Migration of Health Workers from Commonwealth Countries

Experiences and Recommendations for Action

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COMMONWEALTH SECRETARIAT

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Health Department
Human Resources Development Division
Commonwealth Secretariat
Marlborough House
Pall Mall, London SW1Y 5HX, United Kingdom
Tel: +44 (0)20-7747 6320
Fax: +44 (0)20-7747 6287
E-mail: j.parris@commonwealth.int

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Preface

In recent years there have been renewed concerns worldwide about the tremendous drain of resources that can occur when skilled health professionals migrate, particularly from developing to developed countries. Although such movement often has many advantages for the individuals concerned and their families, from the point of view of donor countries, it can have far-reaching consequences both for their economies and the development of their health services.

In the Commonwealth, migration of health professionals is a major problem for some member countries, particularly small states. As a result, Health Ministers, at their meeting in Barbados in November 1998, called for a study to identify practical strategies that would assist them in addressing the issue.

In response, in 1999 the Commonwealth Secretariat commissioned consultants to carry out literature reviews and to collect data from Ministries of Health in each of four Commonwealth regions (Africa, Asia, the Caribbean and the Pacific), as a basis for recommending policies and strategic approaches to Commonwealth governments. This publication is based on a synthesis of the reports of these consultants.

The main message of this publication is that addressing the problem of migration of skilled health professionals should be part of individual countries' overall approach to human resource management, not an isolated activity. The publication also provides some valuable insights into human resource management in countries today, and identifies gaps in knowledge at the international, regional and country levels. At the same time the report identifies key issues facing Commonwealth governments and recommends strategies which they may find useful in addressing the issues.

The Secretariat is grateful for the contributions of many organisations and individuals. In particular we thank the Ministries of Health whose co-operation in providing data, other information and views was invaluable, and the Commonwealth Steering Committee for Nursing and Midwifery who have allowed us to include as an Annex their recently published guidance on the workforce issues related to the global crisis in the recruitment and retention of nurses and midwives.

We hope that the perspectives in this publication will contribute more widely to current thinking on human resource management, and to migration in particular, and that they will be an incentive to further international action where necessary.

Professor Stephen A. Matlin,
Director, Human Resource Development Division,
The Commonwealth Secretariat

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This project was initiated and managed by Mrs Janey Parris, Chief Programme Officer in the Health Department of the Commonwealth Secretariat, whose input and commitment was crucial to bringing it to completion.

Dr Christine Swinson, Commonwealth Secretariat Health Department, synthesised the consultants' reports and wrote the text, drawing directly from the consultants reports where indicated.

Acronyms and abbreviations

AFRO	World Health Organisation Regional Office for Africa
AMRO/PAHO	World Health Organisation Regional Office for the Americas/Pan American Health Organisation
BESO	British Executive Service Overseas
CARICOM	Caribbean Community and Common Market
CIOMS	Council for International Organisations of Medical Sciences
CTFC	Commonwealth Fund for Technical Cooperation
ECFMG	Examination Commission for Foreign Medical Graduates
ENT	Ear, Nose and Throat
EU	European Union
HDI	Human Development Index
ILO	International Labour Organisation
MERCOSUR	The "Southern Common Market" of South American States created by the treaty of Asuncion on 26 March 1991
NAFTA	North American Free Trade Association
NGO	Non-Government Organisation
SADC	South African Development Community
SEARO	World Health Organisation Regional Office for South-East Asia
UNCTAD	United Nations Committee on Trade and Development
UNDP	United Nations Development Programme
VSO	Voluntary Service Overseas
WHO	World Health Organisation
WPRO	World Health Organisation Regional Office for the Western Pacific
WTO	World Trade Organisation

Executive summary

Introduction

The problems that may result when skilled health personnel migrate from developing to developed countries have been recognised worldwide and have had the attention of the Commonwealth and other agencies since the 1960s. Changes in the socio-economic and health sector environments in recent years and the emergence of HIV/AIDS have only served to exacerbate these problems, so that in the Commonwealth migration is now recognised as a major problem affecting the health systems of some member countries, particularly small states. The concerns of Commonwealth governments were expressed at a meeting of Health Ministers in Barbados in November 1998 when they called for a study to identify practical strategies that would assist them in addressing this issue. In response, the Commonwealth Secretariat commissioned consultants to carry out literature reviews and to collect data from four Commonwealth regions (Africa, Asia, the Caribbean and the Pacific) as the basis for recommending policies and strategic approaches to Commonwealth governments. This publication is based on the consultants' reports.

The nature and extent of movement of trained health professionals

The international and global dimensions of migration mean that an understanding of the size of the problem at global level, the categories of health workers affected, where they go and why, and why others stay at home, is fundamental to any attempt at developing and implementing effective policies aimed at retention of staff within national health services. However, little up to date information exists at either international or regional levels. Even at country level, in many countries where contact was established, accurate information about staff movement was in general not routinely maintained, and data that did exist did not cover all staff groups. Nevertheless some useful, if limited, data were obtained.

The nature and extent of migration

Although the exact extent of current migration and other losses is difficult to quantify, there seems little doubt that loss of trained health professionals is a major problem in many Commonwealth countries. The negative impact of this problem is felt most strongly in small states where the overall numbers of staff are so small that the loss of even one key worker can have a catastrophic effect on the delivery of health services. Although any of the health professions can be affected, physicians and nurses constitute the main groups that migrate. Differences in the patterns of loss of physicians and nurses were observed in the different Commonwealth regions.

Countries and sectors to which personnel are lost

Despite the variations in the nature of the groups of health professionals who migrate from different Commonwealth regions, analysis of the reports indicates there are similarities in the recipient countries to which all staff migrate. The Commonwealth constitutes one of the largest language blocks in the world, with English being used extensively for education and training in nearly all member countries. It is therefore not surprising that many

Commonwealth professionals migrate to English speaking countries, particularly to those countries with which they have ties through past colonial links, previous immigration, or the migration of relatives. The direction of flow tends to be from developing to more developed countries which provide better opportunities for families and higher levels of pay for employees. More developed countries within a region may act as intermediate destinations for those who eventually migrate further afield.

Effects of loss of health professionals

The effects of these losses of health professionals are numerous and multifaceted, with far reaching consequences both for the economies and the development of health services in countries. Within the health sector they include restriction or reduction of service delivery and access as a result of staff shortages; inability to expand training of health workers and poorer quality of training as a result of loss of trainers, particularly specialists; reduced quality of care resulting from a decrease in the number of trained health personnel and inadequate supervision of lower grades; loss of discipline and morale; facilities often run by untrained managers with lack of continuity of management; and inequitable distribution of staff between urban and rural areas.

Issues and problems relevant to recruitment, deployment, utilisation and retention

Addressing the problem of migration needs to be part of individual countries' overall approach to human resource development. Each of the three familiar interacting components of the process of human resource development for health, namely policy/planning, education/training and management/utilisation has significant effects on whether staff are subsequently retained in government health services or lost through migration or to more attractive opportunities within the country. Virtually all countries studied were experiencing problems in all of these areas, for at least some staff groups, although the factors contributing to the problems varied between countries and regions.

Policy/planning

A clear national plan, identifying the goals and objectives of the health sector in the country within the budget available, is now acknowledged as a key factor in the effective recruitment, deployment, utilisation and retention of staff. A fully developed human resource plan must be an integral part of the national health plan. Many Commonwealth countries still lack such plans. Failure to develop systems for maintaining a database on skills and human resources to provide accurate data to feed into the planning process may also contribute to this inadequate planning. The result is that, even where some planning has been carried out, it may not be very comprehensive or appropriate to the circumstances.

The consequences of lack of, or inappropriate, planning are significant. There may be continued production of doctors far in excess of the country's needs; outdated figures for the appropriate numbers of established posts, resulting in establishments that could not be afforded even if staff were available; staff whose educational and technical preparation is unsuited for tasks required; mal-distributions of staff between urban and rural areas; and poor utilisation of staff. These consequences contribute to the problem of unproductive and/or demoralised staff who may be more likely to leave the service should an opportunity arise.

Education/training

Apart from any lack of planning within the health sector for the numbers required, there are particular problems facing some countries in relation to the pre-service education and training of health personnel. There may be too few people eligible to enter professional training, as the existing secondary schools cannot meet the demand for secondary education. There may also be a tradition of sending the brightest young people to secondary schools overseas, as a result of which they may subsequently enter health pre-service institutions abroad and not return to work in their home countries.

Traditionally nurses have been educated in home countries in programmes provided and administered by the Ministry of Health. Despite the undoubted advantages of recent developments in nurse education that have resulted in pre-service education being provided in "main-stream" institutions under the auspices of Ministries of Education, one undesirable side effect is that graduates can more readily gain registration elsewhere. Also, where skilled personnel are needed in relatively small numbers, governments are frequently unable to provide in-country training, and one consequence of sending trainees abroad is that they may subsequently not return to work in their home country. If they do return, the education they have received may not have been suitable for the public health initiatives and rural health services in home countries.

When specialist medical training is undertaken overseas, this can bring additional problems. On return physicians may find there are insufficient patients or facilities to maintain their specialist skills in their particular area of expertise. Furthermore, salaries are low, and the country cannot afford to offer increases. There are also the attractions of a better life elsewhere. In such circumstances, the doctor may choose to emigrate again. Education in country may not obviate these problems if it is based on curricula borrowed from developed countries and produces graduates who may not function well in their own less developed environments and whose expectations may only be met in more developed countries. This too may result in migration.

Management/utilization

Within health services, the management and utilisation of personnel is important as it affects working lives and individual decisions to remain in or return to government service. The implementation of the public sector reforms currently being introduced in many Commonwealth countries, however, requires new management skills both centrally and locally and there is evidence that there has been a failure of managerial skills and practice to keep pace with current requirements. This is reflected in poor human resource policies that contribute to poor retention and utilisation of staff. The manifestations of these management shortcomings include: cumbersome recruitment procedures, leading to considerable delays and frustrations even for staff trained within the country; salary scales amongst professional groups that are perceived as inequitable; poor terms and conditions of service and working environments; deficient utilisation of staff; and limited opportunities for promotion. These management failures result not only in poor retention and utilisation of staff, but also in higher costs of turnover and replacement, the remaining staff may become overburdened and demoralised, quality of care may suffer and the amount of healthcare it is possible to provide may be reduced.

Factors that contribute to migration

At societal level, the differentials that exist in remuneration between sending and receiving countries have been acknowledged as a key factor influencing decisions to migrate. At an individual level the decision of a health worker to migrate is the result of the interaction of "pull" forces in recipient countries and "push" forces in the donor country. The implications of these individual decisions to migrate will depend, for both the exporting and importing countries, on whether the moves are permanent or temporary.

"Push" factors

"Push" factors that appear particularly influential in the migration of citizens from developing Commonwealth countries are the traditions of mobility combined with the similarities of professional training and colonial and cultural links; the production of health workers related to demand for education rather than need for services; educational preparation more appropriate for practice in a developed country; training of health professionals abroad/lack of local training facilities; public sector spending cuts resulting in low expenditures on health and health sector reforms; bureaucratic excesses in employment processes; occupational risks/poor working conditions; lack of adequate social security, pension plans, and other benefits; and social and political insecurities, coup d'états, wars and dictatorships.

"Pull" factors

Significant "pull" factors are the shortages of health workers in developed countries; the opportunities for jobs; salary differentials; the provision of scholarships/fellowships/grants to be utilised in developed countries; the career and intellectual enhancement opportunities; the technical support available for intellectuals and the freedom from political and administrative interference.

Strategic approaches that have been used by countries to reduce outward migration and mitigate its effects

Implementation of successful strategies to influence the retention and movement of health professionals are essential if countries are to overcome the problems caused by migration.

Incentives and disincentives

Most strategies either used or considered by policy makers seek to influence migration by providing incentives or disincentives of various kinds to individual health care workers, with the related aim of getting some form of return on the investment made in training. Such strategies include bonding of health professionals after training; compulsory service requirements; certification controls; economic incentives; using training and career opportunities as incentives; other benefits such as free or subsidised housing; restricting opportunities to take qualifying examinations for entry to other countries; continuing education programmes; and recruitment drives to influence return home. Countries have encountered problems in seeking to implement these strategies, however, and although there have been successes, these have been limited.

Changes in the education and training of health workers

Other strategies seek to bring about changes in the education and training of health workers so that their production is more closely matched to what the country needs or can afford.

Strategies that have been employed and have met with some success include making training more appropriate to local needs; development of local specialist qualifications; development of short relevant training courses for established staff to meet local health needs; and training of new types of staff for service provision.

Bilateral and inter-country agreements

Some countries have attempted to control the numbers that are recruited by reaching agreements with recipient countries. These have had some success in the short term.

Mitigation of losses

Countries have also attempted to mitigate the effects of loss of health care workers by recruiting personnel from countries with an adequate supply and by changing personnel policies to encourage health professionals within the country to return to government service.

Conclusions and recommendations

General conclusions

Addressing the problem of migration for individual countries cannot be seen in isolation and needs to be part of an overall approach to human resource management. Whether particular health workers migrate is determined by their perception of the complex interaction of ever changing economic and policy "push" and "pull" factors in the sending and receiving countries. Thus the nature and extent of migration varies from country to country and from time to time, and attempts by countries either to curb or compensate for the outflow of health manpower by a variety of *ad hoc* means are likely to be unsuccessful. In this situation, it is only the "push" factors operating within a country that it can directly control. Therefore the most successful strategies for retaining staff within national health systems are likely to involve accurate assessment of the particular "push" factors within the county followed by action to eliminate or neutralise them.

Key issues and recommended strategies for governments

The key issues identified for governments and strategic actions they may find useful in addressing them are set out below.

Policy/planning

Key issues

1. Absence of an appropriate health sector development plan incorporating an integrated workforce plan to meet the health needs of the country.
2. The skills of the available workforce may not match those required to provide services.
3. Lack of the institutional capacity to carry out health service and workforce planning.
4. Inadequate data for human resource planning.

Recommended strategies

1. In the short-term focus on integrated service planning to ensure that a health sector development plan or "National Health Plan" is developed that identifies the goals

and objectives of the health sector within the country within the budget available and develops strategies to achieve those goals and objectives.

2. Use the service needs identified in the "National Health Plan" as the basis for determining an associated longer-term workforce plan to meet current and anticipated future needs.
3. In the workforce plan, introduce changes in the distribution and skill mix of staff to better meet health needs and ensure that staff are not over- educated for the service to be provided. As part of this:
    - Recognise the pivotal role of nurses in the provision of front line care and expand their role to include more unsupervised provision of treatment.
    - Develop and train new types of health workers to meet local needs.
    - Consider introducing a "step ladder" approach to specialist training that allows health workers to start from the bottom and eventually end up as more highly skilled categories of staff, including physicians.
    - Where appropriate, consider selective specialisation and sharing of services between/among countries within a region.
4. Promote a culture of human resource planning in Ministries of Health.
5. Train selected staff in human resource development and management.
6. Develop modern information systems to support human resource management and planning.
7. Consider developing and evaluating indicators for migration of health professionals.

Education/training

Key issues

1. Weak joint planning mechanisms at national level between Ministries of Health and Ministries of Education.
2. Where trainees undergo pre-service education and basic training in institutions under the auspices of Ministries of Health, there may be conflicts between service needs and educational needs of trainees.
3. Health personnel may be trained inappropriately, resulting in too few personnel with the skills and motivation to deal with the specific health needs of the country, and/or too many who are over-educated for the service required.

Recommended strategies

1. Strengthen joint planning between Ministries of Health and Education.
2. Consider ensuring that pre-service education is provided under the auspices of the Ministry of Education in "main stream" institutions.
3. Where possible, provide basic health worker training within the country or in another developing country within the region.
4. Ensure in-country curricula reflect local needs.

5. Base numbers trained and supported to receive specialist training on a well-developed national plan for the health sector that meets the health needs of the country.
6. Develop local postgraduate and specialist training schemes.
7. Where health service staff are supported by government or other organisations to obtain specialist qualifications elsewhere, consider whether this should be in a developed country or whether the need would be better met by supporting them elsewhere within the region.
8. Consider developing and strengthening regional co-operation for education and training of health workers.

Management/utilization

Key issues

1. Antiquated approaches to human resource management resulting in inefficient personnel administration systems that are not always perceived as fair and equitable.
2. Poor terms and conditions of service and failure to recognise the special challenges for health personnel in rural areas.
3. Lack of career progression, and poor pension arrangements.
4. Health workers can frequently become discouraged due to seemingly insurmountable difficulties such as shortage of equipment and drugs, poor health facilities, unrealistic community expectations and professional isolation.

Recommended strategies

1. Review and improve personnel management functions including appointments, performance appraisal, promotion, disciplinary procedures and leave allowances.
2. Improve the systems for personnel administration by decentralisation, where this has not already been done, combined with training of selected staff and central formulation of model policies and standards.
3. Provide and encourage more flexible working arrangements, improved local transport, day care facilities at places of work and low cost housing.
4. Create mechanisms that will give health professionals the opportunity to be innovative, expand their professional roles, and develop excellence in management and clinical practice.
5. Consider other incentives, such as special allowances for those working in rural areas and where appropriate develop some means of providing support to retiring or elderly practitioners.
6. Consider promoting and funding links between institutions in developed and developing countries to facilitate planned exchanges of staff, study tours etc.
7. Facilitate improved communication between health professionals, using technologies such as the internet, e-mails, telemedicine and radio-linked methods, to help them remain up to date and in touch with colleagues, and reduce any existing feelings of isolation.

Need for further work

The main message of this publication is that addressing the problem of migration of skilled health professionals should be part of individual countries' overall approach to human resource management. In addition there are gaps in relevant knowledge at international, regional and country level that institutions and organisations need to address. Since the problem has global and international dimensions, international institutions and organisations can play a role in finding solutions.

In particular, there appears to be need for collection and analysis of up to date data relevant to migration at national, regional and international levels. This will involve promoting the development of human resource information systems at country level, training activities and collection and the dissemination of good practice guidelines; sex disaggregation of data relevant to migration and studies of the underlying gender issues; further dialogue between developed and developing countries; research into effective ways of introducing and utilising technologies to reduce feelings of isolation, particularly in rural areas; and collection and dissemination of case studies of good practice in all aspects of human resource management and development.

The Commonwealth Secretariat hopes that the perspectives in this publication will contribute more widely to current thinking on human resource management and that international institutions and organisations will act on it appropriately to assist countries in addressing these issues.

CHAPTER 1

Introduction

1.1 Historical context

Concern about shortages of medical staff and the tremendous drain of resources that can occur when skilled health professionals migrate, particularly from developing to developed countries is not a new issue. These concerns were recognised at the Commonwealth Medical Conference held in Edinburgh in 1965[1]. Subsequently international disquiet about this "brain drain" led to the setting up of the WHO Multinational Study of International Migration of Physicians and Nurses, the findings of which were published in 1979[2]. The objectives of this study were to analyse the migration of physicians and nurses in terms of the characteristics of the migrants and the dimensions, directions, determinants and consequences of the flows and then to suggest ways of modifying migration in the desired manner[1]. This was as a first step to enabling national health administrations to develop and implement more appropriate health workforce policies and plans aimed at overcoming the problems posed by migration.

1.2 Societal factors underlying migration

The findings of this WHO study largely confirmed one of the assumptions from which it sprang – namely, that the migration of physicians and nurses was essentially an incidental result of the unequal development of different nations and of different regions and social groups within nations[2]. There were differences in the mobility of doctors and nurses: doctor mobility tended to be for longer periods of time, and over greater geographical distances than nurse mobility, i.e. for doctors, mobility was more likely to be emigration in the strictest sense of the word. Nurses tended to move shorter distances, make less permanent moves and remit more of their earnings home. Both these groups of skilled health professionals migrated primarily for economic reasons. This had important implications for appropriate action by national governments and other institutions, as it meant that the measures that needed to be taken to stem the flows went far beyond the *ad hoc* measures that had generally been proposed: policies for the health workforce needed to be co-ordinated with other development sectors.

1.3 Health sector factors underlying migration

Within the health sector the primary problem in many countries was the lack of relevance and ineffectiveness of existing health services to deal with the basic types of health services needed by the population as a whole[2]. Inadequate allocation of resources within the health sector lay at the root of this in many countries, compounded in some cases by the low priority given to meeting the health needs of everyone. Similar problems of lack of relevance and co-ordination were also found in policies for developing the health workforce, resulting in the production of "inappropriate" health personnel and the uneconomic utilisation of some categories.

