Chapter 14: Migration and retention of health care workers

SUMMARY POINTS

- The WHO Global Code of Practice on International Recruitment of Health Personnel sets out voluntary principles for ethical international recruitment of health care workers, and is intended to improve the legal and institutional framework for recruitment practices at the country level.

- The Code encourages Member States to scale up the training of health personnel, to consider measures to address the geographical misdistribution of health workers in underserved areas, and to monitor the national health labour market.

- Member States should consider establishing or designating a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code.

- There is a range of strategies that may assist source countries to retain and build their health workforce, while also ensuring a better distribution of health workers between urban, rural and remote areas. These include compulsory service requirements, bonding schemes, improvements in human resource management, a safe working environment, greater investment in facilities and equipment, improved pay and conditions, and career development opportunities.

Introduction

An adequate and effective health workforce is one of the foundations of a successful health system. The health workforce includes medical practitioners (including specialist physicians), nurses, midwives, allied health care professionals, health administrators as well as other public health personnel. A country’s health workforce can be expensive to train and shortages can be difficult to fill quickly, due to the lead-time in recruiting and training new staff. Some countries have no medical schools at all.¹

Over the past 25 years, international trade in skilled services has increased dramatically. While some countries face challenges due to the migration of domestically trained health care workers,² other countries have experienced a rapidly growing domestic market for health care services due to “medical tourism”. The 2006 World Health Report estimated that 57 countries, particularly in sub-Saharan Africa, faced critical shortages of health personnel totalling 2.4 million doctors, nurses and midwives.³ Overall, WHO estimates that there is a global shortage of about 4.3 million health care workers, a shortfall of about 15%.⁴ In France and Germany, for example, the density of physicians per 10 000 population was 32 and 39, respectively, over the period 2007–2013, whereas in a number of African countries it was less than 1 per 10 000 population.⁵ Over this period, the average density of physicians, and of nursing and midwifery personnel for the WHO European Region was 32 and 80 per 10 000 population, respectively, but only 2.7 and 12.4 per 10 000 population for the African
Region. These shortages are aggravated by the migration of health care workers away from the countries that most need them.

Health professionals from developing countries emigrate for a variety of reasons. They may be attracted to high-income countries by the prospect of higher income, better equipment and working conditions, better job security and opportunities for career development, or they may be discouraged by ineffective management or safety and security concerns in their home countries. Migration of health workers within countries, particularly from rural to urban areas and a lack of employment opportunities for health professionals within their own country pose additional problems.

14.1 International strategies

In May 2010, the World Health Assembly adopted the WHO Global Code of Practice on International Recruitment of Health Personnel, which outlines voluntary principles for ethical international recruitment, and is intended to improve the legal and institutional framework for recruitment practices at the country level (Box 14.1).

The Code urges all countries, in their international recruitment practices, to take into consideration the needs of source countries for a sustainable health workforce. It recognizes the benefits that opportunities to study and work abroad can provide, both to source and destination countries, and to health care workers themselves. However, it urges countries to discourage the recruitment of health personnel in countries facing critical shortages. While recognizing the benefits of circular migration, the Code encourages WHO Member States to develop a sustainable workforce that will reduce long-term reliance on migrant health workers. The Code also encourages Member States to scale up the training of health personnel, to consider measures to address the geographical maldistribution of health workers in underserved areas, and to monitor the national health labour market. All States should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code.

Regional and bilateral agreements provide additional tools for implementing the principles of the Code and improving health workforce labour market practices. Bilateral agreements can recognize the need for both source and destination countries to monitor the extent of migration and its impact on the source country, and to ensure adequate training and strategies for financial support to the health system in the source country. Key issues that bilateral agreements can address include: recruitment standards, employment standards, recognition of the freedom to migrate and to engage in professional development, monitoring and implementation, and dispute resolution.
Box 14.1: Key Messages from the WHO Global Code of Practice on the International Recruitment of Health Personnel

| 3.2 | Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. ... |
| 3.4 | Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. ... |
| 3.6 | Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. ... |
| 3.8 | Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries. |
| 4.6 | Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. ... |
| 5.1 | Destination countries are encouraged to collaborate with source countries to sustain and promote health, human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers. |
| 5.2 | Member States should use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. ... |
| 5.4 | As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible. |
| 5.5 | Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. ... |
| 5.7 | Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, social and professional support. |
| 7.3 | For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. |
At the national level, both source and destination countries can develop laws and policies to reduce the loss of health personnel from developing countries and also to promote a more equitable distribution of human resources for health across rural areas – where 50% of the world lives, but only 24% of health professionals work.11

In the United Kingdom, for example, the Code of Practice for the International Recruitment of Healthcare Professionals regulates recruitment practices by the National Health Service.12 Recruitment is only permitted in countries where there is an explicit government-to-government agreement that permits recruitment activities (Box 14.2). There is no active recruitment of health care professionals from those developing countries that are included on the Department of Health website. Any hiring of public sector health workers must occur through an approved recruitment agency that complies with the Code.13

**Box 14.2: United Kingdom: Code of Practice for the International Recruitment of Healthcare Professionals**

**Guiding principles**

3. Developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the UK to support recruitment activities.

6. International healthcare professionals legally recruited from overseas to work in the UK are protected by relevant UK employment law in the same way as all other employees.

