



# WORLD HEALTH ORGANIZATION

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## Recruitment of health workers from the developing world

### Report by the Secretariat

1. The loss of human resources through migration of professional health staff to developed countries usually results in a loss of capacity of the health systems in developing countries to deliver health care equitably. Migration of health workers also undermines the ability of countries to meet global, regional and national commitments, such as the health-related United Nations Millennium Development Goals, and even their own development. Data on the extent and the impact of such migration are patchy and often anecdotal and fail to shed light on the causes, such as high unemployment rates, poor working conditions and low salaries. Even between low-resource countries the context of migration differs. Some countries, such as India and the Philippines, overproduce health workers, whose resultant emigration generates remittance revenue. Indeed, in the past decade developing countries' receipts of remittances is estimated to have exceeded the total of global development aid. In Africa, however, the growing mass exodus of health professionals causes particular concern, depleting human resources, undermining the investment in human capital, exacerbating existing shortages of staff, and diminishing the capacity of the health services to provide adequate services and coverage. Recent WHO studies document the increasing pace of both internal migration and emigration.<sup>1</sup> This report focuses on that continent.

### CHARACTERISTICS OF MIGRATION IN AFRICA

2. Highly skilled professionals represent an increasingly large component of global migration flows, currently accounting for around 65% of all economically active migrants to highly developed countries and comprising in the health care workforce physicians, nurses, dentists and pharmacists. The International Organization for Migration estimates that about 20 000 Africans leave Africa each year to take up employment in industrialized countries. Although it is not known exactly how many health professionals are included in this estimation, a quarter to two thirds of health workers interviewed in a recent study expressed an intention to migrate, indicating the gravity of the situation.

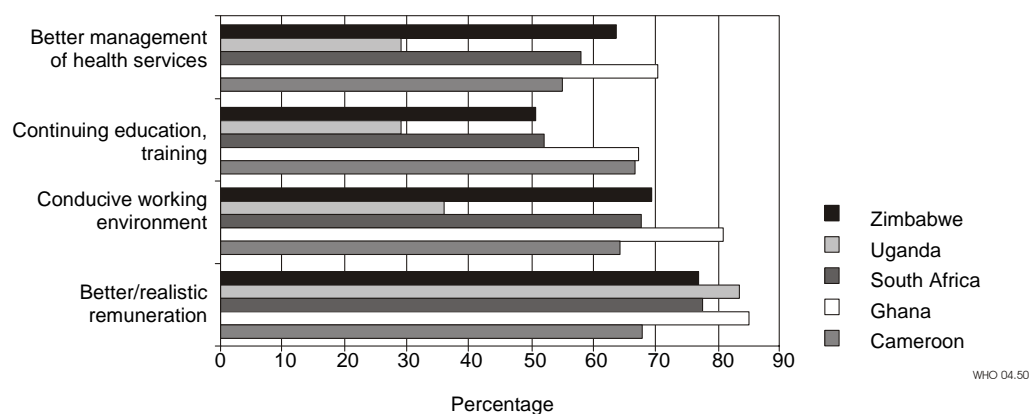
3. Emigration is predominantly determined by political and socioeconomic differences between countries. The main push factors are lack of further training and clear career profiles, poor remuneration and working conditions, political conflicts and wars, while the pull factors range from

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<sup>1</sup> Awases M et al. Migration of health professionals in six countries: a synthesis report. Brazzaville, WHO Regional Office for Africa, 2004, in press; Connell J. The migration of skilled health personnel in the Pacific Region. Study commissioned by the Regional Office for the Western Pacific; Stilwell B et al. Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges. *Human resources for health*, 2003; 1:8.

better remuneration and improved standards of living to opportunities for educational advancement. Dissatisfaction with remuneration and working conditions are the main determinants (see Figure).

**Figure. Factors affecting health professionals' decisions to emigrate  
(data from five African countries)**



4. Efforts by countries and development partners to reduce emigration of health workers and its impact include bonding of newly qualified graduates, provision of more opportunities for professional advancement, regular salary reviews and use of foreign health professionals. For instance, from 1983 to 1999, more than 2000 highly qualified and experienced nationals returned to 11 countries participating in a return and reintegration programme.<sup>1</sup> Comparison of that figure, however, with the estimated figure of about 20 000 leaving per year shows that much more needs to be done.

5. Interventions to mitigate migration and the brain drain have failed, largely because socioeconomic conditions have not significantly improved and approaches have been only piecemeal. Existing shortages of health personnel in Africa are exacerbated by the recruitment drives by agencies in developed countries for health workers from developing countries. OECD countries acknowledge that they are attempting to overcome their acute shortage of human resources for health by, for example, hiring health workers from Africa. One study showed that in OECD countries the proportion of indigenously trained general practitioners in the medical and nursing workforce fell between 1991 and 2000 while the percentage of equivalent foreign-trained staff increased.<sup>2</sup> This finding is consistent with the results of a study on the major destinations for health workers emigrating from countries in the African Region: Australia and New Zealand, Belgium, Canada, France, the United Kingdom of Great Britain and Northern Ireland, and the United States of America.

<sup>1</sup> Migration for development in Africa. Geneva, International Organization for Migration, 2002.

<sup>2</sup> Ad Hoc Group on the OECD Health Project, Paris, OECD, 2003.

## **EFFECTS OF MIGRATION ON SERVICE DELIVERY**

6. The impact of the loss of human resources in terms of skills and numbers in relation to the total size of the health workforce cannot be overemphasized. For small countries the loss of even one skilled health worker can provoke an absolute shortage and inability to maintain basic services.