1.4 Personal factors underlying migration

Whether an individual chooses to migrate was nevertheless shown to be the result of the interaction of "pull" forces in recipient countries and "push" forces in donor countries. Elimination of "pull" forces in countries where they currently exist would nevertheless not solve the problem for donor countries as the fortunes of countries change, with certain traditionally poor countries becoming richer. Thus there would always be "pull" factors somewhere in the world. This implied that in the long run the only measures that would have hope of resolving the problems of migration for donor countries was to eliminate or neutralise the push factors in those countries.

1.5 Conclusions of the WHO study

As a result of the 1979 WHO study a series of conclusions were reached reflecting concepts and principles current in many political, academic and other forums at the time about the ways forward. None of these were "quick fixes". All were going to require concerted effort over time. These[1] may be summarised as follows, namely, that countries should:

- produce only as many physicians as they could afford or, alternatively, take the necessary steps to increase the local demand for the amount and type of medical services implicit in the quantity and quality of the physicians produced;
- plan for the numbers and categories of the health workforce appropriate to what needs to be done, taking into account overall economic projections and the anticipated health budget, the infrastructure and the size of the private sector;
- reorient education and training programmes for the health professions so that they are in consonance with the country's own priority needs;
- develop health workforce management capacity;
- assess the pertinence of the concept of integrated development of health service and health workforce planning in each country and examine how this could be translated into a practical mechanism adapted to local needs;
- although most of problems related to migration are common to many countries and are amenable to solution by concerted effort, each country should use its own judgement to solve its own migration problems, taking into account priority needs of its society as a whole;
- create a national network of technical co-operation among local institutions and programmes, and develop a programme of technical co-operation with other countries by formation of links;
- plan for health development as a whole – but plan together and with other development planners;
- implement the policies and plans designed, keeping in mind that implementation requires as much coordination and realism as does policy making and planning, and that evaluation of progress and subsequent adjustment in the light of unforeseen constraints are essential components of plan implementation.

1.6 Changes in the socio-economic environment

Over the 20 or so years since the WHO report was published, enormous changes have taken place in the global economy that have presented additional challenges to Commonwealth

and other developing countries in many parts of the world seeking to overcome the problems resulting from migration of skilled health workers.

Many governments have experienced economic problems as a result of the global recession in the 1980s. International trade rules, such as those now enforced by the World Trade Organisation (WTO), are having an increasing negative effect on small countries as they have limited opportunities for trade and an extremely small manufacturing base[3]. Some countries have been engulfed in wars and conflicts. All these factors affect the resources available for public services, including health. In the Caribbean, for example, it has been noted that the direct impact of the economic problems that are being experienced by most countries of the region has been the reduction of all resources for health and curtailment of some services, which in turn makes it difficult to deliver efficient and effective health services and to maintain attractive environments in which to work[4].

At the same time, the costs of health services are rising. Recent studies indicate that in the Caribbean this is due to a growing population, increasing life expectancy and prevalence of chronic diseases, violence in societies, expensive technology and the population's rising expectations about the delivery of health services[4]. In the Pacific there is a high birth rate, and people are subject to changing lifestyles and diets that are deleterious to health [2] resulting in increased prevalence of diseases previously common only in developed countries, alongside the communicable diseases more typical of developing countries. The result is that, even if resources for the health sector were not reduced, there would be a widening gap between resource needs and availability.

In response to these challenges to the public sector, many countries, including most Commonwealth countries, have embarked on some form of public service reform, that embraces new means of public administration[5]. These present the health sector with additional challenges, including the need for greater accountability, efficiency and effectiveness, decentralised decision-making, and improved resource management[4].

Additionally, it is anticipated that the global liberalisation of services being brought about by the activities of the WTO and the United Nations Committee on Trade and Development (UNCTAD), and the development of free trade blocks such as the North American Free Trade Association (NAFTA), the European Union (EU), and MERCOSUR, will reduce barriers to mobility. In the health sector these activities are likely to impact directly through increased cross-boarder flows of health professionals[6], particularly since these developments are taking place at a time when several industrialized countries have entered another round of nurse shortage. In contrast to earlier shortages, the present shortage is characterised by a decline in the absolute numbers of people entering the nursing profession and a reluctance of inactive nurses to re-enter governments' health services, thus increasing the difficulties of recruitment from domestic markets[4]. At the same time the existing nursing workforce is aging, and many will leave the workforce in the next 10 years[7]. In these circumstances, developed countries may be more likely to try to alleviate their problems by overseas recruitment.

1.7 The health sector environment

Although it is now acknowledged that human resource is a key factor in the delivery of health services and that the introduction of appropriate human resource management systems is fundamental to health sector reform processes[4,8], this is not always reflected in countries' policies. As Draper has noted[5], in many Commonwealth countries human resource development activity and human resource planning is characterised by the following:

- the absence of a fully developed human resource plan;
- the absence of a data base of human resource assets and requirements;
- no clear process for identifying human resource needs;
- no clear career pathing process or planned ongoing and systematic training and development activity

Even where the need for human resource plans is perceived, there may be a lack of personnel with the relevant skills to carry out such planning and data collection. Some countries have sought to overcome this lack of skills by using external consultants who have developed solutions based on assessments and recommendations that are unrealistic for the country concerned, leaving them with what has been described as "the unfortunate legacy of many well-intentioned externally-supported efforts at manpower planning[8].

The consequences of this lack of planning or inappropriate planning have been described by Green[9] to include countries having, at various times or in combination: too few trained and available staff; too many trained and unemployable staff; distribution difficulties such as urban concentration even when adequate numbers of staff are available; and inappropriate use of personnel.

At the same time, declining revenues and outdated management practices have also had major deleterious effects on health delivery systems. These are manifest by poor work environments and management inefficiencies and ineffectiveness that result in unproductive and/or demoralised staff. In the Caribbean such factors are considered to constitute a major limitation to the delivery of health care in the region[3]. Similar problems have been noted in the African region[10]. Yet it is within such environments that the health personnel are expected to function.

1.8 HIV/AIDS

The growing HIV/AIDS epidemic compounds the situation. By the end of 2000 there were some 36.1 million people living with HIV/AIDS, of whom 70 % (25.3 million) were living in sub-Saharan Africa[11]. In affected countries this is having a profound negative effect on the economy, the entire workforce, businesses, individual workers and their families[43], meaning that it is even more important for such countries not to loose their remaining health professionals through migration. Moreover, half of all new infections are occurring amongst young people aged 15-24[7] and it has been estimated that some populations will be about 20% lower by 2015 than they might otherwise have been[12]. The consequent loss of virtually a whole generation will severely restrict the capacity of these countries to produce the human resources they need for the future.

1.9 The current publication

Against this background, it is perhaps not surprising that there should be continuing concerns about the migration of skilled health personnel in many parts of the world and renewed attempts to address the problem at international[13] and regional level in several regions[14,15,16,17]. Only in South East Asia does it appear that migration is not actively on the agenda[18].

In the Commonwealth, migration is now recognised as a major problem affecting the health systems of some member countries, particularly small states. This resulted in Health

Ministers, at their meeting in Barbados in November 1998, calling for a study to identify practical strategies that would assist them in addressing this issue[19].

In response, the Commonwealth Secretariat, in 1999, commissioned consultants to carry out literature reviews and to collect data from Ministries of Health about the current position in each of four Commonwealth regions (Africa, Asia, the Caribbean, the Pacific), as the basis for recommending policies and strategic approaches to Commonwealth governments. In practice, relatively little recently published literature on the migration of health workers could be identified. Furthermore, contact could not be established in all countries, introducing the possibility of bias into the examples described; and in many of the countries where contact was established, accurate information about staff movements was in general not routinely maintained and data that did exist did not cover all staff groups. Nevertheless, some useful, if limited, information was obtained.

The current publication is based on the consultants' reports[3,4,10,20]. Chapter 2 sets out what is known currently about the nature and extent of migration. Chapter 3 looks in more detail at the related issues of recruitment, deployment, utilisation and retention. Chapter 4 looks at the factors underlying migration. Chapter 5 considers the strategic approaches that have been used by countries to reduce outward migration and mitigate its effects. Chapter 6 draws conclusions about what seem to be the key issues for Commonwealth countries and recommends strategies to assist governments in developing their own strategies for retention. Some suggested indicator data on migration of health professionals is set out in Annex 2. Extracts from the consultants' reports setting out their recommendations for the African[10], Caribbean[4] and Pacific[2] regions are in Annexes 3, 4 and 5 respectively.

During the period in which this publication was being prepared, the Commonwealth Steering Committee on Nursing and Midwifery addressed the general issues of recruitment and retention of nurses and midwives worldwide, which included consideration of international recruitment and the ethical and other principles which countries might wish to consider in developing their policies and practices. Their resulting "*Guidance on workforce issues - the global crisis in the recruitment and retention of nurses and midwives*"[21]was issued in February 2001 to all Commonwealth Health Ministers, national Chief Nursing Officers, and presidents of National Nursing Associations and is reproduced in Annex 1.

CHAPTER 2

The nature and extent of movement of trained health professionals

2.1 Introduction

The international and global dimensions of migration mean that an understanding of the size of the problem of migration at a global level, the categories of health workers affected, where they go and why, and why others stay at home, is fundamental to any attempt at developing and implementing effective policies aimed at retention of staff within national health systems. In the light of this it is perhaps surprising that little up to date information relevant to migration exists at either international or regional levels: there appear to have been no comprehensive studies since the WHO study published in 1979, and directly relevant statistics are not available from WHO[22] or other potentially relevant international agencies[23]. This chapter therefore looks at the information currently available about migration in the Commonwealth, concentrating on movements from developing to more developed countries and the effects of these losses on developing countries.

To understand the impact of losses in individual countries it is necessary to understand something of the countries themselves. One of the strengths of the Commonwealth is that it brings together in partnership highly developed countries (e.g. Canada, Australia, the United Kingdom and New Zealand) and countries with much lower levels of human development, and includes many small island states of varying degrees of development[24]. The impact of losses is very different in each of these situations. Along with this there are great variations in population, GNP growth rate and external debt[25], which affect the ability of countries to deal with their problems of migration. Although it is beyond the scope of this publication to set out all these factors in detail, the discussion of migration is preceded by a section setting out information currently available internationally about relative numbers of different categories of health personnel in different Commonwealth countries and how this is related to their level of development. Absolute numbers of staff, if available, are given later. Some of these data are illustrative only, giving an indication of numbers of staff available in countries in particular regions.

2.2 Estimates of health personnel

As set out in Table 1, there are considerable variations in the relative numbers of different categories of health personnel in Commonwealth countries. The estimates in Table 1 have been extracted from worldwide data collected by WHO[26] and need to be treated with considerable caution because of the non-uniform way in which they were collected[22]. Nevertheless they give the best indication presently available about the current position.

In any one country, the numbers of staff in different categories in relation to population are in general fairly directly related to the level of development, as measured by the Human Development Index (HDI)[24] (Figure 1 and Table 2). The HDI was developed as a tool to measure average achievements in basic human development in one simple composite index

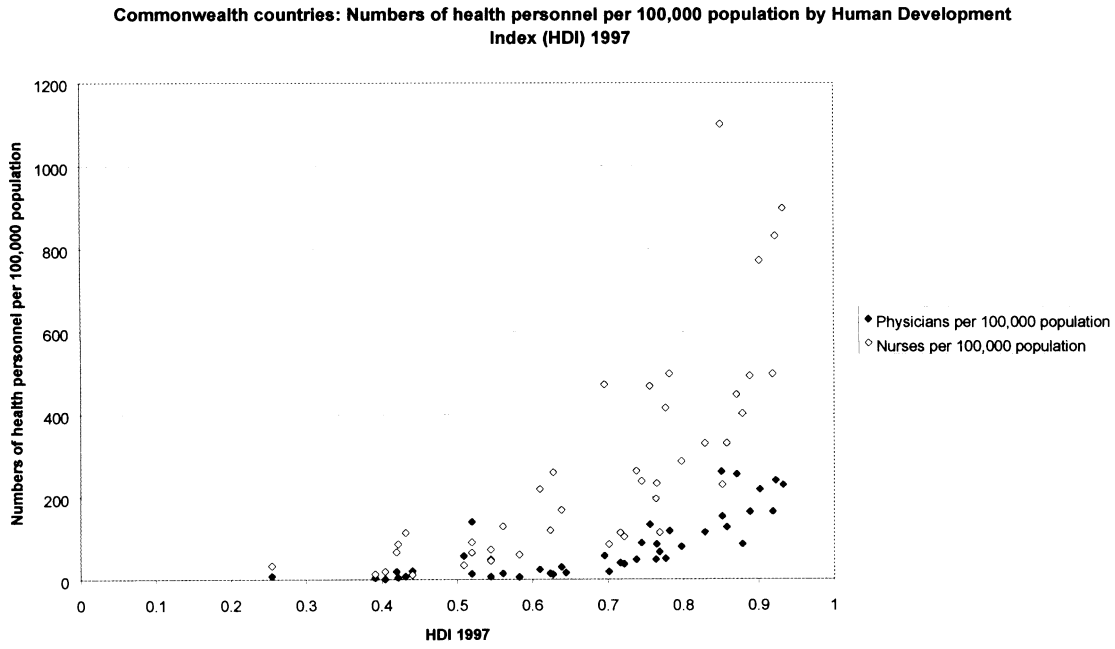
and to produce a ranking of countries. The index reflects achievements in lifespan, being knowledgeable and having a decent standard of living, by a single figure between 0 and 1 based on measures of life expectancy, educational attainment and income. A high figure is superior to a lower one. The methodology was significantly refined for the 1999 human development report[24].

2.3 The nature and extent of migration

Although the exact extent of current migration and other losses is difficult to quantify, there is no doubt that loss of trained health professionals is a major problem for many Commonwealth countries. The negative impact of this problem is felt most strongly in small states where the overall numbers of staff are so small that the loss of even one key worker can have a catastrophic effect on the delivery of health services. Furthermore, although any of the health professions can be affected, physicians and nurses constitute the main groups that migrate.

The Pacific Region, apart from Australia and New Zealand, consists of a number of small island states with low populations and small numbers of most categories of health personnel. Numbers of health personnel for selected countries are illustrated in Table 3. These countries exemplify countries where loss of key workers can have major effects. For example, the emigration of doctors is a particular problem in Fiji, Kiribati, Samoa, Tonga and Tuvalu[3]. In Kiribati, although the number of doctors emigrating in the 5 years up to 1999 was only 4, this together with the loss of one dentist and one pharmacist has had a major effect on the ability to provide health services. In Tuvalu the Ministry of Health estimates that 5 doctors have emigrated in the last five years, and in Tonga the estimate during the same period is 4 doctors lost to emigration. These were all specialists who had been trained overseas. A further

Figure 1



[1] *Source of data*: UNDP. Human Development Report 1999. Available on-line from www.undp/hrdo/report.htlm [Accessed 4 December 2000]

Table 1 Commonwealth countries: WHO Estimates of Health Personnel[1]
Physicians, Nurses, Midwives, Dentists and Pharmacists (around 1998)

Key: ... Data not available
.. Category not applicable
a Includes midwives
b Includes dental assistants

Country	Rates per 100,000 population / Year											
	Physicians		Nurses		Midwives			Dentists		Pharmacists		
Antigua and Barbuda	113.6	*1996*	330.3	*1996*	...	...		18.2	*1996*	...	...	
Australia	240.0	*1998*	830.0	*1998*	40.0	*1998*		40.0	*1998*	...	...	
The Bahamas	151.8	*1996*	229.7	*1996*	...	...		25.4	*1996*	...	...	
Bangladesh	20.0	*1997*	11.0	*1997*	...	...		...	...	...	...	
Barbados	125.4	*1993*	330.3	*1993*	...	...		16.1	*1993*	...	...	
Belize	54.8	*1996*	82.0	*1996*	...	...		10.6	*1996*	...	...	
Botswana	23.8	*1994*	219.1	*1994*	0.0	*1994*		2.2	*1994*	...	...	
Brunei Darussalam	84.8	*1996*	401.5	*1996*	...	...		12.8	*1996*	...	...	
Cameroon	7.4	*1996*	36.7	*1996*	0.5	*1996*		0.4	*1996*	...	...	
Canada	229.1	*1995*	897.1	*1996*	...	...		58.6	*1997*	...	...	
Cyprus	255.0	*1996*	447.0	*1996*	[a] ..	..		65.0	*1995*	104.0	*1995*	
Dominica	49.3	*1996*	415.5	*1996*	...	...		5.6	*1996*	...	...	
Fiji Islands[2]	47.6	*1997*	195.1	*1997*	...	...		4.3	*1997*	...	...	
The Gambia	3.5	*1997*	12.5	*1997*	8.2	*1997*		0.5	*1997*	...	...	
Ghana	6.2	*1996*	72.0	*1996*	53.2	*1996*		0.2	*1996*	...	...	
Guyana	18.1	*1997*	84.2	*1997*	...	...		3.8	*1997*	...	...	
India	48.0	*1992*	45.0	*1992*	...	...		...	...	...	...	
Jamaica	140.1	*1996*	64.5	*1996*	...	...		9.0	*1994*	...	...	
Kenya	13.2	*1995*	90.1	*1995*	...	...		2.2	*1995*	...	...	
Kiribati	29.6	*1998*	235.8	*1998*	...	...		4.9	*1998*	...	...	
Lesotho	5.4	*1995*	60.1	*1995*	47.0	*1995*		0.5	*1995*	...	...	
Malawi	...	...	...	...	...	...		...	...	...	...	
Malaysia	65.8	*1997*	113.3	*1997*	27.1	*1997*		8.6	*1997*	...	...	
Maldives	40.0	*1995*	113.0	*1995*	185.0	*1995*		...	...	...	...	
Malta	261.0	*1998*	1100.0	*1993*	77.1	*1993*		35.8	*1998*	49.3	*1998*	
Mauritius	85.0	*1995*	232.9	*1995*	...	...		13.5	*1995*	...	...	
Mozambique	...	...	...	...	...	...		...	...	...	...	
Namibia	29.5	*1997*	168.0	*1997*	116.5	*1997*		4.0	*1997*	...	...	
Nauru	157.0	*1995*	588.0	*1995*	...	...		...	...	...	...	
New Zealand	217.5	*1997*	771.0	*1997*	56.2	*1997*		39.0	*1997*	...	...	
Nigeria	18.5	*1992*	66.1	*1992*	52.4	*1992*		2.6	*1992*	...	...	
Pakistan[3]	57.0	*1997*	34.0	*1996*	[a] ..	..		2.3	*1997*	34.0	*1996*	
Papua New Guinea	7.3	*1998*	67.0	*1998*	...	...		2.7	*1998*	...	...	
St Kitts and Nevis	117.1	*1997*	497.6	*1997*	...	...		19.5	*1997*	...	...	
St Lucia	47.3	*1997*	263.0	*1997*	...	...		6.2	*1997*	...	...	
St Vincent and the Grenadines	87.7	*1997*	238.6	*1997*	...	...		5.3	*1997*	...	...	
Samoa	34.4	*1996*	155.0	*1996*	36.0	*1996*		4.0	*1996*	...	...	

Seychelles	132.4	*1996*		467.6	*1996*		394.6	*1996*		12.2	*1996*		...	...
Sierra Leone	7.3	*1996*		33.0	*1996*		4.7	*1996*		0.4	*1996*		...	...
Singapore	162.7	*1998*		492.1	*1998*	[a]	...	...		28.9	*1998*		...	...
Solomon Islands	14.0	*1995*		119.0	*1995*		...	...		7.0	*1995*		...	...
South Africa	56.3	*1996*		471.8	*1996*		...	...		17.8	*1996*		...	...
Sri Lanka	36.5	*1999*		102.7	*1999*		41.9	*1999*		2.5	*1999*		4.5	*1999*
Swaziland	15.1	*1996*		...	...		...	...		...	...		...	...
Tonga	44.0	*1997*		315.1	*1997*		31.0	*1997*		9.2	*1997*		...	...
Trinidad and Tobago	78.8	*1994*		286.8	*1994*		...	...		8.4	*1997*		...	...
Tuvalu	30.0	*1999*		300.0	*1999*		90.0	*1999*		10.0	*1999*		...	...
Uganda	...	...		18.7	*1996*		13.6	*1996*		0.2	*1996*		...	...
United Kingdom	164.0	*1993*		497.0	*1989*		43.3	*1989*		39.8	*1992*		58.2	*1992*
United Republic of Tanzania	4.1	*1995*		85.2	*1995*		44.8	*1995*		0.7	*1995*		...	...
Vanuatu	12.0	*1997*		260.0	*1997*		...	...		...	...		...	...
Zambia	6.9	*1995*		113.1	*1995*		...	...		...	...		...	...
Zimbabwe	13.9	*1995*		128.7	*1995*		28.1	*1995*		1.3	*1995*		...	...

