Editorial: Multi-sectoral Approaches to Migration of Health Professionals

Background

The World Health Organisation prioritises health care workers as the "cornerstone of health care delivery systems", and further categorises a well performing health workforce as one of the six building blocks for an effective health system (WHO, 2000).

Whilst migration of health professionals is not a new phenomenon, it has increased significantly, and has continued to do so at an increased rate since the early 1990s. In the 1970s, approximately 6% of the world's physicians and 4% of the world's nurses were working outside of their country of origin, with the majority working in the UK, USA, Germany, Canada and Australia (Smith et al, 2009). Current estimates suggest that in the UK, 50% of foreign nurses are from India and the Philippines. In the USA, 80% are from the Philippines, India, Latin America and the Caribbean (Smith et al, 2009).

Migration today has become problematic because the out-migration of health professionals is to such a degree that the source countries are experiencing a significant loss in their national stock of skills, thus impacting on their capability to provide an effective health service. The WHO estimates that there are critical shortages of health professionals in 57 countries (WHO, 2006).

Expectedly, these shortages are distributed inequitably: Africa has 25% of the world's disease burden, yet it has only 1.3% of health service providers (WHO, 2006). Developing countries in African and Asian countries are suffering the most from such out-migration of health professionals; this has manifested itself in alarmingly low ratios of staff to population (Buchan, 2010).

Push and pull factors influencing migration of health professionals

Whilst deciding to migrate is essentially a personal decision, there are common patterns that enable understanding of the broader issues around the push and pull factors influencing migration. Structural causes at local, nation, regional, and international level also play a role in influencing the migration of health professionals.

Increased globalisation in the form of new and increased access to communication technologies as well as increased access to international travel means that not only are people able to travel more, and more easily but they also have more access to the global labour market.

For health professionals, the lure of higher salaries, perceived increased chances of vertical social mobility, better management and governance structures and better standards of living are all common pull factors in the decision to migrate to a high income country. Additionally, existing networks of migrant communities in the recipient country facilitate not just the migration of an individual to that particular country, but also the integration process upon arrival. Often, these factors are mirrored by push factors in the source country, where health care professionals become frustrated with poor governance and management structures, lack of opportunity, poor salaries etc. Waves of migration are also commonly associated with war and social unrest; significant numbers of health care professionals migrate to developed countries through the asylum process.

Systematic attempts to influence migration from developing countries to developed countries, such as the UK and USA, have played a significant role in increasing migration. Developed countries have used recruitment agencies to actively recruit from developing countries due to their own domestic shortfalls in health care workers. According to the NHS, the cost of training a doctor is between £200,000 to £250,000. Economically, then, it is easy to understand the drive for recruitment of foreign trained professionals.

Impacts of migration

The targeted recruitment of health care professionals by developed countries has amplified the situation in developing countries, whose health systems are experiencing rather more severe human resource shortages. Additionally, developing countries often have weaker health systems, which makes it more difficult for them to overcome losses in human resources.

The impacts of migration are manifesting in diverse forms in different countries. Few countries, such as the Philippines and India, have been able to benefit from this, because their health systems are established enough to absorb the human resource loss. To give an example of this, more than 50% of new nurse registrants in the UK were from India, but this represented just 0.21% of India's total nursing stock (Hawkes et al, 2009). Other countries have not been able to manage the situation as well, such as Guinea Bissau and Ghana, who each have approximately 30% of their health workforce working overseas (Smith et al 2009)

The deficit of health care professionals is having detrimental effects on health systems of developing countries, where often the workforce is unable to provide an effective service delivery of health care. Major concern has been expressed around the achievement of the Millennium Development Goals (MDGs), and the effect migration is having on their attainment, particularly in Sub Saharan Africa.

Current strategies addressing international recruitment of health care professionals

Some countries, such as the Philippines have been able to capitalise on this global trend and are training up to 15000 nurses annually for export (Smith et al, 2009). Remittances from health professionals who have migrated to developed countries is commonly stated as one of the benefits of migration (Smith et al, 2009). In the 1990s, the global monetary input derived from remittances was more than official development aid (Connell, 2008).

There is a significant amount of non binding documentation focussed on out-migration of health professionals from developing to high income countries. The last decade has seen the formulation of various national and regional policies, codes and agreements related to international recruitment of health care professionals. Table 1 below summarises some of the international codes and policies that are currently used in the international recruitment of health care workers.

