SURE Rapid Response

Health Worker migration:

What is its impact in the source country?

What are the different strategies to implement a bilateral government agreement on recruiting professional health workers from Uganda?

March 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key messages

- Earlier migration was voluntary and generally an individual initiation; in recent years however, the trend has shifted to involve active recruiting of these professionals that involves organisations and governments in business like ventures
- Uganda with a physician and nurse expatriation rates of 32.9% and 7.4% respectively (for OECD alone) needs to begin analysing the situation, gauging where and how it can actively be involved in health worker mobility
- It is generally perceived that individual migrants and their families derive the most benefits from health worker emigration while the health system turns out as the 'loser' in the arrangement

UNHRO

SURE Supporting the Use of Research Evidence

EAC JUMUIYA YA AFRIKA MASHARIKI

REACH Regional East African Community Health Policy Initiative

MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES

EVIPNet EVIDENCE-INFORMED POLICY NETWORK

Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

! This rapid response includes:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in Uganda

X Not included:

- Policy or practice related recommendations
- Detailed descriptions

What is SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

- Following urgent calls for bilateral agreements between nations in the context of an increasing global health workforce crisis, several policies and arrangements have been developed in the last few years to help guide managed health worker migration; these include among others bilateral government agreements.

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Background

Although only attracting growing attention in recent years, health-worker migration has raised concerns for several decades now [1, 2]. It is documented as early as the 1950s, initially common to India, Pakistan and Sri-Lanka and later Bangladesh and Nepal [3]. Following independence, highly subsidized medical schools were established in both government and private sectors in these countries leading to high production of health-workers but with governments unable to absorb and utilize their services [1]. This resulted in migration, health-workers beginning their journey mostly to the Middle East [1]. They later shifted attention to meeting staffing shortages in the Western countries in the 1960s and 70s, and later within Africa [4]. Health worker migration is generally market-driven and when this is considered in the business sense it is a natural exchange of resources like any other. The developed world has an excess of money but not enough human resources while the reverse is true (with caution) in the developing countries.

Earlier migration was voluntary and generally initiated by a professional who felt they needed better opportunities and went out of their way to get these. In recent years however, the trend has shifted to involve active recruiting of these professionals, with health care institutions in wealthier countries discovering countries from which they can recruit well trained health workers. At the same time these supplier countries are also discovering the business opportunities this presents and have gone ahead to embrace the venture. Some of them now recruit, train and prepare health care personnel for 'export'.

Uganda has a physician expatriation rate of 32.9% and that of nurses at 7.4%, reflecting the percentage of the country's potential physician and nursing workforce working outside the country and this is for the OECD nations alone [5], and most if not all of this expatriation has been out of unplanned migration. Unplanned or unmanaged out-flow of health workers may damage the health system, undermine planning projections and erode the skills base. Policy-makers must be able to assess the relative loss of staff due to emigration compared to internal flows, such as health workers switching from the public to the private sector or leaving the

profession because in some cases emigration may be very visible but small compared to the number of workers leaving the public sector for other employment within the country. The impacts of this would need to be assessed for planning and projection purposes.
As a country that may soon need to manage health worker migration, Uganda needs to begin analysing the situation, gauging where and how it can actively be involved. This paper looks at the impact on the health system and strategies that can be used in case Uganda goes ahead to arrange for managed migration.

Summary of findings

What is the impact of health worker recruitment (managed or not) in the source country?[6, 7]

Countries experiencing a net out-flow of health workers need to be able to assess its causes and impact on the provision of health care. From the results of several analyses, the general perception is that individual migrants and their families derive the most benefits from health worker emigration while on the other hand, it seems that the health system, the profession and society despite a few gains, in general, turn out as the 'loser' in the arrangement.

Effects on individuals and their families include

- The health workers gain a lot of personal and professional development, including independence, development of professional skills and meeting other nationalities from whom an exchange of culture and work ethic may be invaluable to future dealings and experiences. In addition, there are personal economic advantages derived in terms of wealth, ideas, lifestyle, goods, attitudes and behavior; these are beneficial to the migrant, their family and even the community and offer a chance at better quality life

- However there are personal costs on the migrants and their families which are at times, quite horrendous. Many migrant workers have had pervasive homesickness, which may lead to depression. Furthermore, there are disruptions of family relationships. In the destination countries workers are faced with difficulties in the form of heavy workloads, staff shortages, undesirable work shifts, stress and violence at work, gender and racial discrimination, as well as comparatively poor pay in relation to the workers' level of education. Registration and licensing procedures in host countries are also sources of potential problems which can be limiting.