[1] *Source*: WHO Statistical Information Systems: Estimates of numbers of doctors, dentists and nurses by Member State provided by WHO Regional Offices. Available from www-nt.who.int/whosis/statistics/menu.cfm [Accessed 4 December 2000]

[2] Fiji Islands was suspended from the councils of the Commonwealth in May 2000 following the overthrow of its democratically elected government

[3] Pakistan was suspended from the councils of the Commonwealth following a military coup in that country

analysis of doctor resignations in Tonga over a 10-year period, excluding the one who retired after 39 years service, indicated that 7 of 13 (54%) left to pursue further educational qualifications, 2 left to take up private practice in Australia, 2 left to take up academic or other public appointments elsewhere, and 2 resigned, one on marriage to a national of another country and the other because of family commitments.

The situation with nurses also varies between countries in the Pacific region[3]. In the Cook Islands 30 nurses are estimated to have been lost in the 5 years prior to 1999 as a result of either retirement or migration, and in Tuvalu it is estimated that 6 nurses emigrated in the 6 years up to 1999. In Tonga, in 1999 alone, 25 nurses were thought to have emigrated and gone to New Zealand. In Fiji it was reported in the press in June 1999 that more than 70 nurses attended specially established interviews designed to attract nurses to employment in New Zealand[27]. Although it was not known how many nurses would subsequently take up offers of employment in New Zealand, at the time of the report the requests from the Fiji Nursing Association for improved conditions and salaries remained un-addressed by the government and it was thought that while this situation remained unresolved, an outflow of nurses seeking improved pay and conditions of service would continue. Such an outflow was also thought to jeopardise the eventual success of the newly established nurse practitioner training programme.

Among small states in the Pacific and Indian Ocean regions, only Ministries of Health in the Maldives, Nauru, Papua New Guinea and the Solomon Islands considered that emigration of health service personnel was not an issue, although in the Solomon Islands it was seen as a possible issue in the future[3]. In the Seychelles, emigration appeared to be a cyclical problem,

Table 2 Commonwealth countries. Relationship between human development and estimates of health personnel

Country	Population (000s) 1996[1]	Human development index (HDI) 1997[2]		Numbers of health personnel per 100,000 population[3]		
		Rank	Value	Physicians	Nurses[4]	Dentists
High human development						
Canada	29,964	1	0.932	229.1	897.1	58.6
Australia	18,312	7	0.922	240.0	830.0	40.0
United Kingdom	58,782	10	0.918	164.0	497.0	39.8
New Zealand	3,635	18	0.901	217.5	771.0	39.0
Singapore	3,044	22	0.888	162.7	492.1	28.9
Brunei Darussalam	290	25	0.878	84.8	401.5	12.8
Cyprus	740	26	0.870	255.0	447.0	65.0
Barbados	264	29	0.857	125.4	330.3	16.1
The Bahamas	284	31	0.851	151.8	229.7	25.4
Malta	373	32	0.850	261.0	1100.0	35.8
Antigua and Barbuda	66	38	0.828	113.6	330.3	18.2
Medium human development						
Trinidad and Tobago	1,297	46	0.797	78.8	286.8	8.4
St Kitts and Nevis	41	51	0.781	117.1	497.6	19.5
Dominica	74	53	0.776	49.3	415.5	5.6
Malaysia	20,565	56	0.768	65.8	113.3	8.6
Mauritius	1,134	59	0.764	85.0	232.9	13.5
Fiji Islands[5]	803	61	0.763	47.6	195.1	4.3
Seychelles	77	66	0.755	132.4	467.6	12.2
St Vincent and the Grenadines	112	75	0.744	87.7	238.6	5.3
St Lucia	158	81	0.737	47.3	263.0	6.2
Jamaica	2,547	82	0.734	140.1	64.5	9.0
Sri Lanka	18,300	90	0.721	36.5	102.7	2.5
Maldives	265	93	0.716	40.0	113.0	
Guyana	839	99	0.701	18.1	84.2	3.8
South Africa	37,643	101	0.695	56.3	471.8	17.8
Swaziland	926	113	0.644	15.1	...	...
Namibia	1,584	115	0.638	29.5	168.0	4.0
Vanuatu	173	116	0.627	12.0	260.0	...
Solomon Islands	389	118	0.623	14.0	119.0	7.0
Botswana	1,480	122	0.609	23.8	219.1	2.2
Lesotho	2,023	127	0.582	5.4	60.1	0.5
Papua New Guinea	4,401	129	0.570	7.3	67.0	2.7
Zimbabwe	11,248	130	0.560	13.9	128.7	1.3
India	945,121	132	0.545	48.0	45.0	

Ghana	17,522	133	0.544	6.2	72.0	0.2
Kenya	27,364	136	0.519	13.2	90.1	2.2
Pakistan[6]	133,510	138	0.508	57.0	34.0	2.3
Low human development						
Nigeria	114,568	146	0.456	18.5	66.1	2.6
Bangladesh	121,671	150	0.440	20.0	11.0	...
Zambia	9,215	151	0.431	6.9	113.1	...
United Republic of Tanzania	30,494	156	0.421	4.1	85.2	0.7
Uganda	19,741	158	0.404	...	18.7	0.2
Malawi	10,016	159	0.399	...	...	...
Gambia	1,147	163	0.391	3.5	12.5	0.5
Mozambique	18,028	169	0.341	...	...	...
Sierra Leone	4,630	174	0.254	7.3	33.0	0.4
HDI not available						
Samoa	172	...	...	34.4	155.0	4.0
Tonga	97	...	...	44.0	315.1	9.2
Tuvalu	10	...	...	30.0	300.0	10.0
Belize	222	...	...	54.8	82.0	10.6
Cameroon	13,676	...	...	7.4	36.7	0.4
Kiribati	82	...	...	29.6	235.8	4.9
Nauru	11	...	...	157.0	588.0	

[1] *Source*: Commonwealth Secretariat. *Health in the Commonwealth: sharing solutions 1999/2000*. Appendices. Table 1: Health indicators (i). London: Kensington Publications; 1999

[2] *Source*: UNDP. *Human Development Report 1999*. Figures in 1999 report reflect new and improved data for 1997 and were calculated using new methodology. Available on-line from www.undp.org/hdro/report.html [Accessed 4 December 2000]

[3] *Source*: WHO. Estimates of Health Personnel (around 1998) Available on-line from www.who.int/whosis/statistics/menu.cfm [Accessed 5 December 2000]

[4] Figures for Cyprus, Pakistan and Singapore include midwives

[5] Fiji Island was suspended from the councils of the Commonwealth in May 2000 following the overthrow of its democratically elected government.

[6] Pakistan was suspended from the councils of the Commonwealth in October 1999 following a military coup in that country

with periods of stability followed by periods when emigration took place, based on opportunities that exist overseas.

The Caribbean region also consists of island states, but several of these are highly developed and have larger numbers of health personnel. This is illustrated in Table 4. However, all 10 countries responding to a questionnaire indicated that they had a shortage of one or more categories of health professionals[4]. The main problem was retention of nurses/midwives, but shortages were also noted in all the other categories of health worker specified on the questionnaire, namely, medical laboratory technologists, pharmacists, physicians, public health inspectors, and radiographers. Barbados indicated that it also had problems retaining physiotherapists and occupational therapists, and Trinidad and Tobago was experiencing problems retaining scientific assistants. The survey revealed a clear perception that there were three main reasons for this loss of trained health personnel: poor conditions of service, poor conditions of work and much more attractive opportunities in the private sector and elsewhere.

In contrast the African region is characterised by large countries, some of which are amongst the most poorly developed in the world[24]. Rural populations tend to be widely dispersed and

may be several days journey from the nearest town. Some illustrative overall figures are given in

***Table 3* Pacific region: numbers of health personnel in selected countries[1]**

	Cook Islands		Kiribati		Papua New Guinea		Samoa		Tonga		Tuvalu	
Population	18,500		78,000		4,197,000		169,000		104,000		13,000	
Year	1998		1998		1996		1998		1998		1999	
Staff category[2]												
	Staff in post	Estab-lish-ment	Staff in post	Estab-lish-ment	Staff in post	Estab-lish-ment	Staff in post	Estab-lish-ment	Staff in post	Estab-lish-ment	Staff in post	Estab-lish-ment
Medical	17	...	16	25	259	...	47	60	80	93	6	9
Dental	4	...	10	18	300	...	44	56	34	37	3	3
Nursing	65	...	172	192	3220	...	337	393	337	339	34	43
Pharmacy	4	...	5	7	...	...	17	21	13	15	2	3
Laboratory	7	...	11	15	...	...	28	34	20	23	1	2
Imaging	2	...	3	6	...	...	17	21	14	15	2	2
Allied health	3	...	10	13	...	...	23	27	10	13	1	1
Health Extension Officers	-	-	-	-	268	...	-	-	-	-	-	-
Community Health workers[3]	-	-	-	-	1028	...	-	-	-	-	9	9
Aid-post orderlies	-	-	-	-	909	...	-	-	-	-	-	-
Health inspectors	23	....	9	11	71	...	28	34	29	30	1	1

[1] *Source:* Dewdney J. Draft workforce plans of selected countries 1998. As quoted in Rotem A and Bailey M. *Health personnel migration within Commonwealth countries.* A report prepared for the Commonwealth Secretariat by the School of Medical Education Faculty of Medicine, University of New South Wales, Australia; 1999 (unpublished)

[2] For ease of comparison, in the quoted table staff were "bulked" i.e. nurses and nursing assistants were presented as one total figure; health education officers were included with physiotherapists as "allied health"

[3] Figures for community health workers and aid-post orderlies were recognised as being inaccurate as these may be defined differently in different countries or not counted as part of the salaried workforce

Table 5, but these may mask stark contrasts between urban and rural areas. Migration of health workers is a problem for many of the countries with which contact was made, especially Ghana, Lesotho, Malawi, Nigeria, Tanzania, Uganda, Zambia, and Zimbabwe[10]. Botswana has less of a problem and in Namibia migration is not an issue. In South Africa, emigration is accompanied by significant immigration of health professionals. Immigration is also a feature in some other countries such as Namibia and Lesotho.

In Ghana, for example, studies have shown that the country lost approximately 61% of doctors that graduated from one medical school over the 10-year period between 1985 and 1995 and the indications are that the proportions have increased in recent years[28]. Whereas, in 1980 the average age of lecturers in the University of Ghana Medical School was 35, it is currently estimated to be nearer 55 and this is thought to reflect the unavailability of younger graduates to replace existing lecturers[29]. There is a perception that the severe shortage of nurses has frequently been made worse by active recruitment of nurses by agents from the United Kingdom[10], although this situation should improve following the introduction in the

United Kingdom in November 1999 of a government policy not to recruit actively where this will have an adverse effect on the health care systems of the home

***Table 4* Caribbean region: health professionals by category and ratio per 100,000 population by country (around 1997)[1]**

Country	Year	Physicians		Professional nurses		Dentists	
		Number	Ratio/ 100,000 pop.	Number	Ratio/ 100,000 pop.	Number	Ratio/ 100,000 pop.
Anguilla	1997	14	175.0	29	362.5	1	12.5
Antigua & Barbuda	1996	75	113.6	218	330.3	12	18.2
The Bahamas	1996	419	151.8	634	229.7	70	25.4
Barbados	1993	334	125.4	880	330.3	43	16.1
Belize	1996	119	54.8	178	82.0	23	10.6
Bermuda	1997[2]	113	176.6	523	895.5	27	42.2
British Virgin Islands	1997	23	115.0	66	330.0	4	20.0
Cayman Islands	1997	64	193.9	197	597.0	11	33.3
Dominica	1996	35	49.3	295	415.5	4	5.6
Grenada	1996	46	49.5	342	367.7	8	8.6
Guyana	1997	153	18.1	713	84.2	32	3.8
Jamaica	1996[3]	3,428	140.1	1,578	64.5	220	9.0
Montserrat	1997	2	18.2	32	290.9	1	9.1
St Kitts and Nevis	1997	48	117.1	204	497.6	8	19.5
St Lucia	1997	69	147.3	384	263.0	9	6.2
St Vincent & the Grenadines	1997	100	87.7	272	238.6	6	5.3
Trinidad & Tobago	1994	1,074	78.8	3,910	86.8	109	8.4
Turks & Caicos Islands	1997	11	73.3	29	193.3	1	6.7

[1] *Source*: PAHO/WHO. *Health conditions in the Americas, Vol. 1*. Washington, DC: PAHO/WHO;1998. p.284-286. As quoted in Reid UV. *Human resource development for health project: Commonwealth Caribbean*. A report prepared for the Commonwealth Secretariat; 1999 (unpublished)

[2] For professional nurses, figures in Bermuda relate to 1991

[3] For dentists, figures in Jamaica relate to 1994

countries[30]. In Lesotho, only 30% of persons awarded WHO fellowships returned after studying abroad[6]. Ten doctors trained overseas in a five-year period also failed to return[31].

On the other hand, responses from Namibia and Lesotho indicated that 50% or more of doctors in the public service are expatriates[32,33]. The proportion of expatriates is smaller in South Africa but numerically far more significant. 22% of the 6,705 doctors on the register of the South African Health Professionals Council were expatriates, and 8% of doctors on the register practiced outside South Africa. 18% of the registered expatriate doctors were specialists[34].

In the Asian region, no country-specific data were obtained from countries[20]. The only figures available for migration of doctors from the Indian sub-continent are indirect and relate to "analysis of ordinary passports" (i.e. the numbers of individual doctors applying for passports) and analysis of data from recipient countries[20]. Although holding a passport does not mean an individual has ever gone abroad, or that he or she is practising or has settled in a foreign country, during the 35 years before 1986-87 on average less than 2,220 doctors

applied for passports each year, but in 1986-87 alone 5,300 doctors applied for passports. Studies from Canada, the USA, the UK and the oil exporting

***Table 5* African region: total number of staff in Ministry of Health's services in countries responding fully or partially to a questionnaire[1]**

	Ghana	Lesotho	South Africa[2]	Namibia	Malawi	Sierra Leone
No. of doctors	MOH-1998	MOH-1998	ALL-1999	ALL-1999		
Total doctors	1188	134	36,518	277	101	222
GPs	1093	109	27,012	252	81	...
Expatriates	133	74	5,507	142	...	0
Locals	960	35	21,505	110	...	...
% expatriates	12.2%	67.9%	20.0%	56.4%	...	0.0%
Specialists	95	25	9,506	25	20	...
Expatriates	...	18	1,198	10	10	0
Locals	...	7	8,308	15	10	...
% expatriates	...	72.0%	12.6%	40.0%	50.0%	0.0%
No. of nurses						
Total nurses	12,945	1,305	146,036[3]	1,516	1,643	...
Expatriates	41	10	...	10	...	...
Locals	12,904	1,295	...	1,506	...	...
% expatriates	0.3%	0.8%	...	0.7%	...	...
No. of others						
Total others	...	...	52,175[4]	40[5]	...	...
Expatriates	...	...	...	2	...	...
Locals	...	...	...	38	...	...
% expatriates	...	...	...	5.0%	...	...

[1] Source: Dovlo DY. Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African States. A report prepared for the Commonwealth Secretariat; 1999 (unpublished)

[2] Data from Health Professions Council of South Africa

[3] 1994 data

[4] Others comprise of dentists, psychologists, optometrists, physiotherapists etc

[5] Medical technicians

countries of Saudi Arabia, Libya, Kuwait, United Arab Emirates and Qatar, show that the numbers of doctors immigrating have continued at or above the rates of the 1970s with little evidence that these doctors subsequently return home[20]. More than 382,000 doctors have been trained in India since independence (1947), some 15-16% of whom are practicing abroad. This means at least 60,000 doctors have left India since independence[20]. A recent study by the Foundation for Research in Community Health for the Indian Council for Medical Research has shown that on average 40% of private sector medical doctors migrate abroad[35]. Other sources have assessed the migration rate to be as high as 57% of all graduating doctors in recent years[36]. What is striking about this migration of physicians is that not only are they highly trained, but also they are mostly from the costliest and most elite medical schools, because it is only these institutions that tend to be of international standard[20].

2.4 Countries or sectors to which personnel are lost

Despite the variations in the nature of the groups of professional staff who migrate in the different Commonwealth regions, analysis of the reports indicates there are similarities in the recipient countries to which all staff migrate. The Commonwealth constitutes one of the

largest language blocks in the world, with English used extensively for education and training in nearly all member countries. It is therefore perhaps not surprising that many Commonwealth professionals migrate to English speaking countries, particularly to those countries with which they have ties through past colonial links, previous immigration, or the migration of relatives. The direction of flow tends to be from developing to more developed countries which provide better opportunities for families and higher levels of pay for employees. More developed countries within the region may act as intermediate destinations for those who eventually migrate further afield.

Consequently, the United Kingdom and other developed Commonwealth countries (Canada, Australia and New Zealand) are common destinations for health professionals from the African region, along with the richer developing countries within the region such as Namibia and South Africa[10]. For example, the commonest destinations of Ghanaian Medical graduates who migrated in the period 1985-1994[6] were the United Kingdom 143 (55.2%), the United States: 92 (35.1%), the Republic of South Africa: 16 (6.2%) and Canada: 3 (1.3%). Of the 50% or more of expatriate doctors in Lesotho and Namibia, significant proportions come from other African Commonwealth countries[32,33].

The main destinations for professionals from the Asian region are the English-speaking countries of Canada, the USA and the UK[20]. Additionally it appears that there are significant flows to the oil exporting countries of the Middle East. Although exact data are not available, between 1975 and 1980 the number of foreign workers from Asian countries working in these oil-exporting countries increased from 360,000 to 820,000. Of this increase of 460,000 in 5 years, most were in the engineering and health/medical sectors[37]. Other data indicates that between 1982-86 80 to 99% of foreign doctors in individual Gulf countries were from outside the region, mainly from India and other countries in the Asian sub-continent[20].

The results of a survey undertaken in Commonwealth Caribbean countries showed that the losses of health professionals from the region were mainly to the USA, Canada, and the UK[4], although there was also some movement to other Caribbean countries as well as to the private sector[4].

In the Pacific region, migration was frequently associated with tribal wars, until the nineteenth century when colonial development led to transport of labour to work on tea or sugar plantations[3]. This background has produced a culture which accepts that families will relocate for various reasons. Both Australia and New Zealand now have significant South Pacific Islander populations, and there are increasing numbers of people obtaining permanent residence status in North America, often via migration to places which were previously US dependent territories. Countries of destination tend to be related to race, with the USA being the target for Micronesians, Tongans and Samoans with existing relationships there; New Zealand the target for all Polynesians and some Indofijians; and Australia the target for a smaller number of Polynesians, some Melanesians and Indofijians. Pacific Islands Chinese migrate to the United States, Canada and Australia.

Internal migration with the Pacific Island has also increased significantly, with people being primarily attracted to the towns, mining sites, plantations and tourist areas[3]. Employment is not the only attraction and factors as diverse as extra facilities, anonymity, and a wider range of stimuli draw many people, particularly teenagers and young adults.

2.5 Effects of loss of health professionals

The effects of these losses of health professionals are numerous and multifaceted and have far reaching consequences both for the economies and for the development of health services in countries. As an illustration, the following account describes the consequences as experienced in the African region[10] and these are likely to be common to many developing Commonwealth countries.

2.5.1 Loss of Health Professionals (Service providers, Tutors)

The loss of skilled personnel not only restricts or reduces service delivery and access for the population, but also impacts negatively on the training of health professionals, as persons likely to become trainers are among those lost. For example, the increasing average age of lecturers in the Ghana Medical School, thought to reflect inability to replace lecturers over the years[29], [has] already been referred to. At the same time, nursing training schools in Ghana suffer from a serious shortage of tutors. The effects of loss of health professionals on service delivery are often further exacerbated by limited expansion in training of health workers, despite population growth and expansion of services.

2.5.2 Effects on quality of care – numbers and skills

The reduced number of trained health workers and an increasing work load due to larger populations and demands for services are likely to lead to a decline in quality of care. This issue is further complicated in poorer countries by low economic performance and deterioration of infrastructure and logistic support. Even where some substitution occurs with lower grades such as auxiliaries and assistants, the absence of more highly skilled workers means diminished supervision and support to staff. In the African region quality of care has become an issue, particularly in Ghana and a number of other countries with serious mal-distributions which lead to shortages of skilled personnel in the rural areas[10].

