FIGHTING THE BRAIN DRAIN

WHO wants to close differences in life expectancy. But first, countries will need to get and keep enough healthcare staff. **Karen McColl** reports

In sub-Saharan Africa, 3% of the world's health workforce cares for 10% of the world's population bearing 24% of the global disease burden.[1] Developing countries need an extra 4.3 million health workers, and urgent action is required to scale up education and training.[1] Last month the World Health Organization's Commission on Social Determinants of Health emphasised the importance of building and strengthening the health workforce if the goal of achieving health equity within a generation is to be realised.[2] International cooperation will be essential to strengthen health systems and to manage the migration of health workers from developing to developed countries.

But these measures will take time. What can African and Asian health systems do to recruit and retain health workers now? How can health workers be persuaded to practise in rural areas? Guidelines, commissioned by the Global Health Workforce Alliance, aim to help countries make the best use of incentives to attract and retain health professionals.[3]

Improving recruitment and retention

"It is important that we effectively utilise what is available now. The efficient and effective utilisation of the health workforce which is available is the key," says Mubashar Sheikh, executive director of the Global Health Workforce Alliance. "That is why retention—providing the right kind of incentives, motivation, and support—is absolutely critical."

WHO has identified 57 countries that have been particularly hard hit by shortages in health workers.[4] There are many reasons why health systems in these countries find it difficult to attract and keep staff, particularly in rural areas. Some of these reasons are global; others are local. There are both "push" factors that drive people to leave and "pull" factors that tempt health workers to better packages in the private and non-governmental organisation sectors or in other countries. The push factors include poor working conditions, safety concerns, inadequate training or career development opportunities, poor human resources management, and conflict. HIV and AIDS have also had a major effect on the health workforce; as well as the direct impact on health workers who are infected, the pandemic has increased the workload for health workers and fear of exposure to the virus may deter people from joining the health workforce.

Government spending on health workers' pay has been constrained by macroeconomic factors, such as the recruitment freezes and limits on the public sector wage bill that were often part of structural adjustment programmes imposed as a condition of loans from the World Bank. In many countries, the macroeconomic policies do not allow governments to pay the salaries that would retain health workers.

Paradoxically, some countries have unemployed health workers at the same time as unfilled health vacancies because of these limits on expenditure. Irregular payment is also a common problem for public sector health workers.

The right incentives

Guidelines: Incentives for Health Professionals was produced by six global professional associations, including the World Medical Association, the International Council of Nurses, and the International Hospital Federation.[3] It covers both financial and non-financial incentives to recruit and retain staff (see box). Evidence suggests that both types of incentive are needed. Financial incentives tend to have dramatic, immediate results in terms of attracting new health workers or slowing the rate at which health workers leave. This reflects the reality in many countries where health worker salaries are low making it difficult for them to make ends meet. Non-financial incentives, when combined with financial incentives, are thought to have a consolidating effect in the longer term by improving satisfaction, motivation, and commitment.[5]

Salary increases in Ghana have increased the health workforce, but have reduced the budgets for running services

By dealing with health workers' social needs, non-financial incentives can send a powerful signal that workers are valued and that their welfare is important. Thabsile D'lamini, president of the Swaziland Nurses Association, explained that this was an important part of the rationale for setting up a wellness centre for health workers in 2006. "Because of the shortages and the disease burdens, nurses were getting tired and getting sick and they felt that no one cared for them," she said. "And no one thanked them and appreciated them. This is why there was so much brain drain—because no one cared for them. So we thought, let's take care of them." Although the impact of the wellness centre has not yet been evaluated, the care offered by the Centre is cited by some as one reason that no nurses are reported to have emigrated from Swaziland since 2006.[7]

But incentives need to be carefully tailored to the particular context. Poorly planned measures can be counterproductive. In Ghana, for example, an additional duty hours allowance was introduced to improve retention of health workers. However, the fact that nurses received less than doctors under this allowance is widely reported to have demotivated the nursing workforce. Ministry of Health officials saw an increase in the number of nurses wanting to emigrate, and anecdotal evidence suggested this was linked