- Compensation and working conditions in destination countries may also undermine the welfare of migrant health workers. Discrimination in terms of pay and conditions is often only revealed when cases are taken to national employment tribunals or labour courts,

and yet migrant health workers often feel constrained in making complaints about their employment conditions because of their sense of vulnerability. They fear that employers will retaliate by dismissing them. Without a job they will not be able to pursue their claim and will have forfeited their right to remain in the country.

On the country, economy and health profession

- For the health profession, there is professional growth, as well as development and application of skills and technologies learned abroad upon return to the country. The negative impacts however include the depletion of the pool of skilled and experienced health workers, as well as of medical skills, that could have dire consequences for patients. Inexperienced health workers replacing those who left may have less to contribute to the care of patients and the profession.

- If it is assumed that migrant workers return to practice in their home countries at a later date, the new skills, knowledge and experience they bring back with them to their country of origin can also be imparted to others, improving the profession and practice, and helping in developing and improving local services, thus potentially enhancing economic development.

- The supplier country receives revenue in form of remittances; for example, Philippine migrant workers are recognized for their contribution in supporting the economy through remittances sent back home to family, which constitute a potential advantage for the country. This income can boost the local economy and may sometimes amount up to relatively more value than the physical return of the individual to the labor force. The negative impacts of migration on developing countries can be partially offset by these remittances of incomes earned abroad and the establishment of networks between migrants and their source country.

- Migration can create international networks which can facilitate the exchange of information and expertise between migrant workers, their employers, and relevant organizations and professionals in the country of origin. These links can have a potential impact on economic growth in the source country.

- Migration also has several negative effects on source countries. An excessive loss of domestic labour leads to *brain drain* of young, highly skilled labour, a depletion of the work force and a severe reduction in the availability and quality of services. If only less skilled workers remain in a country, this can lead to a reduction in productivity which might restrict economic development.

- For the economy and society, the negative impacts further include loss of government resources used in education and training; resources that could be used for facility improvements are spent on the training of staff replacements. There is furthermore, reduced government income for the country from taxes of health professionals.

- In source countries, health workers work in situations where they are underpaid, have inadequate resources to perform their functions, are struggling with heavy workloads and, in some cases, have to cope with the threat of violence. This may be the case in developing countries where health systems are under-resourced. In this situation, some workers will leave to go to other sectors, to other parts of the country or abroad, thus creating bigger challenges for those who remain. Furthermore, a diminishing supply of workers in the source country may push wages up, putting added pressure on the economy.

- Health worker migration "deskills" the country's human resources, in the same way many of them end up "deskilled" in their country of destination. They take on jobs that are less in skill than what they are trained to do. Many doctors have been reported to be working as nurses in foreign countries or even as cab drivers or similar when registration fails or is delayed, while many that stay back home have moved to different professions or jobs to make ends meet.

- It is also worth noting that the supplier countries in many arrangements have been forced to comply with the receiving countries' policies and guidelines and not laid down their own conditions thereby not safeguarding their interests or even their migrant citizens.

On health systems in the source countries

- The impact of international migration on health systems, has grown to such proportions that it is affecting the sustainability of health systems in some countries especially in the developing world. While both developed and developing countries are experiencing the negative impact of loss of skills, such a loss is more keenly felt in developing countries, which find it difficult to compete for skilled human resources in the existing global market. They end up as more of suppliers and less of receivers thereby increasing their human resource gap more and more. And even within the developing countries, some have had to become suppliers to others as the latter can offer a little more than the former.

- Recruitment of health workers will mostly target skilled and experienced ones leaving behind mostly freshly graduated ones who will also leave after a year or two of gaining experience. This poses serious implications for the quality of health care provided which will be kept to a sub-optimum because the pool is filled up with the newly graduated less experienced always getting ready to leave.

- The quality of health care is generally low and gets poorer, the continuity of programmes/services is usually adversely affected; quality of care is compromised; people in the community are deprived of health services; improvement of hospital facilities and services are delayed when resources are used to train staff replacements.
- However, the health-care system is enhanced by upgraded skills of those who return, if at all they do.

Strategies for implementation including bilateral agreements[8-10]

With the above issues arising, many actors in this field do appreciate that it would be beneficial for there to be some minimum working guidelines about health worker migration. And so several policies and arrangements have been developed in the last few years to help guide both source and destination countries in what has turned out to be a growing field. There have been repeated and urgent calls for bilateral agreements between nations in the context of an increasing global health workforce crisis. There however have been limitations to this; it being a fairly new proposition there are few international structures to facilitate it and there is a significant lack of clarity on the precise role, form, and content bilateral agreements should take to serve a health-related purpose. However it is generally agreed that whatever policies are formulated, they should serve the following (including but not limited to):

- to protect emigrant citizens from exploitation and abuse in the recipient countries
- there is need to set strategies to attract returning emigrants
- there is also a need for research in the area, and monitoring and evaluating activities to do with this immigration for work in both source and destination countries

The table below presents some of the policies in international recruitment of health workers in both organizational and national arrangements to date.