2.5.3 Effects on ethics and professionalism, discipline and morale

The anticipated effects on the training and updating of health workers set out above may also make inroads into the quality and ethics of health professionals. In Ghana, a few well publicised cases relating to quality of care have highlighted the reductions in supervision of junior staff and the amount of responsibility left in the hands of auxiliaries and untrained personnel. Discipline and morale have suffered as some staff have felt that their supervisors lacked the technical acumen and moral authority to exercise supervisory control over them[38].

2.5.4 Effects on training of new staff

The lack of trainers and the use on non-professional tutors in training schools also affect the quality of training and consequently the quality of the health workers produced. In the African region this has affected the clinical experience that students get in the facilities due to shortage or absence of specialists to provide lectures. The lack of tutors has meant that trainers are asked to be generalists who try to teach a wide range of subjects. The number of students per tutor may also increase and lead to less attention being given to individual students. For example, in Lesotho's National Health Training Centre in 1994, 3 established and 27 un-established staff were running 10 courses that were considered to require an establishment of 43 staff[39].

2.5.5 Effects on service delivery, service management and service development

In addition to the obvious effects of loss of skilled health professionals on service delivery, loss of managers sent abroad for continuing education also has a negative effect on service delivery. Facilities are often run by untrained managers, and there is a lack of continuity in management. As a result, service delivery and the development of new services have suffered from the absence of institutional memory and of lessons learnt from experience. These factors may contribute to lack of morale and a poor work ethic.

2.5.6 Shortage of and inequitable distribution of professionals with skills

The shortages resulting from the loss of health professionals can exacerbate the inequitable distribution of staff between urban and rural areas, a phenomenon that also occurs in well endowed countries. Staff are usually concentrated in urban areas and most are unwilling to serve in less accessible areas. In Ghana, for example, there are no obstetricians, psychiatrist, paediatricians or physicians in the three most northern regions that together account for about 35% of the land area and 18% of the population. Overall the most northern region has only 6% of doctors for its 18% of the population[40].

2.5.7 Drain of resources

Nayak[41] has estimated that India has lost some US$ 3.6 to 5.0 billion in terms of the costs of training the estimated 83,000 doctors who have emigrated since 1951, whereas the USA has gained some US$ 26 billion, in respect of its estimated total of 130,000 foreign medical graduates that it has not trained. Similarly in Ghana, estimating tuition costs conservatively at US$ 20,000 per student[41], during the 10 year period 1985-1994, the 61% graduates from one medical school who migrated are estimated to have cost Ghana US$ 5,960,000. When the costs of educating graduates from Ghana's other medical school who migrated and the costs of educating of nurses who migrated to the UK, Jamaica and the USA, are added up, the overall loss could easily be US$ 10 to US$ 15 million over the 10-year period[10].

Such financial losses are occurring in countries least able to afford them and which do not have the resources to effectively tackle their problems of migration. Where more than 10% to 15% of qualified personnel migrate to other countries, these losses may be debilitating[10]. At the same time the need for external experts continues to increase and countries seek to secure technical assistance at high cost, a significant proportion of which is funded from loans.

On the other hand, in purely financial terms, losses need to be seen alongside the remittances that overseas workers often make to their families and dependents at home[10,42]. Such remittances can be substantial and, for some small states, may represent a significant proportion of foreign income.

CHAPTER 3

Issues and problems relevant to recruitment, deployment, utilisation and retention

3.1 Introduction

Addressing the problem of migration for individual countries needs to be part of their overall approach to human resource development. The three familiar interacting components of the process of human resource development for health, namely policy/planning, education/training and management/utilisation each have significant effects on whether staff are subsequently retained in government health services or lost through migration or to more attractive opportunities within the country. This Chapter outlines the relevant issues and problems currently facing Commonwealth countries in each of these areas.

Analysis of the reports from each of the four Commonwealth regions[3,4,10,20] indicates that virtually all countries studied were experiencing problems, for at least some staff groups. The balance of factors contributing to the problems varied between countries and regions, but there were few, if any, instances where factors were identified that were unique to any one region or country.

3.2 Policy/planning

A clear national plan, identifying the goals and objectives of the health sector in the country within the budget available, is now acknowledged as a key factor in the effective recruitment, deployment, utilisation and retention of staff [2,3]. An integral part of the national plan must be a fully developed human resource plan[3,4,10] that is based on, and integrated with, the identified service needs, covers all groups and occupations together rather than in isolation, and is based on the objective of integrated teams of health workers[43]. This allows the appropriate numbers of staff and the balance of skills (professionals and auxiliaries) required for the service both now and in the future to be determined and, following review of sources of supply and likely losses, allows appropriate decisions to be made about the numbers and types of new personnel that should be trained. Many Commonwealth countries still lack such plans[5].

There are many reasons why Commonwealth countries lack fully developed human resource plans: conditions in recent years may have not favoured planning[4], there may have been a tendency for countries to view workforce planning as a "bolt on" extra that is of secondary importance to other priorities facing their health services[10] and there may be lack of personnel with the relevant skills to carry out such planning[3,4].

Failure to develop systems for maintaining a database on skills and human resources which will provide accurate data to feed into the planning process may contribute to inadequate planning. In the Commonwealth Caribbean countries, for example, it was noted that information systems which are crucial for decision making are absent or weak[3]; in the Pacific region much indicative information is not collected because of the unavailability of experienced statisticians and epidemiologists[3].

The result is that even where some planning has been carried out, it may not be very comprehensive or appropriate to the circumstances. Comprehensive efforts may not have been made to describe and fully understand the issues of staff retention[10] or external consultants may have done the planning, leaving countries with imposed solutions and unrealistic assessments and recommendations[5].

The consequences of lack of, or inappropriate, planning are significant. In India, for example, it appears to have resulted in the continued production of doctors far in excess of the country's needs, even when the output of private medical schools is disregarded[7]. In the African region, there has been a tendency to continue to produce the types of staff who emigrate[10]. In the Caribbean the consequences have been noted to include: outdated figures for the appropriate numbers of established posts, resulting in establishments that could not be afforded even if staff were available; staff whose educational and technical preparation is unsuited for tasks required; mal-distributions of staff between urban and rural areas; and poor utilisation of staff[4]. These consequences are similar elsewhere[3,10] and contribute to the problem of unproductive and/or demoralised staff[22] who are more likely to leave the service should an opportunity arise.

3.3 Education/training

Apart from inadequate planning within the health sector for the numbers of health personnel required, some countries in the Pacific region face particular problems related to the pre-service education and training. As elsewhere, the educational level of people accepted for pre-service health professional training is largely dependent upon the secondary education system. In Tuvalu, for example, the existing secondary school cannot fully meet the demand for secondary education. Standards vary from country to country, but in some countries the output of well-educated high school graduates may be low. As a result, only a small number of eligible people may be available to enter professional training. Low educational qualifications affected recruitment in at least one country in the Caribbean[3].

In the Pacific region the tradition of sending the brightest young people to secondary schools in Australia or New Zealand[3] may encourage their subsequent entry into health pre-service institutions abroad and they may not return to work in their home countries.

Traditionally, nurses have been educated in home countries in programmes provided and administered by the Ministry of Health[2]. Where both pre-service education and delivery of health services take place in the same institution, education may be compromised by the co-existing need for service delivery to patients[3]. Partly in response to this, nurse education worldwide is undergoing review and development. Increasingly, pre-service education in some countries is being provided in "main-stream" institutions under the auspices of Ministries of Education. Within the Pacific region, Samoa is perhaps the most advanced with a three-year diploma course for nurses at the University of Samoa. One undesirable side effect of this is that graduates can readily gain registration in New Zealand, and the loss of nurses from Samoa may increase in future.

Where skilled personnel are needed in relatively small numbers, governments are frequently unable to provide in-country training[3]. For example, there is no University in the Seychelles so that a number of doctors, nurses and pharmacists go abroad for continuing education. In the past, people from the Seychelles were educated in Eastern Bloc countries, Russia and Cuba. Since the Seychelles became a democracy, trainees have been educated in Australia, New Zealand, Zimbabwe and South Africa. An emerging problem is that, whereas people always returned from the Eastern Bloc as they were not permitted to register there, they do

not always return form Western countries which permit registration. A further disadvantage of educating doctors and nurses abroad in developed countries is that the education provided is not necessarily suitable for public health initiatives and rural health services in home countries[3].

In small countries, where the main need is for public health initiatives and rural health services, some specialist practitioners are required to deal with secondary and tertiary referrals. When specialist training is undertaken overseas, this can bring additional problems. For example, until recently, doctors in the Pacific region needed to study abroad to obtain post-graduate specialist qualifications[3] and donor agencies frequently fund post-graduate studies in developed countries[3]. On completion of their courses, doctors often wish to practise for a period before returning home. On return, however, they may find there are insufficient patients to maintain their specialist skills. Salaries may be low, and the country unable to offer increases. The doctors may not be able to meet their financial commitments and may choose to emigrate. There are also the attractions of a better life elsewhere[44,45].

Education in country may not obviate all the problems outlined above, particularly if the curriculum is not tailored to the needs of the country. In the African region, for example, it was noted that specialist training tended to be devised from curricula initially borrowed from developed countries, resulting in graduates who may not function well in their own less developed environments[10]. In the Asian region, it was noted that it is the doctors trained to international standards who migrate[10]. This has high economic costs, and may result in countries being less able to afford to train other health workers, which may be more suited to their health needs.

3.4 Management /utilization

The management and utilisation of personnel within health services is important as it affects working lives and individual decisions to remain in or return to government service[21,46]. The implementation of the public sector reforms currently being introduced in many Commonwealth countries, however, requires new management skills both centrally and locally and there is evidence that there has been a failure of managerial skills to keep pace. Decentralised decision-making forms part of these public sector reforms, and requires new performance management skills centrally, yet in many countries in the African region, with the possible exception of South Africa, personnel administration is still generally centralised and inefficient[10]. In the Caribbean, where there has been some decentralisation, the decentralised units are unable to assume management of transferred responsibilities, as those in management positions do not have the required knowledge and skills[4]. In the Pacific, there has also been some decentralisation, and a need for new knowledge and skills[3]. The failure of managerial practices and skills to keep pace with current requirements is reflected in poor human resource policies that contribute to poor retention and utilisation of staff[3].

These management shortcomings may be manifested in various ways:

- Recruitment procedures may be cumbersome, leading to considerable delays and frustrations even for staff trained within the country. The period of recruitment in Ghana (from application to receipt of first salary) averages one year[10]. The result of similarly drawn-out recruitment procedures in Lesotho was that none of one batch of newly qualified nurses from the National Health Training College were employed in the public service, despite the existence of vacancies[31]. Most were thought to have found employment either in the private sector or in South Africa. Slow recruitment and appointment of qualified staff is also a problem in the Caribbean[4]. Other

personnel practices such as conflict management and improving industrial relations may also be poor[4].

- Salary scales for professional groups may be perceived as inequitable. In the Caribbean, salary scales are developed within public service procedures and negotiated with trade unions that do not exclusively represent health workers, and the salaries do not necessarily reflect educational preparation or performance of health sector personnel[4].
- Terms and conditions of service and working conditions may be poor, particularly in rural areas. The responses to questionnaires sent to Caribbean countries implicated low remuneration, inflexible working hours, lack of educational opportunities, limited training, shortage of supplies and equipment, and poor working environments among the factors contributing to loss of health professionals[4]. In rural areas of the Caribbean these factors may be exacerbated by separation of staff from their families, poor housing with lack of electricity and clean water, and inadequate security. In the Pacific region, health workers in rural areas also experience problems related to the living environment and to educational opportunities for their children[3]. A further problem noted was that if relocation costs were paid, staff may be expected to stay for a given number of years that further reduced their opportunities for continuing education and for maintenance of skills. It may then be difficult for a health worker to "re-skill" even if the opportunity of relocation arose.
- Staff may be utilised poorly. Highly qualified staff may be required to undertake tasks below their level of skill/expertise. There may also be inadequate supervision of lower grades of staff[4]. Both situations can lead to low morale.
- Opportunities for promotion and career advancement may be limited. In the Caribbean, top-heavy management structures in certain professions, such as nursing, may create bottlenecks in the organisation/management structure, blocking opportunities for career advancement[4]. Promotion is often slow and in most instances tied to age or years of service rather than education, training, or performance. At the same time there are limited incentives for good performance and poor use of the performance appraisal system not sufficiently used to guide for staff development.

The consequences of these management weaknesses are significant. Not only do they lead to poor retention and utilisation of staff, but they also result in higher costs of turnover and replacement, the remaining staff may become overburdened and demoralised, quality of care may suffer and the amount of healthcare which could be provided is reduced[4].

CHAPTER 4

Factors that contribute to migration

4.1 Introduction

At societal level, the differentials that exist in remuneration between sending and receiving countries have been acknowledged as a key factor influencing decisions to migrate[2,3,4,10,20]. At an individual level the decision of a health worker to migrate is the result of the interaction of "pull" forces in recipient countries and "push" forces in the donor country[2]. For both the exporting and importing countries, the implications of these individual decisions to migrate will depend on whether the moves are permanent or temporary[6]. This Chapter is not a comprehensive account of all the forces that may operate; rather it attempts to summarise those that appear particularly influential in the migration of citizens from developing Commonwealth countries. Some of these have already been alluded to in earlier chapters and many are inter-related.

4.2 "Push" factors

4.2.1 Tradition of mobility; similarity of professional training; colonial and cultural links

There has long been a tradition of mobility within the Commonwealth[2] that still operates today[3,4,10]. A key factor is the ability of patients, clients and other health professionals in the host country[47] to communicate in a common language, English. The tradition of mobility has been further enhanced in the case of doctors and nurses by the widespread mutual acceptance of medical and nursing qualifications in member states[2] where similar patterns of medical and nursing education and practice have developed based on the United Kingdom model. Thus in the Pacific region the opportunity provided by a transferable qualification, with the possibility of registration in the target country and the likelihood of permanent residency or citizenship, have been identified as the most important factors in the emigration of health workers along with the availability of sponsorship or donor aid for out-of-country education[2]. The patterns of migration already noted from Africa[10], Asia[20] and the Caribbean[4] suggest that similar factors are still important to a greater or lesser extent in other parts of the Commonwealth also.

In the African region it has been further suggested that the depletion of expertise brought about by the exodus of expatriate experts, civil servants and professionals when countries gained their independence affected the future development of systems in those countries[5]. It is thought to have fostered the development of elitism amongst the few remaining professionals and this encouraged them to feel a particular kinship with the United Kingdom and other developed countries where they had been trained.

4.2.2 Production related to demand for education rather than need for services

In the Asian subcontinent, a key factor appears to be the demand for medical education that is part of a general demand for higher education which is unrelated to employment

opportunities[2]. For example, in 1980, in response to the growing unemployment of graduate doctors and the imbalance in the ratio of doctors to paramedical workers, the government of India decided not to increase the number of medical schools or their capacity. The result was rapid growth of private medical colleges that now constitute 17 per cent of all medical colleges in India[20]. Consequently, India is generating a massive surplus of physicians, and this is the case even when only the output of government colleges is considered[20]. Similar factors seem to operate outside the Commonwealth leading to overproduction in some European Union and many Latin American countries, either because there are no controls over entry to medical school (e.g. Italy) or because of proliferation of private sector and largely unregulated universities (eg. Chile, Costa Rica)[43].

It is not only unemployment however, that leads to migration: in the Commonwealth, education systems based on imported school models may predispose people to migrate by making them dissatisfied with their surroundings[48]. In the Asian region, the major exporting schools are all elite institutions with high international standing, as indicated by success rates in the Education Commission for Foreign Medical Graduates (ECFMG) examination for practice in the United States that are well above the average of 32 % for graduates from all Indian Universities[20]. These include the Baroda University Medical College, the Seth S. G. Medical College in Bombay, the Madras University Christian Medical College in Vellore, and the All India Institute of Medical Sciences in New Delhi, all of which are public sector institutions and receive high grants[20]. In terms of scale of migration from these institutions, it has been found that 50% of graduates from Baroda University Medical College spent the majority of their most productive years in the USA[49] and at one time Bombay graduates constituted 11% of all Indian medical graduates in the USA[20]. Yet graduates from these schools are the very people who would be likely to get jobs at home even when there are surpluses[20]. The problem seems to be that the expectations of these graduates in terms of high salaries, logistical support and specialised research and development facilities cannot be met at home, particularly in rural areas [20].

4.2.3 Educational preparation more appropriate for practice in developed country

Somewhat similar factors appear to operate, at least, in some parts of the African region[10]. In Ghana, for example, high proportions of doctors emigrate, yet far more are produced annually (average 97) than medical assistants (average 30 per annum) who are much less expensive to train and invariably almost 100% retained. In part this seems to be because they are selected competitively, trained to international standards and tend to become the elite in society. Yet there is little technical support for them once they are trained. There may be an absence of research facilities and equipment to enable them fully to utilise their training, and many work locations lack libraries and the opportunity for internal conferences and access to knowledge of changing practices[10]. In light of this, the need to be recognised as being on par with international counterparts in developed countries means that a feeling of worth can usually best be derived when working overseas. This can also lead to increased status at home. Information collected from Malawi, for example, indicated that the public held nationals, including health professionals, working in other countries in high regard.

4.2.4 Training of health professionals abroad/lack of local training facilities

Related problems arise when, through lack of capacity or provision of scholarships, health professionals undergo initial or higher/specialised training abroad in a developed country. In both the Pacific[3] and the African[10] regions it is clear that educating doctors and nurses abroad may also fail to prepare them adequately for the public health initiatives and rural

health services that form the basis of health systems in their home countries: tough screening and selection of the best students for medical and other professions result in the creation of elite professionals more primed to practice in an industrialised country[10].

In the case of higher/specialised training, the planning of health services and training of professionals and specialists may not be adequately linked, so that professional skills are developed when facilities are not ready or visa versa[10]. The result for the individual is a tension between deriving job satisfaction from practising acquired skills and providing services and utilising knowledge well below what has been acquired. Alternatively students may specialise in areas of personal interest and expertise for which the country does not have the appropriate infrastructure and technology and find there are not suitable job opportunities when they return home[10].

Furthermore, future development opportunities are often limited at home, so once away staff may try to benefit from as many other opportunities and experiences as possible[10]. The longer they stay away, the more incentives there may be to stay in the developed country: staff develop the trust and respect of colleagues; salaries are much higher; spouses and children get the benefits of more comfortable lifestyles and good education (possibly subsidised); and professional interaction and development are possible and recognised.

4.2.5 Public sector spending cuts/low expenditures in health/health sector reforms

The restructuring of public spending following structural adjustment programmes in Africa has often included major cuts in expenditure for personnel[5]. In one African country, for example, the health sector reduced its workforce by about 25% during a redeployment exercise in the late 1980s and early 1990s. Similar policies of cost containment have been carried forward in the country's Five Year Programme of Work, published in 1996, that foresees a reduction in the wage proportion of recurrent budget from about 55% to 36% by 2001[50]. The effect has been to discourage the recruitment of staff into the public services and to restrict incomes[10].

Similarly in the Caribbean, structural adjustment policies have brought about substantial reductions in government expenditure resulting, *inter alia*, in declining income and rising unemployment [4]. The consequent discontent is a major "push" factor in migration[4].

4.2.6 Bureaucratic excesses in employment processes

In many African Commonwealth countries bureaucracy seems to be the enemy of efficiency in public service organisations[10]. Even minor personnel management procedures are centralised, with recruitment and promotion processes and approval of minor welfare benefits for health professionals often involving several ministries and departments. Administrative processes are often not computerised and promotions and other service processes are carried out inefficiently, resulting in serious frustration of staff and their consequent lack of motivation.

4.2.7 Occupational risks/poor working conditions

According to the International Labour Organisation (ILO), healthcare work is one of the most dangerous occupations[51]. Risks include the possibility of infection with dangerous diseases, physical harm caused by ill patients and relatives and the problems caused, for example, by looking after fighters on both sides in a war situation[10]. In most developing countries in the African region, protection for health workers is rudimentary, and many cases are not covered by health or life insurance policies[10]. In Ghana, for example, the cases of two

seriously ill young doctors who allegedly did not receive adequate treatment at home were extensively covered in the press and are thought to have created a feeling of insecurity among young doctors. Also well publicised have been a number of senior public figures taken abroad for medical treatment while junior doctors have felt their medical needs are not responded to. As the quality of services decline, health professionals are even more aware of the implication of hazardous illness while working for low salaries and with poor protective support. Specialists are few and far between and in the more remote areas may be several days journey away. Thus health professionals such as doctors may seek to ensure their health and that of their families by earning better remuneration and working in countries where medical services offer modern support systems.