Table 1. Existing Codes

Code/Policy	Endorsing bodies
Commonwealth Code of Practice for International Recruitment of Health Workers	Commonwealth Ministers of Health at the pre-World Health Assembly Meeting of Commonwealth Health Ministers, Geneva, May 2003
Pacific Code of Practice for Recruitment of Health Care Workers	The seventh Meeting of Ministers of Health for Pacific Island Countries in Vanuatu, March 2007
Revised Code of Practice for the international recruitment of healthcare professionals	UK Department of Health, London 2004
First DRAFT of WHO code of practice on the international recruitment of health personnel	WHO Secretariat, Kampala, March 2008. Web based hearings on the draft code were held in September 2008

The codes tabled above have all received significant amounts of criticism. In his analysis of The UK Department of Health's Code, Buchan(2008) has identified various weaknesses, including the omission of recruitment agencies and private sector employers. Buchan (2008) suggests that strengthening the code will reduce numbers of migrating health professionals from Sub Saharan Africa. However, with the ever growing demand for health professionals in the UK, coupled with the lure of working and living in a developed country, the strengthening of a Code is unlikely to make a significant impact on migratory patterns.

The Commonwealth Code has tried to create a unified international response to the issue, though has not been signed by the UK, Canada or Australia, due to the possibility of having to compensate for source countries' expenditure on training of health professionals. It is clear that these strategies lack political will for effective implementation.

Multi sectoral approaches to address the problem of out-migration of health care professionals

Whilst the proliferation of national and regional guidelines is a good platform for the management of health worker migration, there is urgent need to address this problem in a more structured and cohesive way.

Considering the multiple levels on which out-migration have effect, and the international spread of stakeholders involved, a comprehensive multi-sectoral approach must be devised and employed. Crucial to the effective management of this problem is a concerted effort, by actors at local, national, regional and international levels. With the negative impacts of migration manifesting in the health systems of source countries most severely, the suggested approach here focuses attention on national health systems of developing countries, using the WHO Framework for Action (2006), with particular reference to the six building blocks, as guidance. The implementation strategies identified have two broad aims: i) to address the most common issues within health systems that push people to emigrate and ii) to increase domestic staff retention rates, thereby reducing emigration rates.

To manage migration effectively, governments need to conduct analysis of their own country context, and proffer feasible and appropriate solutions. As stipulated in Table 2, solutions should be within the WHO framework for health systems strengthening, and address each of the six building blocks.

To maintain and indeed expand health care systems, governments need to increase recruitment and retention, while simultaneously decreasing attrition rates. To do this, Ministries of Health will need to conduct comprehensive research on their workforce, looking particularly at problem areas that could potentially be push factors in out-migration. Stilwell (2003) discusses the importance of information systems, and creating databases of migration as the first step to addressing the issue. Whilst data collection of this sort may not always be feasible in resource poor settings, it is imperative that governments at national and district level have, at the very least, a methodical understanding of push factors causing their staff to emigrate.

Service provision must be targeted, effectively staffed, well equipped and responsive to population's needs. In effect, this means that international donors, both bilateral and multilateral need to be cognisant of these issues, and must ensure that funding streams are context appropriate and results focussed.

The poor morale of health professionals is often due to an inability to perform tasks effectively due to lack of resources/poor resource allocation. This must be addressed adequately to boost morale, increase retention rates and, ultimately, to improve health status. Another factor which is reiterated in studies on migration is that of inadequate and/or untimely payment (Smith et al, 2009). Health systems need to prioritise financing payment of its workforce, and if appropriate, raise funds specifically for this purpose. There must also be effective governance of finances, at all levels, to reduce corruption within the system and to ensure that the workforce is salaried adequately and on time.

The establishment of accurate health information systems is crucial to good workforce planning. Ministries of Health must have accurate records of the actual number of staff in the health workforce, and must also monitor out migration. Where possible, research should be conducted to identify causes of migration. Donors should also have an understanding that emigration of health professionals is a significant problem, and should support governments in their research, and attempts to increase retention rates.

There are certain measures countries can undertake to help reduce out-migration, and to strengthen the overall health system in order to meet targets such as the MDGs. Governance and leadership at all levels are fundamental to this; health managers at all levels must take responsibility for the effective allocation and monitoring of resources. International bilateral and multilateral agencies and donors must be

committed to supporting the health system strengthening of developing countries, and funding should reflect this.

