase funding base for HRH

The Africa Health Strategy 2007-2015[xi] sets out the financial requirements for health system strengthening, including HRH. It calls upon countries to steadily increase their budget allocation for health to at least the 15% of GNI target set by Heads of State. Some countries have increased their health expenditure, and development partners have increased their development aid for health beyond US$10 billion per annum.[xii] However, health funding in most countries remains below what is required to achieve a functional basic health system, even if resources available were optimally used. Only two out of the 53 African countries have met the Abuja 2001 target of 15% of total government expenditure to be allocated to health.[xiii] The African Health Strategy further urges development partners to match the commitments they made in international forums, with longer cycles of predictable, dependable and harmonised aid. European donors pledged to have 0.7% of GNI income allocated to operational development assistance by 2015, this would allow them to allocate 0.1% of GNI to health. This percentage is recommended by the WHO commission on Macro-Economics and health as to achieve the health related MDGs, a target most donor countries are far from attaining.[xiv] Global health initiatives should be encouraged to integrate with national health systems and to fund the core health system and human resources requirements needed for their programmes. At country and global level the importance of long-term predictable financing to address the health workforce crisis must be respected as it is urgently required to scale up the MDG-progress. This must include international commitments on macro-economic constraints to create fiscal space for public sector investment. The wage bill must provide opportunities to absorb a growing national workforce that is fairly remunerated.[xv]

Strategies to control 'push'-factors 3: Discours on Health System Strengthening interventions

In the aftermath of the World Health Report 2006, which alerted the world to a shortfall of more than 4.3 million trained health workers globally, many international initiatives came to live. The GHWA was created as a platform for action to address the HRH crisis. In its Kampala declaration and Agenda for Global Action [xvi] it describes strategies to scale up health workers education and training while at the same time retaining these health workers in a equitable distribution for its citizens. In its report *Scaling Up, Saving Lives* [xvii] evidence is presented on how countries with the highest shortfalls are developing national responses to the crisis. The tone of the Kampala declaration is positive, yet it stresses the need for concerted action of all partners. It further recognises explicitly the need to address migration, internationally by managing its impact, and nationally with interventions to strengthen health systems aiming to reduce 'push'-factors which lead health workers to migrate.
A good practice for instance is seen in Ethiopia, where a plan to train 30.000 health extension workers was financed to provide basic services to population that have limited access to health services. Similar promising practices are also seen in other countries. [xviii] With increased awareness on the importance of health system strengthening, some global health initiatives, like GAVI and GFATM, have initiated an attempt to provide more financial assistance for HRH within their programmes. This needs to be further elaborated by incorporating relevant HRH components to any initiative or funding proposal. [xix]

Strategies for actions HERE to control 'pull'-factors

The movement of better educated / skilled health workers from developing countries to wealthier countries is a reality in a globalising world and within a global labour market. The phenomenon is not new and will not cease. However, in light of the negative consequences of migration (domestic and international) on the global HRH crisis, 'destination' countries have, based on the Right to Health, the moral obligation to manage migration in an ethical and balanced manner, seeking for solutions that are never detrimental to the health system in the 'source' countries. Below presented options address actions to limit the exodus of health workers from developing countries.

Strategy to control 'pull'-factors 1: Develop and endorse coherent European and national codes of practice on the international recruitment of health personnel

The WHO is currently drafting a global code of practice [xx] that should have as a guiding principle that its Member States have the obligation to respect the right to health of other countries and should prevent third parties to violate the integrity of health systems in other countries. This code is currently being discussed in the different WHO regions. Civil society is opting for the code to have at its basis that 'destination' countries refrain from active recruitment in countries that suffer from a HRH crisis. It is expected that the code will be endorsed in 2010 and this will provide guidance to develop national and regional codes (e.g a European code as was announced already in the EU Strategy for Action). Measuring the actual impact of a national code of conduct in the United Kingdom was constrained by limitations in available databases. This demonstrates that explicit objectives of the code must be linked to relevant monitoring capacity. [xxi] The development of a Dutch Code was recently promised by Minister Klink. In addition to current instruments, the Code should explicitly refer to curtail recruitment from countries with staff shortages.