4.2.8 Lack of adequate social security, pension plans, and other benefits

Pension systems in some countries in the African region, for example in Ghana, Tanzania and Sierra Leone, reflect the low salaries received and are considered to be quite inadequate[10]. Housing and healthcare may also not be adequately provided for (although currently in Ghana free emergency care exists for those aged 70 and over). Interviews with doctors in Ghana cite these factors as determinants in their in decision to seek better remuneration abroad. In contrast, good social support systems are cited as one reason for retention of professionals in Namibia, compared with Lesotho (despite similar salaries), with Namibia having provisions for generous end of service payments, subsidised house owning schemes, car ownership and other benefits available for health professionals.

4.2.9 Social and political insecurities, coup d'états, wars and dictatorships

Dissatisfaction with disturbances and threats to life are also important in pushing people to new environments, although, overall, it may not be as important as the economic factors in stimulating migration of health professionals from within the African Commonwealth[5]. Sierra Leone has experienced a war situation in the last decade that has led to a large number of ordinary citizens and health professionals becoming refugees in neighbouring countries. Recent political tensions in Nigeria may also have created a feeling of insecurity that has fostered migration, although it is not clear whether the presence of Nigerian health professionals in many countries in the region can be directly linked to the political situation in Nigeria. Similar circumstances existed in South Africa, Zimbabwe and Namibia before independence when many black professionals lived and worked in other countries for political reasons. In one country in the African region the rule of the previous government was a factor mentioned by professionals refusing to return home[10]. Safety factors, including justifiable concern about danger to self, family and property in a society which is tribally based or divided either through racial difference or income level have also been noted as factors influencing the decision to emigrate in the Pacific region[2].

4.3 "Pull" factors

4.3.1 Increased needs for health workers in other countries

Shortages of health care professionals in some developed and developing countries can act as major "pull" factors for migration, particularly of nurses. In the Caribbean, for example, the cyclical shortages of nurses in the USA and more recently the UK have been observed to result in high impact marketing strategies in the region, causing loss of nurses and further exacerbating domestic problems for those countries that are already experiencing shortages[4]. As the metropolitan markets are now in another cycle of shortage of registered nurses, further

dynamic recruitment is anticipated[4]. In one country in the African region, formal private and public sector recruitment of nurses for the UK took place during 1997-99, including recruitment interviews by three UK National Health Service Trusts for general and psychiatric nurses during the first six months of 1999. A recruitment agency has since opened permanent offices in the country for this purpose. Similar recruitment has been occurring in other African countries [5]. In the Pacific region, recruitment drives were held in Fiji in 1999 to attract nurses to employment in New Zealand[3]. It remains to be seen the extent to which these trends will be altered in future by the growing recognition by developed countries that it is unethical to recruit actively where this might have an adverse effect on the healthcare systems of developing countries[30].

Shortages of health professionals in developing countries occasioned by loss of professionals to developed countries can in turn result in developing countries recruiting professionals from other developing countries[10]. Jamaica lost a large number of nurses to the United States and Canada, so the Jamaican Ministry of Health and the University of the West Indies teaching hospital have sought to recruit nurses from Ghana[10] and Nigeria[52] where remuneration is lower than in Jamaica. In order to manage numbers, agreements were reached to send a certain number of nurses for a specified period. In the earlier agreement with the University of the West Indies, this was successful in ensuring that several nurses returned to Ghana immediately after the specified period ended[10]. However, there is anecdotal evidence that amongst 20 of one batch of 23 nurses who returned home, some 50% were subsequently trying to obtain visas to go to the United Kingdom[53]. Furthermore, in the Caribbean, the offer of better terms and conditions of service to nurses recruited from Ghana and Nigeria is an area of great dissatisfaction amongst local nurses[52].

4.3.2 Opportunities for jobs

Shortages in specific fields of work or locations that cannot be filled by residents in a country may also act as "pull" factors for migration or provide job opportunities for new immigrants that allow them to stay. For example, specific shortages seem to be the reason for the UK seeking to recruit psychiatric nurses from countries in West Africa, and in the United States doctors can apparently receive waivers of training visas if service is provided in remote regions and in Native American Reservations[10].

In Namibia, about 50 % of all doctors in the public service are foreigners[10]. However, in the rural regions the proportion rises to about 90%. A similar situation arises in Lesotho with the majority of public service doctors (68%) in both mission and government hospitals being expatriates[33]. In contrast, in the Pacific region, although the problem of insufficient medical staff has been addressed by the recruitment of relatively large numbers of expatriates, these people generally refuse to go to the rural areas so their employment is limited to the urban areas in divisional and sub-divisional hospitals[3].

4.3.3 Salary differentials

The differential in salaries between developed and developing countries is huge and it is difficult for most countries to bridge this gap to encourage retention[10]. For example, the average monthly salary of a resident doctor in Ghana is US$ 200 compared to US$ 3000 in the United States. Yet not all countries where incomes are low compared to developed countries experience migration losses. In Namibia, for example, migration is not an issue despite only slightly smaller salary differentials with the United States than in Ghana and it has been suggested that terms and conditions of service that include housing, car loans and

other support systems may reduce the attractiveness of migration[10]. Alternatively it may be that where incomes are low emigration only takes place when supply is high relative to the amount of money available for salaries[2]. Then the salary differentials determine the direction of migration[2].

4.3.4 Provision of scholarships, fellowships and grants to be utilized in developed countries

As mentioned earlier, the availability of sponsorship or donor aid for out of country education seems to be one of the most important factors in the migration of health professionals from the Pacific region[3]. The same appears to be true in the African region[10]. As part of aid programmes to developing countries, several scholarships/fellowships are available for training in more advanced countries. In Lesotho, for example, the non-return of professionals awarded such scholarships/fellowships is quite high[10]. The new qualification increases the chances of a better job in another country and provides opportunities for additional training or work experience, opportunities to seek jobs there and opportunities for the development of professional links that may in future lead to migration.

4.3.5 Career and intellectual enhancement opportunities

Many doctors interviewed in Ghana felt discontented about career opportunities that were considered to be unevenly available or implemented with bias[10]. As training slots are few, career or intellectual development becomes very frustrating for young health professionals who feel that colleagues selected for these opportunities quickly become respected specialists who are well acknowledged in their institutions whilst others take years to achieve professional recognition. This may provide a spur for migration.

4.3.6 Technical support for intellectuals

The presence of research facilities and opportunities, as well as equipment to fully utilise professional training and experience, is likely to be a major pull factor for health professionals and health academics[10]. For example, the only cardiac surgeon in one African country was probably retained because of the availability of an up-to-date and fully functioning cardiac centre[10]. Many workplaces lack libraries and the facilities for internal conferences and access to knowledge of changing practices. Without these, and the attendant opportunities for regular debate and access to new information, professional staff may be attracted to other countries where such facilities do exist.

4.3.7 Freedom from political and administrative interference

Professionals may be attracted to pursue their occupations in places where there is an absence of harassment. In the African region, at times there seems to be routine and casual interference by administrative and political leadership of countries in the running of services[10]. High-level corruption may influence procurement of technical equipment and other logistics, leading to inappropriate tools and supplies in health facilities. Furthermore, health workers and their representatives may not be involved in the decisions on services. Implementation of flawed decisions can lead to extreme frustrations and result in migration of staff to countries that are perceived to have better governance and transparency.

CHAPTER 5

Strategic approaches that have been used by countries to reduce outward migration and to mitigate its effects

5.1 Introduction

Implementation of successful strategies to influence the retention and movement of health professionals is essential if countries are to overcome the problems caused by migration. The following discussion examines the experience of countries with strategies which have either been used or discussed by policy makers. These experiences may provide pointers to Commonwealth countries in developing strategies to meet their own needs.

Overall, most strategies seek to influence migration by providing incentives or disincentives in various forms to individual health care workers, with the related aim of getting some return on the investment made in training[10]. These measures may be accompanied by changes in the education and training of health workers that seek to match their production more closely to what the country can either afford or what it needs, and by agreements with recipient countries to manage flows. At the same time, countries may seek to mitigate the effects of loss of health care workers by recruiting personnel from countries with an adequate supply, or by developing policies to encourage health professionals within the country to return to government service.

5.2 Incentives and disincentives

5.2.1 Bonding of health professionals after training

The "bonding" of health professionals whereby graduates of health training institutions are required to provide a surety and serve within their home country for a number of years after funded undergraduate and specialist training has been used or suggested in many parts of the Commonwealth as a method of retaining health workers for reasonable periods of time [3,4,10]. In lieu of the bond, workers are required to refund specified amounts related to the costs of training. The problems related to this are numerous. In the Pacific region, for example, it has been noted that health workers are prepared to buy out their bond and in Fiji this is occurring after only one or two years[3]. In the African region, a particular problem is the difficulty of enforcement once graduates leave the country, and the effect of inflation and depreciating currencies on the value of amounts recouped when individuals can be persuaded to repay[10]. A related inequity is that those graduates who do not migrate may be much easier to trace and to recoup money from, as they may take up government employment, whilst migrants may avoid making any payments at all[10].

5.2.2 Compulsory service requirements

This policy is linked with the "bonding" of trainees discussed above: in return for student loans, fees etc. being met by the government, health professionals are expected to provide a

fixed number of years practice after graduation. This is similar to the system in the US where student loans and fees are met by the Federal government in return for a fixed number of years practice in rural areas[43]. In the Commonwealth, none of the countries contacted enforces compulsory service, although rules exist[10]. Similarly many Latin American countries have compulsory service, but there is much non-compliance[43]. In part, this may be because of the difficulties of enforcing such service. For example, in the mid-1970s, a Ghanaian doctor who had completed specialist training immediately entered private practice on his return to the country and the Ministry of Health lost the case it brought against him as the courts ruled that once the doctor practiced in Ghana, whether privately or publicly, the bond requirements were fulfilled[10]. A related problem noted in the Pacific region is that graduates from training programmes expect employment as a right, rather than as a competitive process, and the compulsory service argument can be successfully used to force a Ministry of Health to employ newly trained health workers when they may already be above their staff ceiling, or where the staff ceiling may not be fully funded by government[3].

5.2.3 Certification controls

In Ghana it was informally proposed to award degrees and certificates to graduates only after they had completed a period of compulsory service in the country[10]. The discussion never reached a formal level but posed a number of problems related to interference with human rights, the inequities of such a system applying only to health professionals and graduates, anticipated difficulties in how to administer and enforce it and whether students should be able to refuse to give service by paying fees for their training. In South Africa a recent development has been a requirement for medical graduates to serve a rural vocational posting for two years after internship/house jobs before they can be professionally registered[10]. This is justified in terms of its educational value, but at the same time the requirement ensures that South African doctors are available for service in under-served rural areas and that they remain in the country for some time after graduation. Similarly in South America, Chile, Peru and Bolivia all have a requirement for doctors and nurses to serve six months or one year in a rural area on graduation[43]. The problem is that it is not properly planned and the new graduates are often isolated at a time when they require support[43].

5.2.4 Economic incentives

Economic incentives may be a successful method of retaining health workers, but in practice it seems to have limited application due to the inability of countries to afford large-scale salary increases. In the UK, where there are particular problems with recruitment and retention of nurses, boosting pay by higher percentages than for other workers does seem to have been a significant factor in improving recruitment and retention[54]. In the African region, however, a key concern of health sector reforms has been to reduce the expenditure on staff, so that salaries in general have remained low[10]. In the Caribbean salaries have also been kept down[3]. In the Pacific region, where "market allowances" have been paid to artificially inflate salaries, some of those implemented, such as those to doctors in Kiribati, have not been sufficient to be acceptable to medical staff[3]. Furthermore, salary increases for one group of staff may have knock-on effects for others. In Tonga, nurses have been arguing for their entitlement to a 35% allowance on salary as they are in the front line of health care, after a 30% increase was awarded to doctors for similar reasons[3].

5.2.5 Using training and career opportunities as incentives

An example from Indonesia[55] indicates that using quicker access to postgraduate training served as an incentive to attract doctors to rural practice and retain them in the country. Within the Commonwealth, this strategy does not seem to have been so successful. Ghana previously required doctors to serve for a minimum of two years in a rural area before qualifying for postgraduate training[10]. The system was gradually abandoned as a result of a continued demand by the Medical Schools to retain exceptional graduates for direct entry to training as lecturers/specialists without their participation in the scheme. Furthermore, selection in this way was not always seen to be fair and seemed to facilitate early migration, whereas those who did serve in rural areas had more difficulty passing post-graduate entry exams as they lacked libraries and supervisors and their entry into specialisation was in effect delayed further[10].

5.2.6 Other incentives

Provision of free or subsidised housing and other benefits have also been used or considered useful in retaining staff[3,4,10], not just in developing countries[56]. However, the evidence for success of this strategy is mixed. The differential in salaries between developing countries in the African region and developed countries is huge and it is difficult for most countries to bridge these gaps and retain their professionals[10]. In Namibia it is thought that provision of housing, car loans and other support systems may reduce the need/urge to migrate compared to other African countries with similar salary differentials[10]. On the other hand, in the Pacific region, where free or subsidised accommodation is frequently used by government for certain categories of staff, or for staff in remote locations where other accommodation may not be available, this tends to be viewed as part of the salary package as a right, and whilst desired, does not seem to discourage emigration[3].

5.2.7 Restricting opportunities to take qualifying examinations for entry to other countries

In India the government banned the holding of the United States Examination Commission for Foreign Medical Graduates (ECFMG) examinations in its attempt to reduce migration, but the numbers taking the examinations remained high as doctors travelled to the USA to take the examinations[20,41].

5.2.8 Continuing education programmes

Some countries in the Caribbean have identified continuing education programmes as a possible approach to reduce outward migration[4]. Although there is no doubt that providing continuing education is important in its own right to ensure the workforce maintains appropriate expertise and skills, the experience from the Pacific region is that, in itself, it is not successful in discouraging health workers from emigrating[3].

5.2.9 Recruitment drives to influence return home

Another possible strategy to influence movement of health workers is formulation of country-specific recruitment drives to influence return home[4]. In the Pacific region where this strategy has been employed it has met with only limited success – only one health worker is known to have returned to Tonga as a result[3]. On the other hand, the Irish government has had some success in targeting Irish nurses working in the UK and elsewhere[43].

5.3 Changes in the education and training of health workers

5.3.1 Reduction in the numbers of highly skilled workers trained

Some authorities see the loss of skilled health workers through migration to be the result of policies of over-production in the "market" sense that countries are training more professionals than they can subsequently pay and retain[10]. From this point of view, the production of health workers should be moderated by the ability of the country to pay a living wage. Without any other changes, however, such a policy would have implications for quality of care, population coverage and workload of a few professionals and is probably not a sustainable solution.

5.3.2 Withdrawal of recognition of qualifications by developed countries

In the Commonwealth, for the reasons outlined earlier, the qualifications of doctors and nurses have tended to be internationally recognised and this enhances the mobility of these staff groups. In the report from the Pacific region, there was acknowledgement that negotiating withdrawal of recognition of qualifications by developed countries would be beneficial in reducing opportunity for migration, but also that such a strategy is probably unworkable[3]. Implementation would require collaboration of all South Pacific countries and of Australia, New Zealand, the United Kingdom and other countries, particularly those where education is undertaken[3]. This would also infringe peoples' rights to live and work where they choose. Furthermore, staff registered abroad, where their initial qualifications were obtained, would experience no barriers and could continue to migrate.

5.3.3 Making training more appropriate to local needs

Where initial training is carried out in country, another approach is to make it more appropriate to local needs. New medical schools in Ghana, South Africa and elsewhere have made attempts to introduce problem solving, student-focused, community based approaches to medical education that are expected to prepare physicians who are more suited to practise within the countries concerned[10]. Elsewhere, in the Philippines for example, this has been taken further by the development of a "step-ladder" career based system that allows health workers to start from the bottom and eventually end up as more highly skilled types of health workers, including physicians. It was felt such workers would be more committed to staying in their communities[57].

5.3.4 Development of local specialist qualifications

A further approach has been the development of local postgraduate courses. Development of local opportunities for specialist education in the Pacific region, in Papua New Guinea and Fiji, have ensured that medical staff received the education that is relevant to their practice and that they do not receive a qualification that provides automatic transferability to a developed country[3]. On the other hand a similar initiative in West Africa by the West African Health Community that led to the setting up of Postgraduate Colleges for Physicians, Nurses and Pharmacists has not prevented migration[10]. In Ghana, for example, although the Medical College set up in 1980 has had some effect on retention, many residents who passed through the programmes still emigrated. After graduation, the specialists often proceeded to the United Kingdom and other developed countries to obtain "international" qualifications equivalent to those of the West African College.

5.3.5 Development of short relevant training courses for established staff to meet local health needs

In 1989 the Ministry of Health in Ghana attempted to resolve major eye care problems, made worse by shortages of eye nurses and ophthalmologists, by setting up local training courses[10]. These were very practical and community-based courses that led to qualification of doctors as "Diploma Ophthalmologists" after 18 months of training, rather than the much longer period required for the usual "Fellowship" courses, and to qualification of nurses as "Ophthalmic Nurses" after 12 months of training. Coverage of eye services increased substantially as a result, with much higher access to eye doctors and nurses. Almost all of the people trained under these schemes have been retained within the country. Subsequently, diploma qualifications were also established in Psychiatry, ENT and Anaesthesia. A request from the Ministry of Health to develop similar courses in the basic specialties of Paediatrics, Internal Medicine, Surgery and Obstetrics and Gynaecology met, however, with resistance from the Colleges, and severe shortages of these specialists still exist in the country.

5.3.6 Training of new types of staff for service needs

More radical solutions have been developed in some countries where lack of the usual types of health professionals have led to important health needs not being met. These have involved the training of totally new types of staff that are unlikely or unable to leave.

In the African region, following years of war and internal conflict, Mozambique and Ethiopia developed Field Surgeons and Clinical Officers who provided a substantial amount of clinical intervention normally reserved for doctors[10]. Malawi and Tanzania, with much more peaceful histories, have developed similar cadres. In Ghana, a "Life Saving Skills" project provided skills and equipped rural midwives to carry out procedures normally only carried out by doctors, such as applying vacuum extraction, manually extracting retained placentas, carrying out and repairing episiotomies, and repairing perineal tears.

In the Pacific region other categories of staff have also been developed to address identified needs[3]. These include Health Extension Officers in Papua New Guinea and Health Officers in Tonga. Medical Assistants have also proved a useful approach to provision of medical services but their employment has not been linked to opportunities for promotion, so those careers have been considered as "dead end". It is thought that the concept of nurse practitioners will take over from medical assistants and, provided that employment is linked to salary and career progression, their practice will be more sustainable.

Fiji has a system of village-based health workers who have received a basic six-week training course and are not employed by the Ministry of Health, but are supported by the village community. In Papua New Guinea there is an extensive system of rural aid-post orderlies who have similarly received basic training. These people function well in their village environment, but if provided with more extensive training often wish to progress within the healthcare system rather than remaining at village level. Community Health Officers with two years training are gradually replacing them.

5.4 Bilateral and inter-country agreements

5.4.1 Managing the flows

In the African region, various arrangements have been tried to control the numbers that are recruited by other countries. These arrangements can also be used to help ensure that migrant workers are well treated in the host country, and to encourage or ensure the

repatriation of earnings or other benefits to the donor country where the health workers originally trained[10]. For example, the Ministries of Health in Ghana and Jamaica reached agreement on the release of Ghanaian nurses to work in Jamaica. The agreement encouraged the acquisition of new skills by the nurses as the benefit to Ghana. It was also agreed to arrange opportunities for nurses and other health professionals from Jamaica to assist in developing local training programmes and providing specialist training services in Ghana.

5.5 Mitigation of losses

5.5.1 Recruitment of doctors from elsewhere

A number of countries, including South Africa, Ghana and Namibia, have had arrangements with Cuba to recruit Cuban doctors[10]. In the case of Ghana, these "medical brigades" arrive every two years. Problems encountered include lack of appropriate language skills, differences in disease conditions and pharmacopoeias between the two countries, and the high specialisation of Cuban doctors, which means that a team of four doctors is needed to man a single district hospital. Cuba is also assisting Ghana to staff a new Medical School and provides undergraduate and specialist medical training for Ghanaians.

