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HEALTH WORKER MIGRATION

The Escape Route

IRIN

What are the push and pull factors behind health worker migration, and what countries are doing to address them.

The global shortage of health workers is estimated at 4.2 million by the World Health Organization (WHO), but the migration of doctors, nurses, midwives and pharmacists from poor to rich countries means the shortfall is not evenly distributed—of the 57 nations identified as having reached a crisis point, 36 are in sub-Saharan Africa.

In some countries with fragile health systems and heavy disease burdens, over half of all highly trained health workers have left for job opportunities abroad. In some of the worst cases rural hospitals have been left with just one doctor and a handful of nurses to attend to thousands of patients.

When the extent of the health worker crisis became apparent around five years ago, the international community and WHO responded by setting up the Global Health Workforce Alliance (GHWA), which has since convened two Global Forums on Human Resources for Health, the first in Kampala in 2008 and the second earlier this year in Bangkok.

The Bangkok meeting reviewed progress in 51 of the worst affected countries and found that 44 now had a Human Resources for Health plan, although only 29 had started implementing them.

In 2010 WHO released a Global Code of Practice on the International Recruitment of Health Personnel which discourages member states from actively recruiting health workers in developing countries facing critical personnel shortages.

The Code was adopted by the World Health Assembly in May 2010, but implementation is voluntary and will depend on developing or "source" countries addressing some of the factors that cause health workers to migrate, and developed or "destination" countries finding ways to reduce their dependence on migrant health workers.

"There have been some success stories," said Dr George Pariyo of the GHWA. "Ghana, Rwanda, Ethiopia and Malawi have all implemented wide-ranging programmes to increase their numbers of health workers."

The issue is now firmly on the international development agenda and donor countries, which are also often destination countries, have expressed a willingness to support initiatives aimed at mitigating the crisis.

MORE MONEY HELPS

Skilled professionals whose salaries are so low that they have to struggle to make ends meet will obviously look for better paying opportunities elsewhere, either in the private or NGO sectors, or overseas.

The first strategy of countries experiencing an exodus of public health workers is usually to offer financial incentives, either in the form of general salary increases or targeted inducements for badly needed designations of health workers or to work in under-served rural areas. However, for cash-strapped governments, the scale and duration of these incentives often depends on the amount of donor support available.

Between 2004 and 2010, Malawi received significant support from the UK Department for International Development (DFID) to implement an Emergency Human Resource Programme that included a 52% salary top-up for all health workers and additional incentives for those working in rural areas.

Martha Kwataine of the Malawi Health Equity Network described it as a "stop gap measure" designed to retain current staff while training institutions worked towards doubling their output of new graduates. The programme has succeeded in significantly slowing the number of doctors and nurses leaving the country (only 16 nurses left the country in 2009 compared to 108 in 2003), but now that its first phase has ended and DFID has announced that it will not be renewing aid to Malawi, Kwataine fears that momentum may be lost and any downward adjustment of health worker salaries will bring a new wave of migration.

A recent analysis of financial incentives as a strategy tor retaining health workers in South Africa, Tanzania and Malawi by the Centre for Health Policy and Management at Trinity College. Dublin, found that they often have unforeseen consequences, such as friction among colleagues receiving different levels of incentives. The researchers concluded that "great care... is needed when designing, communicating and implementing incentive packages".

MONEY ISN'T EVERYTHING

More money is not usually enough to keep an overworked, under-supported nurse in a rural clinic where she lacks the essential drugs and equipment to do her job properly, there are no good schools to send her children, and no opportunities for further training or career advancement.

"One of the biggest de-motivators - if you're trained to provide care and save lives—is to find yourself in a remote, under-resourced location and your hands are tied by a lack of equipment, personnel and drugs," said Pariyo of the GHWA.

In South Africa there are about 67 doctors per 100,000 people, but only 22 of those work in the public sector and a mere 5 are in rural public health facilities, despite the introduction of special allowances for health professionals working in rural areas.

Building better staff housing, ensuring health facilities have a reliable supply of drugs and equipment, and giving staff equal access to further training and education opportunities are some of the strategies that countries are using to improve the working conditions in rural areas and make these posts more attractive.

ADDRESSING PULL FACTORS

Medical training institutions in high-income countries have not kept up with the increased demand for health workers generated by ageing populations and the rise of chronic illnesses like diabetes and heart disease. Pariyo pointed out that it has been proven to be cheaper and easier to recruit "ready-made" health workers from other countries. The WHO Code of Practice urges member states to meet their health personnel needs by producing more of their own health workers.

Norway has committed to pursuing a policy of self-sufficiency for its health worker needs, and to contribute to the strengthening of health systems in low-income countries. The UK has a bilateral arrangement with South Africa not to recruit its health workers unethically, and to transfer skills through short-term placements of its own health workers at certain South African hospitals and medical schools.

An NGO initiative in South Africa is also attempting to reverse the brain drain by recruiting skilled health workers from the UK to work in the country's under-staffed rural hospitals. Since its inception five years ago, Africa Health Placements has recruited over 2,000 British doctors eager to experience a different continent and treat diseases they would never see at home.

Most of the placements only last between one and three years, but according to communications officer Jeanette Strydom, fully staffing a hospital with a dynamic team often has a snowball effect. "'More patients will go there and local doctors start applying for positions, so by the time they leave there are replacements."

Some commentators have described the active recruitment of health workers from African countries by Western corporations and recruitment agencies as a violation of the rights of African people to health care.

Others have pointed out that the Global Code of Practice, as well as other interventions designed to reduce health personnel migration, infringe on the right of health workers to leave their countries like any other workers in search of a better life.

Pariyo insisted that the Code merely lays out some principles for recruiting health personnel in a more ethical way. "while respecting the right of people to migrate".

But Kwataine described it as a potential abuse of human rights. "Why should we make agreements just for health workers?" she said. "As human beings, they have a right to seek employment wherever they want." □□□

—Third World Network Features