Strategy to control 'pull'-factors 2: Aiming for self-sufficiency in 'destination' countries

European countries also face HRH shortages in situations where the development of the health workforce has not kept pace with the aging of the population and changing healthcare needs. Tackling the HRH crisis in the developed world requires responsibility by the authorities to plan, train, retain and sustain its own health workforce. This means that they do not rely on migration from developing countries even when it may appear a quick solution for an acute shortage. The training costs are born by the 'source' country which makes it unethical to actively approach such health workers to move abroad.
The labour market letter *Working on Care* adopted by the Dutch Ministry of Health, Social Welfare and Sports, impedes health care employers to rely on health workers from outside the European Union. The national health workforce policy of the Netherlands Ministry of Health is based on three pillars: innovation, investing in the preservation of health workers, and increase the influx of new cadres of health workers. [xxii] The model may serve as an example of how new technologies and innovation in the health sector effectively can work towards a creating and maintaining a 'healthy' health workforce.

Strategy to control 'pull'-factors 3: 'Mutuality of responsibilities': Develop innovative compensation mechanisms

As part of the international code of practice on international recruitment, it is recommended to define more precisely compensation mechanisms that 'destination' countries can agree upon with 'source' countries. This should at first contribute to assistance to allow for reduction in the 'push'-factors in the 'source' countries itself. Not only training, but also working conditions for health staff, benefits, salaries, human resources management and career perspectives/ opportunities must be strengthened. It must be jointly designed by and agreed upon by a wide range of actors in 'source' and 'receiving' countries (including civil society organisations). In regard to the 'pull'-factors some programs have been developed to circulate knowledge and capacities of migrants to its country of origins. In 2005 the International

Organization for Migration (IOM) started the Migration for Development in Africa (MIDA) Ghana Health Project. The objective of the project is to contribute to the development of the health sector in Ghana. This is realised by mobilising compentences acquired by African nationals abroad for the benefit of Africa's development. In this case, Ghanaian and other African migrants living and working in Europe are encouraged to transfer knowledge, skills and experience through temporary assignments in Ghana. Also the project foresees in the possibility for Ghanaians to come for professional training to the Netherlands or the United Kingdom. The third phase (as of 2008) specifically intends to strengthen Human Resource Development in the health sector.[xxiii] Such initiative may provide capacity to the health system of a country of origen in the mid-term prospect.

For the long-term effect however more comprehensive approaches have to be designed to address 'push'- and 'pull'- factors at the same time. Policies in 'source' countries can make provisions for publicly-trained graduates who wish to work abroad to financially compensate the state for their education ex post. What is required is a vision of expanding options for international movement while creating mechanisms so that those choices need not drain public funds. 'Destination' countries can take their share and contribute to develop such mechanisms of compensation.[xxiv] Detailed monitoring and research of current (and future) trends, policies and factors that influence health worker migration are mandatory in this. We see a role for actors for 'destination' countries to undertake action and provide support.

Wemos contributes to the structural improvement of people's health in developing countries through advocacy. Wemos believes investing in health system strengthening, including human resources for health, deserves a high priority in Dutch development cooperation.

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iii N. Pillay. *Right to health and the Universal Declaration of Human Rights.* Lancet. Vol.237. Dec.13, 2008. p.2005-6
iv Netherlands Ministry of Justice and Ministry of MFA/Development Cooperation (2008). *International Migration and Development.* Policy Paper (in Dutch)
v Skill flow; a fundamental reconsideration of skilled-worker mobility and development, Michael A. Clemens, Center for Global Development, August 2009
vi Source: WHR2006, p.98 table 5.1
vii WHO/GHWA (2008). Scaling Up, Saving Lives. Report of the Task Force for Scaling up Education and Training for Health Workers
viii European Commission (December 2005). A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013). COM (2005) 642 Endorsed in May 2007
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x Mwale HF, Smith S (2008) *Human Resources Retention Scheme: Qualitative and Quantitative Experience from Zambia.* Health Services and Systems Program, Global Health Workforce Alliance. Presentation at first forum on human resources for health in Kampala march 2008
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xii Ibid
xiii Ibid
xiv Action For Global Health (2008) *Innovative Financing Mechanisms- Lessons learn from the Health sector.* Position paper 02
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xxiii For more information see: http://www.iom-nederland.nl/
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