Expatriate health workers can, however, be expensive to recruit and employ and most poor countries in the African region tend to rely on funding by third parties including religious organisations, NGOs, donor and international organisations. In the Pacific region also, these types of organisations may be used to provide care[3]. This may be of high quality, such as that provided by church organisation hospitals in rural areas of Papua New Guinea and the Solomon Islands[3], but sometimes the quality and experience of volunteers may be less good and the period may be more of a learning opportunity for the volunteers[10]. In any case the use of expatriate staff paid for by external sources is not in the long run, a sustainable system for health service delivery[10].

5.5.2 Changes in personnel policies to encourage return of staff

In the Caribbean, where the main problem is the difficulty in retaining professional staff, particularly nurses, it is thought that paying greater attention to conditions of employment/service and conditions of work may help mitigate current losses[4]. This will include review and improvement in personnel management functions such as appointments, performance appraisal, promotion, disciplinary processes and leave allowances; creation of mechanisms that will give health professionals the opportunity to be innovative, expand their professional roles and develop excellence in management and clinical practice; introduction of structural changes in staffing patterns and skill mixes including introduction of auxiliaries as appropriate; provision and maintenance of more flexible shift systems, improved local transport arrangements, day care facilities at places of work, low cost housing schemes, educational opportunities and improved career mobility; and changes in management structures from vertical, hierarchical structures to flatter, more responsive structures[4].

5.5.3 Elimination of market distortions

There have been suggestions that either there should be a "tax on brains" that could be collected from immigrant professionals by receiving (rich) countries and sent back to donor (poor) countries, or that when a physician emigrates to another country to work the receiving country should give back the cost of producing the physician to the donor

country[20]. However, the former may be impossible to implement and could prove discriminatory, and there are at present no mechanisms in place for the latter [20]. Nevertheless, the Philippines, which seems to train nurses for export[43] deliberately, has apparently devised a system for receiving a remittance of a proportion of earnings back home[42]. In other countries, although formal mechanisms may not exist for remittances of money directly back to the government, remittances by migrants to their families constitute a major source of foreign exchange[10].

5.5.4 Introduction of cost-recovery and user charges in medical education

Research on financing higher education in the Indian sub-continent and elsewhere in developing countries has supported implementing cost-recovery strategies and/or charging user fees[20]. The argument is that it if this strategy were implemented it would then be of no concern to donor countries if staff subsequently migrated[20]. This does however seem to raise questions about equity of access to education as people other than those in the most affluent sections of society are likely to be deterred from entering higher education.

CHAPTER 6

Conclusions and recommendations

6.1 General conclusions

Addressing the problem of migration needs to be part of individual countries their approach to human resource management, although the international and global dimensions of the problem mean that it is an area where international institutions and organisations can contribute. People migrate primarily for economic reasons, and so long as differences in development between countries or regions within a country remain, people will continue to migrate.

In light of this, it is perhaps surprising that so little up to date information relevant to migration seems to exist at regional or international level. A recent initiative by the WHO Regional Office for the Americas/Pan American Health Organisation (AMRO/PAHO) to promote the development of evidence-based human resource policies[15] is therefore timely and plans to extend this initiative to other WHO regions[22] are welcome. In the Caribbean the initiative has resulted in 14 countries joining together in an Observatory in Human Resources project. The project involves promoting the development of relevant information systems in human resources, comparative and evaluative studies, training activities, and the sharing of experiences[15]. There are plans to post data from the project on the PAHO website[15].

It is also surprising that although it has been known since the 1979 WHO study[2] that patterns of migration of doctors (mainly men) and nurses (mainly women) are different, none of the data that currently exist are sex disaggregated, and apparently no studies of the underlying gender issues have been done.

A further gap is the lack of any international consensus on how to balance the perceived needs of developed countries to recruit staff from developing countries, with the needs of developing countries to retain their own staff, taking into consideration also the personal freedom of individuals to live and work where they choose. The recent development by the Commonwealth Steering Committee for Nursing and Midwifery of guidance on recruitment and retention of nurses and midwives, which includes principles relevant international nurse and midwife recruitment[21], is therefore also timely and welcome. This is reproduced at Annex 1.

In the end, however, individual countries need to develop their own strategies to address the problems of migration. Whether particular health workers migrate is determined by their perception of the complex interaction of ever changing economic and policy "push" and "pull" factors in the sending and receiving countries. It is therefore perhaps not surprising that the nature and extent of migration varies from country to country and from time to time, and that attempts by countries either to curb or compensate for the outflow of health manpower by a variety of *ad hoc* means have generally been unsuccessful. In this situation, it is only the "push" factors operating within a country that it can directly control, so the most successful strategies for retaining staff within national health systems are likely to involve accurate assessment of the particular "push" factors within the county followed by alterations

to existing processes to eliminate or neutralise them. These alterations need to be built around sound human resource management and development practices. The key issues identified for governments and strategic actions they may find useful in addressing them are set out below.

6.2 Key issues and recommended strategies for governments

6.2.1 Policy/planning

In many Commonwealth countries a key issue is *absence of an appropriate health sector development plan incorporating an integrated workforce plan to meet the health needs of the country*. An appropriate health sector development plan, or "National Health Plan", will identify the goals and objectives of the health sector within the budget available, and develop strategies to achieve those goals and objectives[2]. One of these strategies will relate to workforce development. Such a workforce plan is now acknowledged as a key factor in the effective recruitment, deployment, utilisation and retention of staff[3,4,10]. Together these plans should form the basis for discussions and negotiations with the Public Service Commission (where one exists), the Treasury and other relevant government departments/ministries[3] to secure appropriate resources for the health service without which it cannot function effectively. Thus in countries where health sector development and associated workforce plans do not exist, it is recommended that each country should:

- in the short term focus on integrated service planning to ensure that a health sector development plan or "National Health Plan" is developed that identifies the goals and objectives of the health sector within the country, within the budget available, and develops strategies to achieve those goals and objectives
- use the service needs identified in the "National Health Plan" as the basis for determining an associated longer term workforce plan to meet current and anticipated future needs

The workforce plan should include identification of the mix of skills that are required at each level of the health service[3], as it is clear that another key issue is that *the skills of the available workforce may not match those required to provide services to provide the services*. In particular, the distribution of staff between urban and rural areas may not be appropriate, personnel may be over-educated for much of the service required to meet the health needs of the population and at the same time there may be a shortage of specialist skills to meet particular needs. These problems are compounded when staff are required, in addition to applying their own particular areas of expertise, to carry out routine tasks that could be done effectively by lesser qualified staff. These issues will only be fully addressed if the workforce plan identifies the mix of skills that are required at each level of the health service and plans how these are going to be provided.

It is worth noting that, in many places, health services are to a large extent dependent on nursing staff who often are prepared to work in remote, rural areas and function as part of the community[3]. The developments taking place in nurse education for the production of "specialist nurses" or "nurse practitioners" are therefore helpful as it would seem to be an appropriate way to strengthen health service delivery at local level. Countries have also had some success using non-traditional types of staff, developed especially to meet local health needs, and, particularly for small states, there may be advantages in planning to meet some specialist health needs on a regional rather than individual country basis. Together these considerations suggest that countries might:

- in the workforce plan, introduce changes in the distribution and skill mix of staff to better meet health needs and ensure that staff are not over- educated for the service to be provided. As part of this:
    - recognise the pivotal role of nurses in the provision of front line care and expand their role to include more unsupervised provision of treatment;
    - develop and train new types of health workers to meet local needs;
    - consider introducing a "step ladder" approach to specialist training that allows health workers to start from the bottom and eventually end up as more highly skilled types of staff, including physicians;
    - where appropriate, consider selective specialisation and sharing of services between/among countries within a region.

Such plans for the health sector can however only be developed by skilled health planners within the Ministry of Health working collaboratively with other government departments and consumers, yet it is also clear that many countries *lack the institutional capacity to carry out health service and workforce planning*. This suggests countries should:

- promote a culture of human resource planning in Ministries of Health
- train selected staff in human resource development and management

This failure to plan and lack of skilled planners may be compounded by *inadequate data for human resource planning*. Although this may be because the relevant data is not collected, there is some anecdotal evidence that part of the problem is that collected data is not always collated and made available to decision makers[22,53]. Either way, the result is that decision makers may have no accurate information for some or all staff groups on factors such as numbers in post, vacancies, or historical patterns of loss from various causes including death, retirement and migration, that are essential in planning for the future. Advances in technology may make it easier to capture and collate this data in a timely manner in future. In addition various indicators have been proposed to assist countries to assess the extent of loss among their health workers[10] (see Annex 2). Countries should, where possible:

- develop modern information systems to support human resource management and planning
- consider developing and evaluating indicators for migration of health professionals

6.2.2 Education/training

Implementation of a human resource development plan that aims for a country to be self-sufficient in the production of healthcare workers depends crucially on the availability of an adequate supply of school leavers eligible to enter training. In some countries, however, there may be *weak joint planning mechanisms at national level between Ministries of Health and Ministries of Education*. This may result in insufficient numbers of well-educated high school graduates being available to meet health sector needs eligible trainees. Thus countries may find it beneficial to:

- strengthen joint planning between Ministries of Health and Education

Once in training, it is important that personnel are adequately prepared both educationally and technically for future practice in their country. Nevertheless, *where trainees undergo pre-service education and basic training in institutions under the auspices of Ministries of Health, there may be conflicts between service needs and educational needs of trainees*. Such conflicts arise

where service delivery is dependent on personnel whose primary objective is to obtain their basic qualification, and may be detrimental to the educational preparation of individuals to practice. Although it is recognised that changing this requires greater commitment by governments to health service funding and to training of health service personnel[3] countries might nevertheless:

- consider ensuring that pre-service education is provided under the auspices of the Ministry of Education in "main stream" institutions

Perhaps more significantly *health personnel may be trained inappropriately, resulting in too few personnel with the skills and motivation to deal with the specific health needs of the country, and/or too many who are over-educated for the service required.* Apart from the direct effect of this on the health services, where the staff are over-educated this acts a significant "push" factor for migration as personnel see better opportunities to use their skills and gain personal satisfaction from their work abroad.

In part the inappropriate training of staff arises, as already indicated, thorough lack of planning for the skill mix required at each level of the health service. Furthermore, at an operational level, important contributing factors include providing basic and specialist training abroad in a developed countries, and in-country curricula for training that are borrowed from developed countries rather than tailored to the needs of the home country. To address these problems countries might:

- where possible, provide basic health worker training within the country or in another developing country within the region;
- ensure in-country curricula reflect local needs;
- base numbers trained and supported to receive specialist training on a well-developed national plan for the health sector that meets the health needs of the country;
- develop local postgraduate and specialist training schemes;
- where health service staff are supported by government or other organisations to obtain specialist qualifications elsewhere, consider whether this should be in a developed country or whether the need would be better met by supporting them elsewhere within the region;
- consider developing and strengthening regional co-operation for education and training of health workers.

6.2.3 Management/utilisation

The way personnel are recruited and subsequently managed and deployed within health services can have significant effects on motivation and job satisfaction, factors that are important in determining whether they are subsequently retained or lost through migration or to more attractive opportunities within the country. Yet this study has shown that countries may have *antiquated approaches to human resource management resulting in inefficient personnel administration systems that are not always perceived as fair and equitable.* These result in serious frustration and consequent lack of motivation of staff.

Job satisfaction also depends on selection of the right person for each job so that the health worker feels personally fulfilled through the job to be done, and not over-educated for the level of service to be provided[3]. Linked to this is some form of career progression, and appropriate recognition through the salary structure of the health worker's importance to the

development of the country as a whole. Yet there may also be *poor terms and conditions of service and failure to recognise the special challenges for health personnel in rural areas* that leave personnel feeling undervalued, *lack of career progression, and poor pension arrangements* that may mean they will be unable to support themselves adequately after retirement.

Furthermore, *health workers can frequently become discouraged due to seemingly insurmountable difficulties such as shortage of equipment and drugs, poor health facilities, unrealistic community expectations and professional isolation.* To address these issues countries might:

- review and improve personnel management functions including appointments, performance appraisal, promotion, disciplinary procedures and leave allowances;
- improve the systems for personnel administration by decentralisation, where this has not already been done, combined with training of selected staff and central formulation of model policies and standards;
- provide and encourage more flexible working arrangements, improved local transport, day care facilities at places of work and low cost housing;
- create mechanisms that will give health professionals the opportunity to be innovative, expand their professional roles, and develop excellence in management and clinical practice;
- consider other incentives, such as special allowances for those working in rural areas and where appropriate develop some means of providing support to retiring or elderly practitioners;
- consider promoting and funding links between institutions in developed and developing countries to facilitate planned exchanges of staff, study tours etc.
- facilitate improved communication between health professionals, using technologies such as the internet, e-mail, telemedicine and radio-linked methods, to help them remain up to date and in touch with colleagues, and reduce their feelings of isolation.

At the same time all personnel (and indirectly patients) are likely to benefit from involvement in quality improvement processes[3] as providing a good quality service improves both motivation and job satisfaction. Strategies to support continuous quality improvement are therefore important and countries might:

- involve staff in developing objectives and planning action, and in continuous quality improvement initiatives that are affordable and have tangible benefits;
- provide opportunities for continuous professional development for all health workers including those in rural areas;
- consider performance-based rewards to provide further incentive for best-practice approaches that achieve optimal patient outcomes;
- ensure supportive supervision of personnel at all levels of the health service.

6.3 Approach to implementation

If the above recommendations in relation to human resource development were easy to implement then they would already be occurring. As pointed out in the report on the Pacific region[3], the practicality is that such processes are difficult to implement and are dependent on the availability of money, political will, relinquishing of entrenched interests and on active communication with all those involved with health, as well as on overcoming the

difficulties which come from artificial professional barriers. Overcoming these difficulties and implementing appropriate policies requires involving all relevant stakeholders such as other government departments (especially that responsible for finance), NGOs, the private sector, professional associations, health managers, patient groups etc. from as early in the process as possible[43]. Within this context, and recognising that no single measure or group of measures would be suitable for all countries, a strategic approach to initiating strategic planning to develop sound human resource management and development policies and practices was proposed in the report on the African region[10]. A possible practical approach to achieve the same ends was proposed in the report on the Pacific region[3]. These are set out below as they may be of assistance to countries.

Possible approach to initiation of strategic planning for human resources

The four-step process recommended in the African region report to initiate strategic planning[10] is set out in Box 1.

Box 1: Four step process to initiate strategic planning

- Research, information and data collection - to assess the size of the [migration] problem, the costs to the country and to health services, and the groups of staff and services or areas that are most affected, and reasons why this occurs
- Undertake all-inclusive stakeholder consultations and strategic reviews aimed at reaching consensus on options for action
- Conduct detailed planning for human resources including loss management, costs, matching production with ability to retain and pay, and determining the likely strategic policy options
- Implementation planning of a human resources plan and strategies including retention, developing integrated long term, medium term and short term implementation measures based on options identified

Possible practical approach to human resource development

The report from the Pacific region suggested first of all a series of questions that health ministries need to consider, which will provide a focus for human resource development in the health sector within each country:

- How can we increase the prominence of and our commitment to human resource development?
- How can we improve the present practices in relation to management of human resources?
- What processes and methodologies should we use in our particular situation? How can we sustain a momentum of development?
- How can we bring about real co-operation with the private and non-government sectors?
- How can we integrate the efforts of all health workers? How can we resolve the series of existing imbalances?
- How can we further mobilise our training and educational institutions?

These questions, it was suggested, would form a structural basis for initial analysis prior to establishing a detailed human resource plan. The plan should incorporate estimated workforce needs, which are accurately costed, so as to provide information to government on the future budgetary implications. As it was pointed out, there is no point in establishing a comprehensive plan on paper, if the expenditure implications preclude it from ever being implemented.

The human resource development plan itself needs to be of a practical nature. Population trends and economic development indicators will be necessary to place the plan in a context of overall national development.

Once a human resource development plan has been established, the Ministry of Health needs constantly to monitor that plan and to assess progress towards meeting the various targets. As information changes, the plan should be altered and up-dated. At definite periods of approximately five years, the plan should be extensively reviewed and adjusted along with current staffing issues and on-going skills needs analysis.

Some countries are investigating the provision of health services in association with fee-for-service or cost-recovery principles. The report cautioned that such processes should be developed carefully in order to avoid over-provision of services. In addition, attention to the actual allocation of funds raised is an important process for further health service development. It was recommended that cost-recovery revenue be distributed in a three way process to provide funding to local health services, local staff salary enhancement and for central health service administration.

The report went on to suggest that the development of appropriate networks for health can also be important in assisting countries to meet the challenges posed by the need to deliver health services within finite budgets. There is considerable scope for the non-government provision of health services.

Non-governmental provision of health services may be private-practice based and could include dental, medical and pharmacy services. Associated with such a development, it is necessary to provide regulation and monitoring in order to ensure quality health service delivery and to prevent over-activity (which in developed countries may be known as doctor-induced demand).

Such regulatory, monitoring and inspection processes become a new demand for the Ministry of Health and cannot be left to regulation by market forces if consumers are to be adequately protected.

Traditionally, not-for-profit agencies such as NGOs and church-based organisations are able to provide quality health services to people in need, particularly to those in rural locations. Examples from the Pacific region include church organisation hospital services in Papua New Guinea and in the Solomon Islands. The Ministry of Health should continue to have the role of co-ordinating the government and NGO sectors in the provision of optimal health care for the population in each country.

The report also suggested that in addition, consideration should be given to the development of some part-time appointments to work in the government service. The remainder of time would be spent in providing health service through the non-government sector. This concept of part-time private practice could initially be investigated in dental, medical and pharmacy services.

6.4 Recommendations for particular Commonwealth regions

Migration is perceived as a significant problem in the African, Caribbean and Pacific regions[14,15,16,17]. Recommendations for each of these regions based on the particular situations in each of them are set out in Annexes 3, 4 and 5 respectively. These have been extracted from the respective regional reports[10,4,3].

In South East Asia, migration is not currently high on the agenda of WHO member countries[18] and particular difficulties were encountered in obtaining relevant up to date information either from published sources or health ministries[58]. The report on Commonwealth countries in the Asian region nevertheless identified two associated problems: drain of resources and the preference of doctors to work in secondary care and urban settings. To overcome these problems the report recommended that every time a physician migrates to another country to work, the receiving country should give back the cost of producing the physician to the donor country; that cost-recovery and/or user charges in medical education should be introduced; and that schools of public health should be set up to train health workers in public health and primary health care[10].

6.5 Need for further work

The main message of this publication is that addressing the problem of migration of skilled health professionals should be part of individual countries' overall approach to human resource management. In addition, there are gaps in relevant knowledge at international, regional and country level that institutions and organisations need to address. Since the problem had global and international dimensions, international institutions and organisations can play a role in finding solutions.

In particular there appears to be need for:

- *Collection and analysis of up to date data relevant to migration at national, regional and international levels*. This will also involve promoting the development of human resource information systems at country level, training activities and collection and the dissemination of good practice guidelines.
- *Sex disaggregation of data relevant to migration and studies of the underlying gender issues*. The patterns of migration of doctors (mainly men) and nurses (mainly women) are different and further understanding of the different experiences of men and women would be valuable.
- *Further dialogue between developed and developing countries* on the international recruitment of staff to help balance the needs of developed countries to recruit with the needs of developing countries experiencing shortages to retain staff and taking into consideration the rights of individuals to live and work where they choose. The increased understanding brought about by this might lead to helpful changes in practice in both developed and developing countries.
- *Research into effective ways of introducing and utilising technologies* such as the internet, e-mail, and telemedicine to help staff remain up to date and in touch with colleagues, and reduce feelings of isolation, particularly in rural areas. At present there is a large "digital divide" between developed and developing countries. This needs to be bridged and the barriers to introduction of new technologies in developing countries overcome.

- *Collection and dissemination of case studies of good practice* in all aspects of human resource development so that countries can learn from each other.

The Commonwealth Secretariat hopes that the perspectives in this publication will contribute more widely to current thinking on human resource development and that international institutions and organisations will act on it appropriately to assist developing countries in addressing these issues.

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Annex 1

GUIDANCE ON WORKFORCE ISSUES

THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

Commonwealth Steering Committee for Nursing and Midwifery

February 2001

GUIDANCE ON WORKFORCE ISSUES

THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

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Commonwealth Steering Committee for Nursing and Midwifery

GUIDANCE ON WORKFORCE ISSUES - THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

1. Introduction

1.1 Many countries are experiencing shortages of nurses and midwives, either generally or in particular specialities or locations (eg rural settings). The effects of shortages may become pronounced, and may potentially threaten the delivery of nursing and midwifery services if they are not addressed urgently.