Policy interventions in international recruitment

National	
Government-to-government agreement	The destination country develops an agreement with the source country to underwrite costs of training additional staff, and/or to recruit staff for a fixed period, linked to training and development prior to staff returning to source country, or to recruit surplus staff in the source country.
Ethical recruitment code	The destination country introduces a code restricting employers' choice of target countries

	and employees' length of stay. Coverage, content and compliance issues all need to be clear and explicit.
Compensation	The destination country pays cash or other compensation to the source country, perhaps related to the length of stay, cost of training or cost of employment, possibly brokered via international agencies. But this rarely occurs.
Managed migration(can also be regional)	A country (or region) with out-flow of staff initiates a program to stem unplanned emigration, by attempting to reduce the impact of push factors and supporting others to planned migration.
Train for export	The government or private sector makes an explicit decision to develop training infrastructure to train health professionals for the export market, to generate remittances, or up-front fees.
Engagement of the business and civil society	Recruitment agencies as well as professional associations within the private health sectors of receiving countries should analyze their own needs and project them over a few years in order to meet their demands for particular categories of health workers. Twinning and exchange programs should be developed between health training institutions, hospitals and clinics in the receiving countries and those in source countries
Organizational	
Twinning	Hospitals in source and destination countries develop links, staff exchanges, support and flow of resources to the source country.
Staff Exchange	Temporary move of staff to the other organization, based on personal, career and organizational development opportunities.
Educational support	Educators, educational resources from the

	destination to the source organization.
Bilateral agreement	Employers in the destination country develop agreement with employers or educators in the source country to contribute to or underwrite costs of training additional staff, or to recruit staff for a fixed period, linked to training prior to returning to the source country.

Adapted from: WHO-Health worker migration in the European Region: Country case studies and policy implications, 2006.

A closer look at the National strategies

Managed migration: Many of the other strategies stem from this effort in which a country (or region) with net out-flow of human resource initiates a program to stop or control unplanned emigration, by attempting to reduce the impact of factors pushing people to leave their countries, and supporting those who choose emigration to do it in a planned and appropriate manner.

Government-to-government agreement: in this strategy the destination country develops an agreement with the source country on several issues; these may include the underwriting of costs for training additional staff, and/or to recruit staff for a fixed period, linked to training and development prior to staff returning to source country, or to recruit surplus staff in the source country, among others. Bilateral formal and written are a mainstay of modern international relations and are accepted devices for maintaining structured, relatively formal, and ongoing relations between nation states. Where there is no international legislative body, bilateral agreements are particularly important in the international effort to pursue common objectives [10]. These have been seen in the cases of South Africa and the UK [11]. Under the memorandum of understanding, South African healthcare personnel can spend time and limited education and practice periods in organizations providing NHS services. Similarly clinical staff from England work alongside healthcare personnel in the Republic South Africa, with particular emphasis on the rural areas. There is also an exchange of information, advice and expertise in several areas including, professional regulation issues, public health and primary care, workforce planning and development, incl. the service and academic interface, medicines regulation and medical devices, public –private partnerships, including private finance initiatives, revitalisation of hospitals, including governance (corporate and clinical) etc. Other countries with similar arrangements include between UK and Spain, and Poland and the Netherlands.

Ethical recruitment: this is a strategy that has been adopted by the Norwegian government as a recipient country. Having realized that its output of doctors and nurses will not be able to

meet its health needs over the next 25 years, it has embarked on a strategy to train more health workers and also support training in the countries which end up supplying it with health workers [12]. This approach which is viewed as a human rights approach to health worker migration is seen as a better and fairer approach than many other forms of compensation which undermine the health system capacity of poorer supplier countries. Other forms in this strategy include the destination country restricting employers' choice of target countries and employees' length of stay, all aimed at respecting the right to health in the supplier country too.

Compensation: The destination country pays cash or other compensation to the source country, perhaps related to the length of stay, cost of training or cost of employment, possibly brokered via international agencies. This is a quite straight forward approach but actually rarely occurs.
Train for export: The government or private sector makes an explicit decision to develop training infrastructure to train health professionals for the export market, to generate remittances, or up-front fees. This is quite a common phenomenon now in many Asian countries, including the Phillipines and India.