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"Non-financial incentives can send a powerful signal that workers are valued and that their welfare is important"

to the demoralising effect of this perceived unfairness.[8] In Lesotho the allowance paid to doctors for night shift duty generated resentment among other health workers working night shifts, and in Botswana the higher pay, free housing, and other benefits for foreign doctors were resented by local doctors.[5]

This potential for poorly designed incentives to backfire is one of the reasons that the six global professional associations representing doctors, nurses, pharmacists, dentists, physiotherapists, and health service managers have collaborated to produce the guidelines.[3] Drawing on examples from both developed and developing countries, the guidelines are clear that no "one size fits all" template exists. The emphasis is on incentive packages that combine financial and non-financial incentives and that are "well designed, strategic, and fit for purpose."

Incentive packages require investment and have costs. Although non-financial incentives may have fewer financial constraints, they require major organisational changes. The expanded health workforce, if incentives are successful, will also cost more and will need adequate resources to run services. Salary increases in Ghana, for example, have successfully increased the health workforce. But budgets are now so stretched by the costs of the health workforce that the money for running services is substantially reduced, resulting in little improvement in productivity.[9]

External funding will clearly be needed. It is vital that this funding is sustainable and predictable to enable countries to build up their health systems. Collaboration, both nationally and internationally, is also essential to manage the labour market effectively.

In reality, how much impact can incentives have on the ground in a world where there is such inequity between developed and developing countries? David McCoy, clinical associate at the Centre for International Health and Development at University College London, argues that it "will depend on the size of the incentives and the extent to which they've been properly structured and organised. The impact will depend on whether the incentives are big enough—for example, to overcome the global forces that are driving the international brain drain.

"Certainly one of the things that we need to get a better handle on is what is a fair, basic wage for health workers in poor countries," he continues. "Both relative to the country context they are working in and also to the global context they are living in."

The *Kampala Declaration and Agenda for Action* from the first global forum on human resources for health in March 2008 sets out the vision that "all people, everywhere shall have access to a skilled, motivated and facilitated health worker within a robust health system."[10] If this aspiration is to be realised, concerted action will be needed to tackle both the overall shortage of health workers and the unfair distribution of the existing health workforce. In May, the Global Health Workforce Alliance's task force on scaling up education and training for health workers published its findings and recommendations to address the

UNDERSTANDING INCENTIVES[3 5 6]

Financial incentives: Salary top-ups and allowances can play an important part in increasing health workers' pay. In Kenya, payment of various allowances effectively tripled doctors' pay, and this is reported to have attracted 500 extra doctors. Scarce skills allowance, risk allowance, uniform allowance, housing and transport allowances are a few examples

Allowances for working in rural locations—South Africa's rural allowance, Lesotho's mountain allowance, and the disturbance allowance in Mauritius, for example, were all designed to increase the numbers of health professionals working in remote areas

Pensions and retirement packages— In Malawi midwives were offered a retirement package that included a 25% contribution from government after 20 years' public service

Access to loans—In Ghana for example, health professionals can apply for a loan and tax waiver on purchase of a car. Repayments for the car are deducted from salary payments over 5 to 7 years

Funding for education and training—Some countries offer scholarships or bursaries for study, tied to a commitment to work for a specified period in the country's public health system

Non-financial incentives: Improved working conditions—Health workers need sufficient resources to do their work, supportive management, work autonomy, recognition, a safe working environment, and a manageable workload. The shortage of health workers leads to deteriorating working conditions, which, in turn, contribute to further staff shortages

Flexible working, holiday, and sabbatical opportunities—A scheme rotating midwives between rural and non-rural areas in Malawi for example, found that midwives were more willing to work in rural areas for shorter periods. Flexible working is particularly important for health workers with caring commitments and for older workers

Access to training and career development—Professional development, education, and training are important for motivating staff. Botswana announced plans in 2006 for two telemedicine pilot schemes to reduce isolation of health workers. Continuing professional development activities, including distance learning and visiting tutors, are in place for health professionals working on the outer islands in Mauritius

