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.