7. Difficult working conditions, characterized by heavy workloads, lack of equipment, poor salaries and diminished opportunities for advancement, result in increased migration out of Africa, and, in countries, from the public to the private sector and from rural to urban areas. The net effect is to increase the workload of those who remain, especially in rural areas, where caring for disadvantaged people causes stress and demotivation, in turn encouraging even more professionals to migrate, and to decrease the quality of health care provided in institutions. The heavy workload on staff working in difficult conditions – in one country, the outpatient attendance-to-nurse ratio rose from 623 in 1995 to 963 in 2000 at district hospital level – results in long waiting times for patients. Furthermore, inequity in access to health care is increasing. Rural areas have always been disadvantaged, but, with loss of health workers, some health facilities no longer function or are run by unqualified staff.

8. The quality of education has reportedly declined in nursing and midwifery schools owing to emigration of teaching staff, and the remaining trainers are unable to cope with the demand for the training and specialized programmes of research needed in Africa. The quality of training and the capacity to provide evidence through research are thus compromised. Lack of supervision and mentoring is also a concern; senior, experienced staff are being lost through emigration.

## **POLICY OPTIONS**

9. Developing countries that are experiencing absolute shortages in their health workforces need to intervene more aggressively to stem further losses and to replenish those workforces. Each country has to make concerted efforts to deal with these factors and seek support for what is beyond their capacity. Governmental strategies and policies can influence a country's ability to retain health workers. It is more important and more effective in the long term to reduce or inhibit migration than to increase the number of trained health workers. Motivation and retention strategies are also essential.

10. Individuals have rights of movement and choice, but poor countries have no mechanisms for compensation for the loss of investment made in educating skilled health professionals. The cost of such education amounts to hundreds of millions of dollars annually, and, although remittances benefit many countries, there is no way of ensuring that they are used to compensate the education or health sectors. One policy option could be to structure some form of direct compensation to be paid by host countries to source countries, for example as a tax or proportion of salary paid per health worker recruited. For source countries finding ways in which remittances can be channelled directly into the health system offers another mechanism of compensation.

11. Ethical codes of conduct with regard to migration, such as the Commonwealth Code of Practice for International Recruitment of Health Workers, are widely being formulated and advocated. They seem, at best, though, to have a transitory effect, and it is difficult to know how they can be implemented when they have no legal status. Detailed agreements between countries could specify more exactly terms and conditions for recruitment of health professionals. One key option is that the recipient country will invest in training institutions in the source country – that in effect some

countries will act as providers of health personnel for other countries by producing surplus health workers.

12. Other policy areas for action include trade agreements regulating cross-border movement of health professionals. Recognizing the inevitability of migration and creating opportunities for health workers to go overseas for limited periods are possible through bilateral agreements, with granting of temporary visas, or through institutional agreements to take – or even swap – workers for a limited time.

13. Another area is training; national and regional institutions need to be strengthened in order to increase access to and use of such facilities in order to meet national needs.

14. Wage differentials between source and destination countries are currently so large that small reductions are unlikely to affect migration flows. More research is needed to assess the determinants and impact of international migration at different stages of economic development.

## **RECOMMENDATIONS**

### **Recommendations to countries and groups of countries**

15. Each country should devise its own strategy for dealing with the brain drain. For example, an intervention programme to counteract migration should be developed, with proposals for reviewing and implementing salary and other incentive systems, especially for underserved areas and in the caring professions. There should also be a general review and implementation of policies and strategies to enhance retention of health workers.

16. Source countries should:

- (a) establish and maintain appropriate information systems on human resources, including a database on migration in order to provide evidence for policy, planning and day-to-day decision-making and to monitor the effect of any intervention programme implemented;
- (b) consider using resources accrued from debt relief and development-assistance programmes to augment salaries and incentives for health workers; and
- (c) strive to create an enabling sociopolitical environment for provision of health services, improving equipment and drugs supply, and expanding continuing education for health workers, so as to contribute to the retention of health workers.

17. The Commonwealth Code of Practice for International Recruitment of Health Workers should be adopted, implemented and adhered to by all countries. Regional and international organizations could support adoption and implementation of a similar code of practice as well as provision of sufficient financial resources for development of human resources for health including incentives.

18. Source countries should agree mechanisms of compensation for the loss of skilled health workers to developed countries and of recouping their investment in training, so that the issue can be taken up at the level of Heads of State and Government and their OECD and G8 counterparts.

19. Steps should be taken to foster international cooperation and benefit all parties, such as bilateral national agreements and international rotational exchange programmes.

**Recommendations to international partners**

20. The newly established United Nations commission on migration should pay special attention to moderating the movement of health workers, given the grave effects that severe shortages have on already weakened health systems. Regional groupings such as the New Partnership for Africa's Development and the African Union can use relevant forums to facilitate dialogue between stakeholders.

21. Investing in human resources for health, including implementing strategies for motivation and retention through means such as incentive packages to retain health staff, should be part of development-assistance programmes. Resources accrued from debt relief could also be used to mitigate the brain drain in developing countries.

22. Support should also be provided to programmes such as the Migration for development in Africa programme of the International Organization for Migration that will facilitate periodical transfers, distance interventions, and short-term and eventually permanent returns of African diasporas.

**WHO actions**

23. WHO could work with development partners to review their practices in funding and technical assistance in order to strengthen human resources for health. It could use aggregate data from countries to monitor trends of migration and give feedback to countries accordingly. WHO might consider working with the Commonwealth Secretariat towards full adoption of and adherence to the Code of Practice, and to advocate for its universal adoption and application.

24. National and regional training institutions should be strengthened to enhance their role in expanding education and training of health workers in terms of numbers and range of skills relevant to the needs of their health systems.

**ACTION BY THE EXECUTIVE BOARD**

25. The Executive Board is invited to note the report.

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