Social needs—Issues relating to family and social life, such as schooling, housing, and transport can affect health workers' willingness to work in remote areas. In Zambia, doctors signing a three year contract to work in rural areas were offered a package which included an accommodation allowance and an educational allowance for up to four children

Access to healthcare—Many countries have introduced specific HIV care programmes for health workers and their families, often including access to antiretroviral drugs. National nursing associations in Swaziland, Lesotho, Zambia, and Malawi, working with the International Council of Nurses and other partners, are establishing wellness centres to care for health workers

massive shortfall in the production of health workers.[1] Another task force will look into how to finance the health workforce.

Another key issue under scrutiny is migration of health workers. As part of this, the recruitment practices of health systems in developed countries are now being tackled internationally. In December, the European Commission is due to publish a green paper on the European Workforce for Health, which will include ethical recruitment of health workers from outside the European Union. The recommendations of the health worker migration policy initiative, another task force set up by the alliance, will feed into the development of a global code of practice on health worker migration for discussion at the World Health Assembly in 2009.

Dr Sheikh is convinced that the effective use of incentives is a vital part of the policy response. "We do believe, and there is enough evidence to show, that retention is the key," he says. "And it does work—if we are willing to address the issues which force people to move out of the profession altogether, or within the profession to move from one place to another."

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1 Global Health Workforce Alliance. *Scaling up, saving lives*. Geneva: WHO, 2008.
2 Commission on Social Determinants of Health. *Closing the gap in a generation. Health equity through action on the social determinants of health*. Geneva: WHO, 2008.
3 International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, World Dental Federation, World Medical Association. *Guidelines: incentives for health professionals*. Geneva: ICN, 2008.
4 World Health Organization. *The world health report 2006— working together for health*. Geneva: WHO, 2006.
5 Dambisa YM. *Discussion paper 44: a review of non-financial incentives for health worker retention in East and South Africa*. Harare: Equinet, 2007.
6 Munjanja OK, Kibuka S, Dovlo D. *The nursing workforce in sub-Saharan Africa*. Geneva: ICN, 2005.
7 Health Workforce Advocacy Initiative. *Addressing the health workforce crisis—a toolkit for health professional advocates*. HWAI, 2008. www.healthworkforce.info/advocacy/HWAI_advocacy_toolkit.pdf.
8 Buchan J, Dovlo D. *International recruitment of health workers to the UK: a report to DfID*. Department for International Development Health Systems Resource Centre, 2004. www.dfidhealthrc.org/publications/country_information/int-rec-main.pdf.
9 Global Health Workforce Alliance. *Country case study—Ghana: implementing a national human resources for health plan*. Geneva: GHWA, 2008.
10 World Health Organization, Global Health Workforce Alliance. *The Kampala declaration and agenda for global action. Health workers for all and all for health workers*. Geneva: WHO, 2008.

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Listen to Karen McColl interview Mumbashar Sheikh in a podcast on bmj.com.

Mary Robinson, co-chair of WHO's working group on health worker migration policy, tells **Karen McColl** about a global code of practice on international recruitment of health workers

ROBINSON'S CRUSADE

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Mary Robinson, at the launch of the Global Call to Action Against Poverty's "In My Name" campaign last month: "We at least have to pay for the education in other countries if we are drawing from those countries"

The migration of doctors, nurses, and other health service staff from developing countries already short of health workers can be disastrous for health systems that are struggling to cope. A quarter of doctors and one in 20 nurses trained in Africa are working in countries in the Organisation for Economic Cooperation and Development.[1] So some of the world's poorest countries, having educated and trained these health workers, are essentially subsidising the world's richest health systems.

Earlier this month world leaders meeting in New York pledged to train one million health workers by 2015 and tackle migration of health workers.[2] "There needs to be more understanding in the developed world that if you draw doctors and nurses from poor countries you are getting a development gain because you haven't had to pay for their education," explains the former Irish president and UN high commissioner Mary Robinson, who co-chairs the World Health Organization's advisory council on health worker migration global policy along with Francis Omaswa of the African Centre for Global Health and Social Transformation. "And the countries you are taking them from are losing in every sense and, in particular, in being able to provide for the health of their people."

