Migration: an opportunity for collaboration not conflict

Francis Omaswa and Robert Odedo offer a perspective on the global health workforce crisis

Health Workers are the vehicle for access to health. Without skilled, supported, motivated, empathetic, trusted and well distributed health workers it will not be possible to achieve Sustainable Development Goals and Universal Health Care. The Joint Learning Initiative a study led Dr Lincoln Chen and published in 2004 showed that there is a global health workforce crisis characterised by gross shortages, maldistribution and poor working conditions. At that time the global health workforce (HWF) shortage was estimated at 4 million, but more recently the World Health Organization (WHO) has estimated that by 2030 this shortage will reach 18 million. The World Health report of 2006 revealed that Africa is the worst affected by these shortages. Of 57 countries with critical HWF shortages, 36 were in sub-Saharan Africa (SSA). Further, it is now evident that the rich countries will be able to afford and meet their HWF demand and need by supplementing domestic recruitment with importation from other countries. Low-income countries (LICs), on the other hand, will not have resources to employ the health workers that they need and will lose them to rich countries.

Push and pull

The pull and push factors in HWF migration are rooted in the following factors. First is that in the richer countries, people are living longer and ageing and therefore need increasing health care for extended pain-free life. Due to population ageing, there is an overall shortage of young people to train, but these countries have the resources to meet their HWF needs through international recruitment.

Second, the disease burden in LICs, especially SSA, is growing with a double burden of both infectious and non-communicable diseases and a rapidly growing young and dependent population. Poverty levels and dependency still persist in these countries, limiting their ability to mobilise resources to attract, train and retain the HWF that they need. Third is a long history of neglect, with the HWF issue being swept under the carpet as a complex matter for each country to handle independently. We have also seen wrong policies, such as the World Bank structural adjustment programmes of the 1990s that ordered some LICs to ban recruitment of health workers trained with public funds despite acute worker shortages. There are also issues within professions of protecting job markets and fighting turf wars – the 'professional tribalism' described by the Lancet Commission on Health Workers for the 21 Century.

Another push factor is poor HWF leadership and management in LICs resulting in weak HWF planning, education, training, deployment and regulation. In many countries health workers cannot live on their salaries, are overworked and lack the tools they need for their work.

Brain Drain to Brain Gain

In response to the growing phenomenon of HWF migration, the global community adopted the Code of Practice on International Recruitment of Health Personnel at the 63rd World Health Assembly in 2010, ratified by 193 Member States. This convention demonstrated the clear recognition of the urgent need for promoting well-managed health-worker migration policies. The Code calls upon member states, recruiters and relevant stakeholders to cooperate in the ethical management of health professionals' migratory flows.

To assess the level of implementation of the Code, a multi-country study project named *Brain Drain to Brain Gain* funded by the European Commission and managed by the WHO Health Workforce Department was implemented by three research institutions (ACHEST, the Royal College of Surgeons in Ireland and the African Institute of Health and Leadership and Development, South Africa). In-depth studies on HWF migration were conducted in Nigeria, Uganda and India (source countries); South Africa (source and destination country); and Ireland (destination country). This study found that HWF migration is a growing global phenomenon driven by push and pull factors. It established that the supply of health workers in low-income source countries is not matched by in-country labour market demand. The poor absorptive capacity of the health sector and labour market imbalances resulted in pools of qualified health workers that are not absorbed in the system.

Nigeria is among the major health professionals exporting nations on the African continent; the study showed that more than one thousand registered General Practitioners (GPs) requested for Certificates of Good Standing with intention to migrate to greener pastures in 2016 alone.

The largest number of requests was for the UK, Canada, South Africa, Australia, Ireland and United Arab Emirates. This high rate of migration related HWF attrition resulted in severe shortages of trained health workers in health facilities with negative consequences on health care coverage, access and quality.

Uganda[1] is another country with critical HWF shortages. The health workforce in Uganda in 2015 stood at 81,982, representing the stock of qualified health workers

Robert Odedo is a Social Policy Analyst by training with research interests in Global Health Workforce Migration. He is Chief Operating Officer at ACHEST. Francis Omaswa, CEO of ACHEST, founding Executive Director Global Health Workforce alliance, and Publisher of Africa Health

available for recruitment in both public and private sector. Records from the Health Professional Councils show that 42,530 (52%) were employed in the public sector, at least 9,798 (12%) employed in the private not-for-profit sector, while about one-third (29,654) were either private practitioners, unemployed or have emigrated. A total of 119 doctors sought Certificates of Good Standing to seek jobs or study abroad in 2014. Their destinations included Southern Africa, East Africa and Europe.

GPs accounted for 76% of requests for Certificate of Good Standing during the study period. Most of the migrating workforce (68%) was destined for African countries, most notably Botswana and South Africa. North America accounted for 17%, Canada 13.6%, and European destinations a combined 11%. Qualitative evidence points to the need for improved working conditions, infrastructure, and supportive management in order to improve retention of health workers in Uganda.