1.2 The transferability of skills, and possible future opportunities in other countries, may be among the factors which attract people to work in nursing or midwifery in the first place. However, the movement of nurses and midwives to work abroad may be exacerbating nurse and midwife shortages in some countries, including some developing countries which are unable to offer the pay or opportunities available elsewhere.

1.3 Such issues are not unique to nursing and midwifery. However, in the absence of existing international guidelines which can be applied to nursing and midwifery in Commonwealth countries, and in order to address the concerns expressed by Health Ministers, the Commonwealth Steering Committee for Nursing and Midwifery have worked to offer some guidance on the recruitment and retention of nurses and midwives, including international recruitment.

1.4 Not all Member States will have existing co-herent policies on these issues, and this can increase the difficulties in dealing with any concerns which arise between Member States, or with other countries. It is hoped that the provision of these guidelines will encourage all Member States to review their policy/practice on this issue, bearing in mind the legal and ethical considerations involved (both at the national and the international level), so that they develop and implement consistent and justifiable policies and practice.

1.5 Developing policy on this issue is one of the steps which Member States can take in progressing Health Ministers' commitment to identifying and addressing issues affecting the nursing and midwifery workforce, as part of their wider human resources policies (paper HMM(98)7 (Addendum) paragraph 7, adopted at the 12CHMM, refers).

1.6 Readers may also like to refer to the Commonwealth Secretariat's publication "Migration of Health Workers from Commonwealth Countries" (in press) which describes how migration currently affects Commonwealth countries. It also recommends strategies to assist governments to meet the challenge of migration through development of sound human resource policies and practices.

2. Additional background to the problem of nurse and midwife shortages

(Drawing on papers presented to, and discussions at, the 12th Commonwealth Health Ministers Meeting, held in 1998)

2.1 Workforce issues are moving to the top of the agendas of governments and of employers generally, and were a key theme of the Commonwealth Health Ministers Meeting in Barbados in 1998. Issues discussed in papers for that meeting included the migration of nurses and doctors, as well as domestic workforce issues affecting all health workers (eg human resource and capacity building, gender management systems in the health sector).

2.2 These discussions took place in the context of a growing recognition of the vital role played by nurses and midwives, both as a major component of the health service workforce and as those who are very often at the cutting edge in the provision of care to patients. A nurse or midwife may be the only health care provider in a remote area. They know the community and its particular needs, and are in a position to build up ongoing relations with patients and their families, and to gain their trust. This enables them to influence life-style factors affecting public health, as well as, for example, giving treatment or delivering babies.

2.3 Ensuring that the future supply of nurses and midwives is sufficient to meet demand is a matter of concern throughout the Commonwealth, and more widely. The reasons for the projected increase in demand in some countries are related to :

- demography
- advances in medical practices and technology
- the impact of diseases such as HIV/AIDS, and
- changes in public expectations of the healthcare system.

2.4 Factors contributing to problems in recruiting and retaining sufficient nurses to meet that demand include :

- absence of involvement of nurses and midwives in the development and implementation of health care policy
- an ageing current workforce
- insufficient training places, or intake to training courses
- funding problems

- low status of nursing and midwifery
- increased employment opportunities for young women
- out of date working conditions
- increased health risks, including from HIV/AIDS
- lack of family friendly working conditions
- limited opportunities for continuing education, training, development and research

2.5 Specific examples from individual countries include :

- frequent changes of Ministers and/or policies
- nurses pay being frozen at a low level
- poor salary structure
- heavy workloads due to staff shortages
- nursing being seen as "women's work", and so of low status. Nurses being expected to carry out menial as well as professional roles. Parents preferring a girl to marry rather than to work as a nurse or midwife
- threats to the health or well being of the nurse or midwife (including violent attack, medical hazards - including from communicable diseases - unsafe working environment)
- lack of accommodation, or transport
- poor working conditions, including poor building maintenance, shortage of supplies and equipment.

2.6 There are increasing problems for many countries in maintaining the supply of new nurses through traditional routes such as pre-registration training. As a result, many healthcare employers are beginning to pursue alternative strategies through, for example :

- improving the working environment
- better career prospects
- targeting nurses not currently working
- recruitment from other countries.

2.7 Within this context, many nurses and midwives around the Commonwealth, including some from countries which are experiencing temporary surpluses, are seeking employment opportunities abroad which may offer a better standard of living and enhanced career opportunities. Other reasons for nurse and midwives moving to

another country may include the urge to travel and study overseas, or the wish to accompany a family member who is moving abroad, for example in connection with their employment.

2.8 Whilst international mobility has long been a characteristic of the nursing profession and freedom of movement is an important right, the ethical considerations involved in recruiting nurses between Member States have now come to the fore, particularly where local health service provision may be put at risk. Whilst the free movement of nurses and midwives can bring many advantages to both the individual and employer, including broadening of skills and cross cultural expertise, there may be a need to examine these issues and consider ways of addressing them.

3. General considerations for Member States seeking to increase their nursing/midwifery workforce

3.1 Options for dealing with nursing and midwifery shortages for any one country, or one employing unit within a country, will depend on its staffing requirements, available resources and labour market conditions. Each country needs to identify the solutions appropriate to its particular circumstances, and which may help to contribute to maintaining a healthy pool of trained nurses/midwives.

3.2 Whilst pay is an important aspect of dealing with exceptional recruitment and retention problems, a healthy working environment, employment practices, staff involvement in decision-making, and career prospects are all key elements in recruiting, retaining and motivating nursing staff. Nurses and midwives need to both feel valued, and have a real influence through involvement in health policy development and implementation, particularly as there may be increased competition for staff as alternative career opportunities open up for people who might otherwise have become nurses.

3.3 Some more specific points for consideration by Member States seeking to increase their nursing and midwifery workforce follow.

3.4 Comments from nurses and midwives attending the recent workshops organised by the Commonwealth Steering Committee for Nursing and Midwifery in New Delhi and in Brisbane during the year 2000 are summarised at Appendix 1.

Recruitment

3.5 **Workforce planning** is essential. It is too late when the crisis occurs. In some countries many nurses and midwives are due to retire in the next 10 years. There is an urgent need to plan and prepare for effective replacements.

3.6 **Information about the emigration/immigration of nurses and midwives** may need to be collected. (In the survey of Commonwealth countries organised by the Commonwealth Steering Committee for Nursing and Midwifery in 1998, 85% of respondents reported the existence of centralised information about the nursing and midwifery workforce. These databases most commonly hold information on training and recruitment of staff, but information on emigration was less frequently held.)

3.7 **Pay and conditions** are key factors in determining whether people consider nursing as a career.

3.8 **Perks** can also be significant.

3.9 **Start seeking to attract recruits from a young age** - including through work in schools and colleges.

3.10 **Consider alternative entry routes,** such as bridging courses, cadet schemes.

3.11 **Seek to attract qualified staff back to work.** (In England, publicity aimed specifically at nurses who had left for family reasons, coupled with short practice courses enabling them to refresh their skills, brought an encouraging response.)

Retention

3.12 **It is a waste of time and money to recruit nurses and midwives but then fail to retain them.** Dreams and good intentions can be stifled by the overwhelming realities of, for example :

- unhelpful working hours
- low pay
- poor supplies and equipment
- inadequate support systems
- lack of career opportunities.

3.13 **Scope for development and progression is important.** In some countries there had been no promotions for years. This is likely to discourage nurses/midwives from continuing with a career in these professions.

3.14 **Alternative career development opportunities** may need to be considered, as not all nurses and midwives are content to lose direct patient involvement as they progress. In England (for example) new nurse, midwife and health visitor consultant posts enable post holders to spend some 50% of their time in direct patient care, but also to be involved in expert practice, education, development, professional leadership or consultancy.

3.15 **Recognition** of the contribution of nurses and midwives can make a difference, eg the presentation of certificates or other awards. (We all like to feel appreciated.)

3.16 **Retirement age.** Some countries may wish to consider reviewing their current retirement age for nurses and midwives, or adopting a measure of flexibility over the age of retirement.

Improving working lives

3.17 **Family friendly policies** such as flexible working hours, and career breaks are important. Nurses often report that their greatest personal challenge has been to combine being a wife and mother with the pressures of work.

3.18 **Employer/staff partnerships are mutually beneficial** - perhaps with occasional surveys of staff views and needs.

3.19 There must be **equal treatment** of all staff regardless of race, gender, religion etc.

3.20 Employers should take all reasonable measures to provide a **safe working environment** for nurses – safe both from attack and from environmental risks.

4. Principles relevant to international nurse and midwife recruitment

4.1 In developing their policies on recruitment and retention, including international recruitment, countries need to take account of relevant national and international legislation alongside human rights and ethical considerations. A review of domestic legislation may be appropriate if in any case these considerations appear to be in conflict.

4.2 In developing their policies and practice on international nurse and midwife recruitment, Member States may wish to consider adopting principles such as the following.

Rights of individuals

4.3 Like other workers, nurses and midwives should have the right to choose to move to another country to work there.

4.4 There should be no discrimination against a nurse or midwife who is seeking employment in a new country - as compared to nationals of that country - on grounds of race, ethnic origin, religion etc.

4.5 There should also be no discrimination as regards rates of pay, grading, promotion or any other matters relevant to the working conditions or career of a nurse or midwife from another country.

Rights of employers

4.6 Employers have the right to seek to attract individuals to work as nurses or midwives, provided they do so in an open, honest and non-discriminatory manner.

4.7 While not acting in a discriminatory way (see above) employers have the right to take reasonable steps to confirm the comparability of the qualifications and experience of nurses and midwives seeking employment there after moving from another country. Also, that the candidates' language skills and understanding of

practice are sufficient to enable them to practice competently and safely in the country in which they are seeking employment.

5. Good practice principles

5.1 The following are additional principles which Member States may feel it appropriate to adopt, as matters of good practice, in addition to the more fundamental principles outlined in the previous section.

5.2 Good practice by Member States/employers seeking to recruit nurses and midwives :

(a) ensuring that domestic policies and practice are as effective as possible in recruiting and retaining nurses and midwives (see Section 3 for some specific points to consider), rather than considering active measures to recruit from abroad as a first option;

(b) as part of the above, considering special measures to recruit from any immigrants who have already settled in the country who may already have had nursing training/experience, or be qualified to undertake it;

(c) if deciding to actively recruit nurses or midwives from abroad :

- considering what principles to apply in selecting which countries to seek to recruit from - for instance in the light of the implications for the countries the nurses and midwives would move from, to avoid exacerbating any shortages there. (See Section 6 below for suggestions for relevant principles.)
- checking that national immigration policies are sufficiently flexible to meet changing needs.

5.3 Good practice by governments in countries which nurses or midwives may move from :

(a) ensuring that they do not breach nurses' or midwives' human rights or rights as workers, if they seek to place any restriction on their movement to work abroad;

(b) in responding to any requests from other countries to recruit nurses or midwives (see Section 6 below) : not discriminating between countries

making such requests, except where this is justified by specific factors (eg agreement to reciprocal arrangements for recruiting by that country, or the relative extent of nurse shortages there).

5.4 Good practice by employers in dealing with nurses or midwives who have last worked in another country :

(a) providing specific induction/adaptation training and/or mentoring for nurses and midwives who have last worked in another country;

(b) providing induction packs for such nurses and midwives, bringing together information helpful to them not only in their job but as people new to the country;

(c) appointing induction co-ordinators for units or groups of units employing nurses or midwives from abroad.

5.5 Good practice by employers : in relation to existing policies and staff

(a) arranging "equality" training for existing staff, and those involved in recruiting, to seek to reduce/eliminate potential discrimination against immigrant nurses or midwives.

5.6 "Just compensation" for international recruitment

There have been suggestions in some quarters that "just compensation" should be paid when a nurse or midwife moves from one country to work in another.

5.7 Two different interpretations of the term "just compensation" are possible, and it is important not to confuse them in discussing the issue :

(a) that immigrant nurses and midwives should receive "just compensation" from their new employers, ie that they should be appropriately recognised and paid, rather than possibly exploited as cheap labour;

(b) the payment of financial compensation by countries importing nurses or midwives to the countries those nurses or midwives came from.

5.8 The first of these interpretations is in line with the principle set out in paragraph 4.5 of this guidance.

5.9 The second interpretation raises a number of issues of principle and of practice which may not be easy to resolve fairly :

- the right of nurses to chose to move to work in another country (paragraph 4.3 refers);

- the absence of any precedent for such a measure in relation to any other group of professionals;

- questions of compatibility with EU and other legislation;

- the extent to which the "exporting countries" may themselves have contributed to the desire of their nurses or midwives to move to work in another country. Contributory factors could include failure to provide adequate pay, conditions or scope for advancement – even taking into account the country's overall financial position. (For example, a country may chose to spend only a comparatively low proportion of its GDP (gross domestic product) on health care, or may fail to take active measures to develop or support the roles of nurses and midwives);

- questions about whether "importing" countries should always make payments to "exporting" countries, or whether additional considerations would apply. For example should compensation be paid even if the "importing" country was a developing country and the "exporting" country a developed country, or if both parties were developing countries (or if both were developed countries)?;

- how any payments could be calculated fairly? For example, could a distinction be made between those nurses or midwives who took the initiative themselves in making a move (ie those not directly influenced to move by the "importing" country), and those "actively recruited" by the "importing" country ?

6. Possible principles for deciding which other countries to actively recruit from (Section 5.2(c) above refers)

6.1 In addition to considering the likelihood of being able to attract recruits from the countries concerned, Member States may wish to consider adopting a priority order in deciding which counties to seek to actively recruit from, or even that they will not actively recruit at all from some categories of countries.

6.2 There are a number of types of criteria Member States could seek to apply in developing their policies. In doing so, they will wish to consider the practicality of obtaining information on which to judge the satisfaction or otherwise of each criteria, as well as its inherent validity.

6.3 The sort of criteria countries might wish to consider using if developing a list of countries they will/will not seek to actively recruit from, or a priority order for recruitment, might include :

(a) recruiting first/only from countries with a surplus of nurses/midwives;

(b) recruiting first/only from developed countries rather than developing countries;

(c) recruiting first/only from countries which had specifically agreed to such recruitment (although recognising that as a matter of law such consent is not necessary for recruitment to take place).

6.4 Such principles could be operated in relation to nursing/midwifery in general, or in relation to particular categories of nurses or midwives (eg at particular levels, or with particular skills).

Factors affecting the recruitment and retention of nurses and midwives : views and experience of nurses and midwives at recent workshops

1. The following notes are based on group discussions at regional workshops organised by the Commonwealth Steering Committee for Nursing and Midwifery, held in New Delhi and in Brisbane in the year 2000.

General

2. Seemingly small factors can swing the balance in determining whether an individual becomes, or remains, a nurse or midwife.

Reasons for leaving nursing/midwifery

3. Several participants knew people who had given up careers as nurses or midwives because of related problems, eg with night duty or their children's education. Many had themselves found it difficult to combine work with family responsibilities, and some had at times thought of giving up their career, citing reasons such as :

- stagnation
- stereo-typing
- lack of autonomy
- family pressures
- poor appreciation of the contribution of nurses
- nursing compared unfavourably with other professions
- they felt their skills were not fully employed.

Reasons for continuing as a nurse or midwife

4. Key motivators in their own decisions not to leave had included :

- commitment to the profession
- promotion/increased salary
- professional development.

Practices helpful to recruitment/retention

5. Practices which participants felt were/could be helpful in the recruitment and retention of nurses and midwives or improving their working lives, included :

- re-registration
- the nurse practitioner role
- job sharing
- counselling
- in service education
- better career structures
- appropriate pay
- continued professional development.

Commonwealth Steering Committee for Nursing and Midwifery : background

1. A Steering Committee for Nursing and Midwifery was set up, and a Commonwealth Action Plan for Nursing and Midwifery developed, at the request of the 9th Commonwealth Health Ministers Meeting (CHMM) in 1989.

2. The remit of the Steering Committee has been renewed by subsequent CHMMs. Most recently, at the 12th CHMM in 1998, Ministers adopted recommendations for action to further develop nursing and midwifery in Commonwealth countries, including the continuation of the work of the Steering Committee for Nursing and Midwifery in order to co-ordinate, progress, and evaluate the contribution of nursing and midwifery to the achievement of Ministers' objectives.

3. Membership of the Steering Committee is constituted by the Commonwealth Secretariat. In addition to the Chair (currently Professor Anna Maslin, International Nursing Officer, Department of Health, England) membership currently includes :

   - the board members of the Commonwealth Nurses Federation
   - a number of invited national chief nurses/other senior nurse leaders
   - representatives of the Commonwealth Secretariat, the Royal College of Nursing, the International Council of Nurses and the International Confederation of Midwives.

4. The Steering Committee provides regular written reports on its work to Commonwealth Health Ministers Meetings.

Annex 2

Suggested indicator data on migration of health professionals[1]

Indicators	Possible information sources	Remarks
1. Vacancy rates for professionals in public health services	Public Service Commission, MOH Personnel Units	May indicate low supply of health workers or low leaver rates
2. Expatriate employment rates	Registration bodies, MOH Personnel Units	As above
3. Resignation rates (health professionals compared with professionals from other public services)	MOH Personnel Units/Civil Service Authority	Quite a good indicators but may also measure *internal brain drain* to private sector or other professions and sectors
4. Salary levels compared to the cost of living index	Ministry of Econ Planning/Finance	A good "push" factor indicator
5. Compare specialist/generalist vacancy rates	MOH Personnel Units	May reflect training policy or remuneration policy. High specialist vacancy rates important
6. Perceptions of service benefits by health workers	Surveys, Unions, Professional Associations	May have other "confounding factors"
7. Organisational environment – *"Bureaucracy Index"* (time for processing promotions, delays in appointments of new recruits)	Surveys, time and motion studies	Important indicator to assist other indicators when finding solutions
8. Vacancy rates of lecturers/trainers in health professions	Medical schools, Training schools	Especially trends showing vacancies increasing over time
9. Trends in average age of specialists/postgraduate staff	Surveys	May reflect training and replacement policy/efforts
10. Trends in doctor: nurse population ratios	Statistics Bureau/ MOH Personnel Units	Usually good indicator but may reflect high population growth rates and a slow training policy
11. Trainee return rates from external courses	WHO, MOH-HRD	Good indicator
12. Unemployment rates (graduates, other technical staff)	Surveys, analysis of applications	? Measure of "push" level and over-production?
13. Number of health workers registered to migrate (e.g. "Good Standing" certificates, J-1 visa clearance requirement rates) pa	Regulatory bodies/councils, MOH Personnel Units, Labour Departments	Good indicator of "intent" and maybe actual actions

Other factors such as inappropriate placement of staff (e.g. technical staff in administrative positions, over-specialisation at the expense of primary care staff training, inappropriate orientation of health trainees to tertiary hospital systems rather than primary health care etc) are more difficult to measure and need more qualitative assessment.

The indicators will also need to be further evaluated. What "benchmark" levels will indicate a problems? (e.g.: 10% vacancy or 20%? Are established staffing levels too high/too low?)

[1] ***Source***: Dovlo DY. Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African states. A report prepared for the Commonwealth Secretariat; 1999 (unpublished). Appendix 2.

Annex 3

African region: Summary of main factors influencing migration in Africa and Recommendations on policy directions

Extracts from the report on the African region[1]

Summary of the main factors influencing migration in Africa[1]

These may be summarised as

- Low salaries (ranging from "relatively low" to "ridiculously low") in an increasing free market environment.
- Limited administrative and human resources planning capacity of Ministries of Health, resulting in delays and frustrations of professionals.
- Some have cited "over-production" of physicians and nurses as a problem for countries contributing to the migrant labour. (In Ghana, however, a severe shortage is worsened by frequent recruitment of nurses by agents in the UK).
- Inappropriate training raises expectations of the health worker that may only be met in the richer countries.
- Inaction by recipient developed countries and the helplessness of dispatching countries to come up with acceptable and workable policies.

Recommendations on policy[1]

Policies should aim at resolving the underlying issues and root causes of the brain drain.