Critical balance

International migration, which has risen sharply in recent decades, has been described as "one of the defining issues of the 21st century."[3] The right of individual health workers to migrate is not in question, but some recruitment practices in developed economies exacerbate the problem. Policy makers are seeking to ensure that wealthier countries recruit ethically and that they take responsibility for training more health workers to meet their own needs, while limiting the damage that migration causes to health systems in poorer countries.

"When I go into a village in Africa there is no health system, there are no health workers, and the clinic has no medicines. It is a critical situation. A really urgent life and death problem. There is a very severe shortage of health workers and that's because those who have graduated from African countries, many of them leave. Understandably—they have a right to migrate and to seek to better themselves. But there is a kind of recruitment which is unethical, an aggressive recruitment in the rich countries who don't train enough doctors and nurses because it's expensive and who woo them out of the poorest countries who have spent money educating them," explains Mrs Robinson.

"It is a difficult and complex problem, because you are balancing the right of individuals to leave and seek a better future and the need to preserve a standard of health for the whole population, which is part of the responsibility of governments," she adds.

Guidelines

Last month, WHO held a public consultation on its draft global code of practice on the international recruitment of health workers,[4] which should lead to a revised code to be discussed by WHO's executive board in January and presented to the World Health Assembly next May for adoption. The code sets out ways to maximise the benefits of health worker migration, mitigate the negative effects, and safeguard the rights of individual health workers. Countries are urged to set up bilateral or multilateral agreements, including arrangements such as providing aid, enabling access to training, and supporting health workers to return home.

"You are balancing the right of individuals to leave and seek a better future and the need to preserve a standard of health for the whole population"

"We acknowledge that it [the code] is good, in particular, on the rights of individual health workers, and they are well identified and protected," Mrs Robinson said. "Where it is weak is in recognising the major problem, which is the undermining of health systems in the poorest countries."

The WHO council says the code should set out the principle that a country that does not produce enough health workers to staff its health services has some shared responsibilities as a global employer. It also says the code should spell out the specific roles and responsibilities of source and destination countries.

The proposed code of practice is voluntary, and its effectiveness will depend on how well countries adhere to it. "We hope that there will be compelling arguments from civil society that every country should be part of it, particularly the countries which draw health workers," Mrs Robinson said.

Ethical recruitment

One example of a forward-thinking approach to health migration is by the Norwegian government, which has realised that it will not be able to meet its health needs over the next 25 years with home grown doctors and nurses. As a result, the government has been developing a cross government strategy to train more health workers and also to support training in the countries which end up supplying health workers to Norway. Mrs Robinson argues that other countries should be encouraged to look at working in this way. "We have to have a fairness here, and we at least have to pay for the education in other countries if we are drawing from those countries. I think that is probably a better approach than looking for some abstract compensation, which is a switch-off at the international level," she said.

As a former UN high commissioner for human rights, Mrs Robinson approaches the issue of health worker migration from a human rights perspective—highlighting that governments have obligations under international law in relation to the right to health and that these obligations extend beyond national borders.

"We are talking about governments' duty to respect, protect, and fulfil the right to health," she explained. "That also means not—through what you do with your own recruiting—undermining the health system capacity of poorest countries."

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1 WHO. *Migration of health workers. Fact sheet No 301*. Geneva: WHO, 2006. www.who.int/mediacentre/factsheets/fs301/en/index.html.
2 United Nations. *Secretary General's concluding remarks to the high-level event on the millennium development goals, 25 September 2008*. www.un.org/millenniumgoals/2008highlevel/sgstatement.shtml.
3 McKinley B. *Migration in the twenty-first century*. www.iom.int/jahia/Jahia/pid/241.
4 WHO. *WHO code of practice on the international recruitment of health personnel. Draft for discussion*. Geneva: WHO, 2008.

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