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.