Strengthening capacity and systems for personnel administration: Complex and frustrating bureaucracy seems a major factor in many Commonwealth countries affected by migration. The situation should be assessed and documented, and information systems developed to help build new and efficient administrative systems. In many countries, this will include enhancing the decentralization of personnel administration. Improved transparency and consensus in managing Health Professionals (e.g.; Postings, Scholarships & other learning opportunities, Promotions and Appointments,). Confidence in a fair system is likely to play an important role in migration decisions where economic situations are more stable. (e.g.; In Lesotho, some cite political interference in appointments etc., as reasons for migration[2])

Developing Human Resources Policies, Strategies and Plans: The WHO-AFRO has initiated a programme for assisting countries to develop HR Policies and Plans. However this will also be influenced by building the capacity of HR managers and Policy Makers to develop and implement appropriate strategies. The lack of plans causes [a] the lack of knowledge on the situation, [b] the continued over-production of expensive staff types or inappropriate skills, [c] inability to match staffing types with services and costs. Effective planning and implementation alone will not limit or remove mobility of health professionals but will assist to understand the situation and take actions that minimize rather than worsen migration. Strategies must be comprehensive, incorporating the key areas of Human Resources development, training and management.

Promoting and funding professional links between Institutions in developed and developing countries: The developed countries can assist by building links with scientists and professionals in developing countries. (An example is cited of the links and funding support between Hughes Institute and Russian scientists that enables them to carry out research at home and possibly improves retention[3]).

Strategies for improving communication between professionals using new technology such as Email, Telemedicine and radio linked methods also help to prevent or reduce "professional isolation" which is often mentioned as a reason for migration of intellectuals[4].

The Commonwealth can assist to support such organizational linkages (possibly already available) that allows senior academics and practicing professionals to exchange ideas and participate in conferences and meetings. Such interactions even with and between neighbouring countries can be less expensive and can be supported financially by even the poorer countries.

Developing local Postgraduate and Specialist Training Systems: Lack of opportunity for higher training is often as a reason for migration of the younger professionals in Ghana[5] and possibly in other countries. Support for early postgraduate training for doctors can be used to attract them into deprived areas for a period and thus reduce deployment difficulties. Examples from Indonesia[6] show that these strategies can be successful if faithfully implemented and relatively early specialization occurs. However, specialization incentives must also assure that the right types of specialist are produced otherwise post specialization brain drain occurs. The development of local and relevant courses is important either within countries or as part of regional cooperation strategies. It is suggested[6] that targeting scholarships to persons from specific deprived communities and groups may influence retention and the likelihood of the professional working in his/her home locality. However, we must recognize that acquisition of highly demanded qualifications may rather enhance mobility and the risk of migration.

Offering specialist training to older and more settled personnel (e.g.; through example of Philippines "Step ladder" system) may reduce the likelihood of migration when a family is already built and other demands and responsibilities reduce migration.

Bilateral or Multi-lateral "Brain Export/Exchange" agreements: In many countries, the target countries for brain drain are few (usually one or two main target countries responsible for over 60% of movements of professionals). Agreements on managing the process and on numbers permitted as well as the involvement of the sending countries in the recruitment and selection process can assist improve the situation as well as ensure some remittance of earnings. It can also involve technical and financial support from receiving countries to assist develop health systems in the poorer country. Ghana's MOH has entered into agreements with MOH Jamaica and recruitment agencies from the United Kingdom aimed mainly at restricting numbers recruited so as to avoid collapse of services, to ensure return after a period (and allow others to go) and also to ensure adequate conditions of service for its citizens. A standard system and process of considering these agreements could be developed to assist countries extract as much benefit as possible from exporting their well trained health professionals. A system which allows health workers to rotate in turns to work outside might be a good strategy.

Other incentives and motivations factors: Pay systems and methods for professionals in countries where mobility is high and remuneration is a factor, need to be reviewed. Some countries have experimented with "Extra Duty", "Rural", "Hardship", "Mountains" and

other allowances to encourage distribution and retention of health workers. Ghana has proposed introducing intra-Mural private Practice in public hospitals for specialists to help enhance their incomes, and "hardship" and extra duty allowances for other health workers (especially in rural areas.).

Other motivational issues in the poorer countries relates to retirement and its benefits. Social services are poor and low salaries generate very low pensions. This social security issue remains an important reason for migration which must be dealt with either by creating additional trust funds to support retiring or elderly health practitioners.

Development of new career options for health workers is an important motivational factor. The lack of clear career options remains a factor in many countries where careers are limited to routine promotion with new titles every few years. General and family practitioners as well as public health practitioners have limited opportunities and often lack the recognition given to the clinical specialties. New career schemes should provide incentives to encourage relevant and needed cadres.

Skills Delegation/replacement: Many countries have utilized various distinctive cadres to carry out functions originally reserved for doctors or other professionals in the face of shortages and expanding services. Examples given the text include the Assistant Medical Officers of Tanzania, Field Surgeons in Ethiopia, Nurse Practitioners in many countries, Midwives with extra Life Saving Skills in Ghana, etc., . This has a two fold benefit of [a] Service providers trained at lower costs, [b] Obtaining the services delivered (also possibly at lower costs than doctors would provide them) and [c] Motivated staff due to new and respected responsibilities given them and [d] Staff who are much less mobile because of registration difficulties outside the country of origin.

Recruitment of Expatriates: Almost all countries in the Africa region have expatriate health workers either as volunteers, representing NGO[7] service providers, or recruited by the government services from neighbouring countries. Some have arrangements to receive VSO[8] or BESO[9] volunteers to work in the health services. No formal inter-government agreements were elicited in the region except for arrangements with the Cuban government for doctors made with a number of countries including Ghana, South Africa, Namibia and the SADC[10] arrangements in southern Africa. Language difficulties are often a problem with Spanish speaking Cuban doctors but can be reduced by efforts made to provide language lessons to such expatriates. Agreements also can assist both the receiving and dispatching countries to better plan the numbers and reduce detrimental effects on either country of flooding of migrants to recipients or a collapse of service in the dispatching country.

Health Sector Reforms: Funding human Resources needs (beyond sponsorship for postgraduate training etc.,) is generally neglected as part of Sector Reforms. Adjustments in many countries have meant projected reductions in the wage proportions of budgets, limiting the options for providing and retaining professional health workers. Can approaches to Health Sector reforms find new ways of supporting Human Resources Investment in health along similar lines as for infrastructure and funding arrangements to support retention of priority staff and encourage deployment to the areas of greatest need?

Donors and partners are reluctant to support funding of wages which is seen unsustainable expenditure where eventual withdrawal may even worsening motivation problems. Targeted and indirect support aimed at providing non-monetary incentives to workers in unpopular locations or difficult jobs may be considered including supporting staff to obtain additional

qualifications and supporting communication and links with professional and academic institutions to reduce the phenomenon of professional isolation.

Ministries of Health will need to debate and restructure the balance between personnel costs and other recurrent and capital costs. Human resource costs will necessarily be relatively high if equipment, logistics, infrastructure and other resources are to be efficiently utilized. In addition, substantial investments into training of health professionals should not be wasted by allowing migration due to low wages. This has to be countered against having significant salary raises that leave little funding available for service delivery.

Overall, the issues of good governance, efficient economic management, transparent and efficient staff administration systems are the underlying important issues affecting the success of any strategies that are implemented.

References and notes to Annex 3

1. This annex comprises two extracts from Dovlo, D.Y. *Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African states.* A report prepared for the Commonwealth Secretariat: 1999 (unpublished). *Summary of the main factors influencing migration in Africa* is from p.30; *Recommendations on policy directions* is from p. 33-35. Numbering of the references have been changed to make the Annex freestanding.
2. Wireko TB. *Brain Drain in Lesotho.* A consultancy report sponsored by Commonwealth Secretariat CTFC with assistance from UNDP; 1997 (unpublished)
3. Agovino T. 'Stemming the brain drain from the former USSR.' Lancet. 11 July 1998; 352(9122): 125
4. Schlegel M. Brain 'Drain with regard to Africa.' Available on-line from www.sas.upenn.edu/african_studies/articles_gen/menu_articles_gen.html [Accessed 28 February 2001] Article discussing information technology systems and means to help scholars on the continent keep updated and in touch with colleagues.
5. Dovlo D and Nyonator F. 'Migration by graduates of the University of Ghana Medical School: a preliminary rapid appraisal.' *Human Resources Development Journal* 1999; 3(1) [Electronic Journal] Abstract available on-line from www.moph.go.th/ops/hrdj [Accessed 26 February 2001]
6. Martineau T and Martinez J. *Human resources in the health sector: guidelines for appraisal and strategic development.* Health and Development Series, Working Paper No. 1. Brussels: European Commission; 1997. p.14. Available from www.liv.ac.uk/lstm/hrdcover.html [Accessed 6 February 2001]
7. NGO – Non-Governmental Organisation.
8. BESO – British Executive Service Overseas
9. VSO – Voluntary Service Overseas
10. SADC – South African Development Community

Annex 4

Caribbean region: Recommendations at both policy and strategic level

Extract from the report on the Caribbean region[1]

The following recommendations to be implemented at both policy and strategic levels are based on findings from the literature review, professional experience and expertise, as well as the results of the returned questionnaire survey of ten of the fourteen Commonwealth Caribbean countries which was conducted as part of this study.

A regional goal should be to reduce the 'brain drain' by paying greater attention to conditions of employment/service and conditions of work including dysfunctional workplaces, enhancing job satisfaction and teamwork.

1. Policy orientations and strategic planning are required for the strategic placement of human resource within the context of national health sector development.
2. The level/grade structure and classification of health workers be reviewed and a more equitable system among categories introduced. The resulting levels/grades be reduced, with appropriate number of steps introduced accordingly.
3. Introduction of new categories of health workers. Several impacting forces as well existing occupational skill deficiencies point to the need for introduction of new skill types within the health service.
4. "The countries need to review the process of human resource management so that health personnel are able to deliver acceptable, effective, and efficient health care in a satisfactory work environment, despite the marked contraction of resources available to health. These goals imply quantitative and qualitative changes in the patterns of service delivery, along with improved management skills and a systematic framework of information, which are both valued and used by leaders and decision-makers. Development of the latter is perhaps the single most important challenge facing the health system"[2]
    - Review and improve personnel management functions such as appointments, performance appraisal, promotion, disciplinary process, and leave allowances.
    - Create mechanisms that will give the health professionals the opportunity to be innovative, expand their professional roles and develop excellence in management and clinical practice.
    - Introduce structural changes in staffing patterns, which entails skill mix.
    - Distribute health workforce on the basis of health service requirements.
    - Emphasize substitutions within the different professional groups, introducing auxiliaries as appropriate and arriving at a mix of staff that is cost-efficient and of high quality.
    - Increase nurse workforce supply through:

        - appropriate ratio of professional to non-professional nursing personnel
        - substitution of one type of labour for another
        - efficient allocation and utilization patterns and appropriate mixes of nursing personnel
    - Provide and maintain incentive programs such as:
        - more flexible shift system
        - improved local transport arrangements
        - day care facilities at place of work
        - low cost housing schemes
        - educational opportunities
        - improved career mobility.
    - Change from vertical, hierarchical command organizational structures to comparatively flat responsive structures.
5. Reform the regulations particularly those dealing with hiring, promotion, and disciplinary measures, and delegate to the work sites as appropriate.
6. Given the spiraling cost of health technology and the limited demand for some services, the English-speaking Caribbean countries must continue to explore opportunities for selective specialization and for sharing services among themselves to overcome discrepancies between the available workforce and the needs of the health sectors.

According to Buchan[3], "...the real challenge to management and planners is not identifying potential solutions to recruitment and retention difficulties (which by now are well documented); it is identifying which solutions are appropriate to their circumstances, and evaluating the effectiveness of these solutions".

The commitment of the governments in identifying solutions and their implementation is imperative.

References and notes to Annex 4

1. This annex is an extract from Reid UV. *Human resource development for health project: Commonwealth Caribbean*. A report prepared for the Commonwealth Secretariat: 1999 (unpublished). p.28-30.
2. PAHO/WHO *Health conditions in the Caribbean. Scientific Publication no. 561*. Washington DC: PAHO/WHO: 1997. p.88-89.
3. Buchan J. 'Nursing shortages and human resource planning.' Journal of Advanced Nursing 1993; October: 469

Annex 5

Pacific regions: Discussion and recommendations

Extract from the report on the Pacific region[1]

Alterations to existing processes in order to reduce emigration of health personnel should be built around sound human resource management and development practices. It must be recognised that a quality health service is dependent on the personnel providing that service, and that investment in the selection, education, monitoring and training of those people in association with appropriate rewards for their expertise, skills and dedication, is the only way to further develop the health services in a sustainable and affordable manner.

All Ministries of Health will benefit from enhanced human resource management and the further development of workforce plans. These plans can only be developed by skilled health planners working collaboratively with the government, Health Ministry and consumers. For this essential criterion to be possible, health planners must be employed in each Ministry of Health and recognised appropriately by that Ministry, so that their expertise is not recruited by other Ministries or other countries.

The first task, should be to identify the goals and objectives of the Health Service within what are for every country, finite budgets. Strategies must then be developed for the achievement of those goals and objectives. Part of the business plan which will arise will involve the identification of the mix of skills which are required at each level of the health service, and the best method of delivering those skills through the identification of the personnel who will be required. It is important to emphasise that the health service must meet the identified needs of the population to be served based on the primary health care model, and not merely be an imposed solution which is reached by well intentioned, but unrealistic assessments and recommendations from external consultants.

It is important to state however, that over emphasis on the primary health care approach may send the wrong message. It is not intended that health services be provided on artificially low budgets which are sufficient to employ only semi-skilled personnel. The aim must be to have staff who are all of a high calibre regardless of the level of the health service where they are engaged. There must in each country be well funded secondary and tertiary referral hospitals and a commitment by government to adequately fund the health services and not to rely on donor aid for every development initiative.

The importance of a well documented health service development plan is emphasised. This "National Health Plan" and the associated health workforce plan should form the basis for discussions and negotiations with the Public Service Commission, Treasury and other government ministries for securing a greater percentage of resources for health service training programmes.

Once the numbers and types of staff required have been identified for each level of the health service, consideration must be given to the education and training required for the existing school leavers to attain those skills and education. It is considered that education should meet the identified requirements.

For these reasons it is considered that the health services will to a large extent be dependent on the nursing staff, who along with their undoubted compassion, commitment to service

and expertise, are prepared to work in remote rural areas and to function as part of the community which they are serving. The developments taking place in nurse education for the production of "specialist nurses" or "nurse practitioners" are applauded, as this would seem to be an appropriate way to strengthen health service delivery at the local level.

It is important that in the rural health services, the special challenges for health service staff be recognised by government. Augmentation of salaries for these personnel may be appropriate so that their take-home-pay is higher than that offered to urban personnel of equivalent skills and position grade.

As far as is possible within financial efficiency considerations, health worker education should be provided in-country, or certainly within the region at existing tertiary education facilities such as the University of Papua New Guinea, the University of Samoa, the University of the South Pacific, the Fiji School of Medicine and the Fiji School of Nursing. The World Health Organization and donor governments should be encouraged to change their support from scholarships to countries such as Australia, New Zealand, and the United Kingdom to support for education within the home country or within the region where such educational opportunity exists.

Consideration should be given to ensuring that pre-service health worker education is provided under the auspices of the Ministry of Education in "main-stream" institutions, rather than in Ministry of Health institutions which may be compromised in educational terms by the co-existing need for service delivery to patients. To achieve this desirable objective there will need to be a greater commitment by governments to health service funding and to training of health service personnel. Service delivery should not be dependent on personnel whose primary objective is to obtain their basic qualification.

Health service staff who wish to obtain specialist qualifications, should if such qualifications meet the identified needs of the population, be supported to study and practice only in countries of the region. This means that there should be processes in place for better matching of skills with needs, stronger incentives for personnel to upgrade their basic skills, more professional management and planning of human resources, and active commitment given to the retention of professionally and technically qualified people within the public health service.

All staff (and indirectly the patients) benefit from involvement in quality improvement processes. Health Ministries should ensure that personnel are deployed and co-ordinated in a fair and rational manner, and appropriately monitored so that further improvement in their skills and performance can be supported through first identifying the need, and secondly through providing the opportunity. Such processes should not be punitive in nature, but be positive in intent so 'as to achieve quality in outcome. There must be supportive supervision of personnel at all levels of the health service.

Strategies to provide support to continuous quality improvement are important. Such strategies could include government financial support to continuous professional development (CPD) programmes which are developed and provided by the various professional organisations. In addition, performance-based rewards for health

personnel would provide further incentive for a best-practice approach which achieves optimal patient outcomes.

Health workers can frequently become discouraged due to seemingly insurmountable difficulties such as shortage of equipment or drugs, poor facilities, unrealistic community

expectations, or working in a sole practitioner environment. The result is a loss of morale with absence from the work post which may commence as short-term and then progress to permanent absence or to a decision to emigrate. The solution to these difficulties is a combination of solving the apparent problems, supportive supervision associated with constant motivation of staff to high levels of performance.

It is crucially important for staff to be able to derive satisfaction from their work, and the Health Ministry must ensure that processes are in place which enable satisfaction to be attained whether the employee is in a remote rural location, or in a central (national) hospital. Satisfaction is dependent upon selection of the right person for each job, so that the health worker is personally fulfilled through the existing activity level, and not over-educated for the level of service to be provided. Linked to satisfaction is some form of career progression, and appropriate recognition through salary structure of the health worker's importance to the development of the country as a whole.

There are periods of difficulty and self questioning for all health workers. It is important that all are encouraged in their continued commitment to the attainment of the health goals. The National Health Plan should be focused on attainable health goals which are finance and time reasonable, and those goals should be collaboratively reviewed in a continuous manner so that health workers feel part of the process of improving health for the entire community.

If these recommendations were easy to implement then they would already be occurring, and there would be no need for this review. The practicality is that such processes are difficult to implement and are dependent not only on the availability of money, not only on political will, and not only on reallocation of entrenched interests, but on active communication with all involved in health, without the difficulties which come from artificial professional barriers and from entrenched interests.

It is proposed to now suggest a series of questions for health ministries, which will provide a focus for human resource development within each country:

How can we increase the prominence and our commitment to human resource development?

- How can we improve the present practices in relation to management of human resources?
- What processes and methodologies should we use in our particular situation?
- How can we sustain a momentum of development?
- How can we bring about real co-operation with the private arid non-government (NGO) sectors?
- How can we integrate the efforts of all health workers? .
- How can we resolve the series of existing imbalances?
- How can we further mobilise our training and educational institutions?

These questions form a structural basis for initial analysis prior to establishing a detailed human resource plan. The plan should incorporate estimated workforce needs, which are accurately costed so as to provide information to government on the future budgetary implications. There is no point in establishing a comprehensive plan on paper, if the expenditure implications preclude it from ever being implemented.

The human resource development plan needs to be of a practical nature timed over a period it is suggested of twenty years. Population trends and economic development indicators will be necessary to place the plan in a context of overall country development.

Having established the human resource development plan, it is then necessary for the Ministry of Health to constantly monitor that plan and to assess progress towards meeting the various targets. As information changes, so too should the plan be altered and up-dated. At definite periods of approximately five years, the plan should be extensively reviewed and adjusted along with current staffing issues and on-going skills needs analysis.

Some countries are investigating the provision of health services in association with fee-for-service or cost-recovery principles. It is considered that such processes should be carefully developed in order to avoid over-servicing. In addition, attention to the actual allocation of funds raised is an important process for further health service development. It is recommended that cost-recovery revenue be distributed in a three way process to provide funding to local health services, local staff salary enhancement and to central health service administration.

The development of appropriate networks for health can also be important in assisting countries to meet the challenges posed by the need to deliver health services within finite budgets. There is considerable scope for the non-government provision of health services.

These may be private-practice based and could include dental, medical and pharmacy services. Associated with such development comes the necessity to provide regulation and monitoring in order to ensure quality health service delivery and to prevent over- activity (which in developed countries may be known as doctor-induced demand).

Such regulatory, monitoring and inspection processes become a new demand for the Ministry of Health and cannot be left to regulation by market forces if consumers are to be adequately protected.

Traditionally, not-for-profit agencies such as non-government-organisations (NGOs) and church-based organisations are able to provide quality health services to people in need, particularly to those in rural locations. Examples from this study are church organisation hospital services in Papua New Guinea and in the Solomon Islands. The Ministry of Health should continue to have the role of co-ordinating the government and NGO sectors in the provision of optimal health care for the population in each country.

In addition, consideration should be given to the development of some part-time appointments to work in the government service. The remainder of time would be spent in providing health service through the non-government sector. This concept of part-time private practice could initially be investigated in dental, medical and pharmacy services

Reference and note to Annex 5

1. This annex is an extract from Rotem, A. and Bailey, M. *Health personnel migration within Commonwealth countries in the Pacific Region.* A report prepared for the Commonwealth Secretariat by the School of Medical Education Faculty of Medicine, the University of New South Wales: 1999 (unpublished). p. 29-34.

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