An assessment health workforce stocks based on the register of licensed practitioners of the Uganda Medical and Dental Practitioners Council revealed that 38% of GPs registered in Uganda were foreign nationals from at least 74 countries, with North America and Europe contributing significantly to the numbers. Most of these doctors were engaged in the private not-for-profit sector attached to donor-funded projects and stayed in the country for short- to mid-term periods.

Indian physicians are estimated to be the largest 'émigré physician workforce' source country in the world: over 100,000 doctors trained in India are working abroad, with the largest proportion (about half) employed in the United States, followed by the United Kingdom, Canada and Australia.[2] The Organisation for Economic Co-operation and Development (OECD) International Migration Outlook (September 2015) estimated that 86,680 Indian doctors were working in OECD countries alone.[3]

The migrating health workers include highly trained and specialised medical professionals; data sourced from the General Medical Council in the United Kingdom show that 2,334 Indian-trained surgeons and 1,270 anaesthetists are currently working in the United Kingdom.

Ireland was the country the research project chose to investigate migration from the destination country point of view. The Irish health workforce relies heavily on migrant health professionals. Since 2000, Ireland has become a popular destination country for doctors, nurses and midwives from low- and middle-income non-European Union countries.[4] Ireland is among the top OECD countries in terms of reliance on international medical graduates (IMGs) in its workforce, with only Israel, New Zealand and Norway recording higher percentages of IMGs in 2013.[5]

The trend from 2014 to 2015 shows that the contribution of graduates of Irish medical schools fell to second place behind graduates from outside the EU – from the LMICs whose contribution increased by almost 100%. IMGs now account for most new entrants to the medical register. This is a quite dramatic demonstration of the challenge facing Ireland, which is unable to meet its needs through only training and retaining its own graduates and

recruiting doctors from LMICs.

South Africa is both a source and destination country for health workers. Each year the regulatory authority in South Africa processes applications for medical doctor registration from over 60 countries, with Nigeria the leading source. The UK is the second largest source, followed by Cuba and the Democratic Republic of the Congo. The second round of national reporting on the WHO Code evidenced that migrants constituted more than 10% of South Africa's total medical workforce, which was further confirmed by the Health Professions Council data. Enabled by the Foreign Health Professionals policy, approximately 3,000 migrant doctors mostly from the UK, were absorbed into South Africa's health system during the study period, including some 430 refugee doctors from the Democratic Republic of the Congo.[6]

These studies showed that factors behind HRH challenges in source countries revolved around: (1) insufficiently resourced and neglected health systems; (2) poor human resources planning, management practices and structures; (3) unsatisfactory working conditions characterised by heavy workloads, lack of professional autonomy, poor supervision and support, long working hours, unsafe workplaces, inadequate career structures, poor remuneration, poor access to needed supplies, tools and information, and limited or no access to professional development opportunities; (4) internal and international migration of health workers.

It is against this background that HWF migration takes a central place in efforts to provide access to quality health care and the achievement of UHC that leaves no one behind. HWF migration will be inevitable, driven by factors described above and is growing rapidly.

Recruitment Code

Following acrimonious debates at several successive World Health Assemblies (WHA) on HWF migration, the WHO Code on the International Recruitment of Health Personnel was negotiated and adopted by the WHA in 2010. This Code provides an excellent instrument for training and sharing a global pool of portable health workers as a win-win arrangement between countries. In the last few years the UN High Level Commission on Health Employment and Economic Growth showed that HWF employment contributes to economic growth and employment, especially of women. It also made recommendations that led to establishment by ILO, OECD and WHO of the International Platform on Health Worker Mobility and the UN Global Compact on Safe, Orderly and Regular Migration. The key elements of this are to build global skills partnerships among sending and receiving countries that strengthen training capacities of national authorities and relevant stakeholders. There are institutions such as the Foundation for Advancement of International Medical Education and Research (FAIMER) whose focus is to stimulate international accreditation efforts, promote universally accepted standards for enhancing and evaluating medical education, protect the public and promote people-centered approaches to health care. International accreditation based on universally accepted standard will produce portable health workers to be shared under the guidance WHO Code.

All countries should therefore prioritise investment in HWF development as the entry point into ensuring people-centred Primary Health Care as the vehicle for achieving UHC. This call is to governments, global health initiatives, CSOs, the private sector and the people themselves. We have the tools and structures to achieve this but we lack the will and the right climate of opinion. Investment in the global HWF movement has declined in the last ten years. There is need to build strong, national, regional and global institutions for HWF such as the Global Health Workforce Network (GHWN), the African Platform on Human Resources for Health (APHRH), the Asia-Pacific Action Alliance on Human Resources for Health (AAAH), professional associations, education and training institutions, and regulatory and accreditation systems, both national and global, and embrace technology and artificial intelligence to mediate and drive all the above.

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