Recruitment agencies: These are a fairly new phenomenon and their role is an issue to examine when taking into account the factors that influence health worker migration. They can either function as stimulators actively encouraging health workers to migrate or as intermediaries in the process of international recruitment, fulfilling a facilitative or supporting role [13]. A critical assessment of these is necessary to assess their impact in health worker migration; some agencies have been criticized for disseminating misleading information about pay and the employment situation in the destination country, and for charging large fees to enable workers move from one country to another. Some importer countries have tried to regulate this by establishing "preferred providers" which are lists of agencies that comply with ethical criteria.

Conclusion

Health worker mobility is an inevitable phenomenon that is bound to continue growing with or without it being managed. However without being managed, migrant workers are faced with difficult situations that they might not be able to manage on their own, and source countries with their health systems lose out on potential benefits. Several policies that present opportunities for government interaction and intervention are presented in this paper; such policies are expected to help protect emigrant citizens from exploitation and

abuse in the recipient countries and also set strategies to attract those returning to their home countries, among other things. With such arrangements, governments are able to undertake research and monitoring activities that would make the ventures beneficial to them to a given extent and help them plan and project their needs too. In addition they are able to set activities that would help them meet their obligations to the partner recipient countries that they have agreed to as well.

References

1. Merson, M.H., R.E. Balck, and A.J. Mills, eds. *International Public Health: Diseases, Programs, Systems and Policies*. 2nd ed. 2005, Jones & Bartlett Publishers. 730.
2. Skeldon, R., *Globalisation, Skilled Migration and Poverty Alleviation: Brain Drains in Context*. 2005, Development Research Centre on Migration, Globalisation and Poverty: Sussex. p. 39.
3. WHO, *International migration of health personnel: a challenge for health systems in developing countries: report by the Secretariat*. 2006, World Health organization: Geneva.
4. Martineau, T., K. Decker, and P. Bundred, *"Brain drain" of health professionals: from rhetoric to responsible action.* Health Policy, 2004. **70**(1): p. 1-10.
5. International Migration Outlook. *Expatriation rates for nurses and doctors, Circa 2000*. 2007 [cited 2011; Available from: www.oecd.org/health/workforce.
6. Ivy Lynn Bourgeault, et al., *IEHP Report: Brain gain, drain and waste: Insights from the Literature on Health Labour Migration*. October 2010, CIHR/HEALTH CANADA CHAIR IN HEALTH HUMAN RESOURCE POLICY: Ottawa.
7. Fely Marilyn E Lorenzo, et al., *Nurse Migration from a Source Country Perspective: Philippine Country Case Study*. Health Service Research, 2007. **42**(3 Pt 2): p. 1406–1418.
8. WHO, *Health worker migration in the European Region: Country case studies and policy implications*. 2006.
9. International Organization for Migration. *Managing the Migration of Health Care Workers: The Need for Action*. 2006 [cited 2011; Available from: http://iom.ch/jahia/webdav/site/myjahiasite/shared/shared/mainsite/activities/health/infosheet_MHCW.pdf.
10. Ibadat S. Dhillon, Margaret E. Clark, and Robert Kapp, *Innovations in Cooperation: A Guidebook on Bilateral Agreements to Address Health Worker Migration*. 2010, Aspen Institute: Queenstown.
11. Daisy MAFUBELU, *Seminar on Health and Migration; Session IIIB: Migration and Health Policies- Using bilateral arrangements to manage migration of health care workers: The case of South Africa and the United Kingdom*, in *IOM's international dialogue on migration*. 9-11 June 2004: Geneva.
12. Karen McColl, *International action on migration of health workers.* BMJ, 2008. **337**(a2065).
13. Buchan J, Parkin T, and Sochalski J, *International Nurse Mobility—Trends and Policy Implications (WHO/EIP/OSD/2003.3)* 2003, World Health Organization: Geneva.

This summary was prepared by
Rhona Mijumbi, Supporting Use of Research Evidence for Policy (SURE Project), Office of the Principal, College of Health Sciences, Makerere University, New Mulago Hospital Complex, Administration Building, 2nd Floor, P.O Box 7072, Kampala, Uganda

Conflicts of interest
None known.

This Rapid Response should be cited as
Rhona Mijumbi, MPH, MSc. **Health worker migration: What are the impacts in the source country and strategies for government intervention?** A SURE Rapid Response. March 2011.

For more information contact
Rhona Mijumbi, mijumbi@yahoo.com

The **Regional East African Community Health-Policy Initiative (REACH)** links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States.
www.eac.int/health

The **Evidence-Informed Policy Network (EVIPNet)** promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.
www.evipnet.org