Table 2 below summarises the key aspects of action, and identifies the key actors concerned.

Table 2: Implementation at national level, in accordance with WHO Health Systems building blocks

Building Block	Key Aspects of Action at National Level	Key Actors
1. Service Delivery	• Ensure guidelines and standards for quality of care • Ensure mechanisms for provider accountability	• Ministries of Health • Managers at local/district/national level • I/NGOs
2. Health Workforce	• Improve staff recruitment, education, training and distribution • Ensure an enabling work environment • Ensure effective communication within the workforce	• Ministries of Health • Managers at local/district/national level • I/NGOs
3. Health Information Systems	• Monitoring of out migration, possibly through use of database • Ongoing research on context specific reasons for migration	• Ministries of Health • I/NGOs • National governments
4. Essential medical products and technologies	• Ensure essential training on medical products, diagnostic and treatment protocols • Ensure medical products availability	• Ministries of Health • Multi/bilateral donors • National governments
5. Health systems financing	• System to raise funds specifically for salaries • Allocation of funds to salaries to ensure timely payment • Frequent public expenditure reviews	• Multi/bilateral donors • National governments • Ministries of Health • I/NGOs
6. Leadership and governance	• Health authority to take responsibility for steering of health sector • Defining, and communicating with health workforce national health policies and strategy • Ensure mechanisms for accountability • Channel donor funding for context specific priorities	• Ministries of Health • Managers at local/district/national level • Multi/bilateral donors • I/NGOs

Conclusion

The migration of health workers from developing to developed countries is likely to continue increasing. Although the reasons for migration are essentially personal, we must acknowledge that there are structural causes that are increasing the numbers of health professionals who chose to migrate. The unequal distribution of health care workers globally is intensified by this process, and the impacts are felt most in developing countries with weak health systems, particularly in Sub Saharan Africa. This is effecting countries capacity to meet internationally set targets such as the MDGs.

The solution lies in understanding the issues for migration, managing current migration patterns, and safeguarding against growing attrition rates.

The need for reliable data is central to the management of migration of health professionals, and the effective planning of the health workforce. Policy makers must have a clear idea of the drivers behind migration, and policy must incorporate factors that will work towards higher rates of staff retention on national levels.

The issue of migration of health professionals needs to be made a global priority, with assessable targets for all stakeholders. This will require recognition and understanding of the issue, and political commitment to manage it, on national and international levels. Finally, health professionals must be valued, and recognised as the fundamental building blocks of any health system.

References

Buchan J., (2008) *How can the migration of health service professionals be managed so as to reduce any negative effects on supply?* WHO, Geneva.
http://www.intlnursemigration.org/assets/pdfs/7_hsc08_epb_10.pdf (accessed 15 May 2010)

Commonwealth Code of Practice for the international recruitment of Health Workers. London, Commonwealth Secretariat, 2003.
http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf (accessed May 12 2010)

Connell J., (2008), *The International Migration of Health Workers*. 1st ed. Oxon: Routledge.

Hawkes M, Kolenko M, Shockness M, Diwaker K, Nursing Brain Drain from India, *Human Resources for health* 2009, **7**:5 http://www.human-resources-health.com/content/7/1/5 (accessed 14 May 2010)

Labonte R, Blouin C, Chopra M, et al. Towards health equitable globalisation: rights, regulation and redistribution. Globalisation knowledge network final report to the Commission on Social Determinants of Health. Ottawa: Institute of Population Health, University of Ottawa, 2007.
http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf (accessed 14 May 2010)

Smith R, Chanda R, Tangcharoensathien V, Trade in health related services. *Lancet* 2009; **373**: 593-601

Stilwell B, Diallo K, Zurn P, Vujicic M, Adams O, Dal Poz M, Migration of health care workers from developing countries: strategic approaches to its management. *Bulletin of the World Health Organisation*, 2004; **82** (8)

Vujicic M, Zurn P, Diallo K, Dal Poz M. The role of wages in slowing the migration of health cqare professionals from developing countries. *Human resources for Health [online journal]* 2004; 2:3.
www.human-resources-health.com/content/2/1/3 (accessed 14 May 2010)

WHO (2000) *Health Systems: Improving Performance.* World Health Report 2000. WHO, Geneva

WHO (2006) *Working Together for Health.* World Health Report 2006. WHO, Geneva