**Best practice benchmarks for international recruitment**

1. There is no active recruitment of healthcare professionals from those developing countries that are included on the Department of Health website.

   - No active recruitment will be undertaken in developing countries by UK commercial recruitment agencies, or by any overseas agency sub-contracted to that agency, or any healthcare organisation unless there exists a government-to-government agreement that healthcare professionals from that country may be targeted for employment.

   ...

   - Healthcare organizations may consider unsolicited applications direct from an individual in a developing country if that individual is making an application on their own behalf and not using a third party, such as a recruitment agency.

2. All international recruitment by healthcare employers will follow good recruitment practice and demonstrate a sound ethical approach.

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   - Any international recruitment will be sensitive to local healthcare needs so that international recruitment from any country should not destabilize local health.

3. International healthcare professionals will not be charged fees in relation to gaining employment in the UK.
Retention strategies for source countries

Countries that tend to be source countries for the migration of health care workers frequently face both critical shortages, and large disparities in access to health care workers between remote, rural, and (more developed) urban areas. Countries may consider a range of policies to address these problems including compulsory service requirements, bonding schemes, human resource management, improved pay and conditions, greater investment in facilities and equipment, and greater career development opportunities.

Compulsory service schemes may require medical practitioners to remain within the country, or to locate to rural or remote areas during their normal period of clinical residency, or for a specified period following completion. In Indonesia, for example, doctors, dentists and midwives were previously required to work as contract staff during a period of compulsory service which ranged from six months to three years, depending on the remoteness of the location. In 2007, this period of service became voluntary, but the contract scheme has remained popular among new graduates due to increased financial incentives, and the short length of the contract period. In 2009, the Ministry of Health introduced an additional Special Assignment Programme in order to address specific shortages in “strategic health workers” including nurses, nutritionists and public health workers, in specific underserved locations.

For more than four decades, Thailand has adopted a policy of compulsory rural service for early-career health workers graduating from government-funded professional schools. Doctors and nurses sign a rural service contract at the commencement of their training in a public medical or nursing school. Although there are penalties for breaking this commitment (up to US$ 10,000 for physicians), some nevertheless break these contracts in order to take up more highly-paid positions in the private sector. Following the introduction of Thailand’s universal coverage scheme (originally known as the “30 baht” policy), demand for medical services in rural areas increased substantially. In response, the Thai Ministry of Public Health established new medical schools in rural areas and offered higher salaries to government-employed doctors in rural areas. The government has also established special admission tracks for entry to medical school that target high-school graduates in particular provinces. Following graduation, these health workers are required to undertake mandatory service (for a period of three years, or 12 years, depending on the scheme) in provinces that are experiencing health worker shortages. In addition, those who want to seek specialty training are required to complete one year of rural service, and those who work in a rural setting for at least three years are eligible for a full scholarship for specialty training. In an effort to retain an adequate number of experienced physicians in rural areas, the government offers board certification (with an accompanying pay raise) for those who work in rural areas for over five years.

Bonding schemes require health professionals who received State-funded scholarships during their period of training to fulfil public service obligations after graduation. In Australia, for example, individuals who receive government support for their medical education must perform a contracted number of years of public service, often in rural hospitals, before they can receive a billing number that allows them to be paid under the national health care system. Buy-outs are not allowed, and medical practitioners who fail to complete their contract are required to wait twice the contract period before they are given a billing number. To reduce the possibility that health professionals

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workers will seek to avoid their service obligations by migrating, the WHO Global Code of Practice encourages recruiters and employers to respect the legal obligations of health personnel that apply within their countries of origin.  

Box 14.3: Bonding schemes for retention of health care workers: an example from Australia

Health Insurance Act 1973

Section 19ABA. Medicare benefits not payable in respect of services rendered by doctors who breach certain contracts with the Commonwealth

(1) Despite section 19AA, a medicare benefit is not payable in respect of a professional service rendered by, or on behalf of, a medical practitioner who has breached a contract with the Commonwealth under which the practitioner agreed to work in a rural or remote area.

(2) The period during which medicare benefits are not payable under subsection (1) is a period equal to twice the length of the period that the practitioner agreed, under the contract, to work in the rural or remote area or such shorter period as is determined in, or in accordance with, the contract.

(3) Subsections (1) and (2) apply whether or not the medical practitioner referred to in those subsections was a medical practitioner at the time of entering the contract or at the time of the breach.

Strategies that rely on compulsory service and bonding schemes may be effective in dealing with urgent gaps and shortages, but may not address the underlying reasons why experienced health professionals are reluctant to settle in rural or remote areas. Policies for work retention are best coupled with human resources management strategies designed to make service in underserved areas more attractive. Important elements in an effective human resource management strategy include:

- detailed job descriptions for health workers at all levels, consistent with their training;
- defined career trajectories at all levels, with a clear explanation of what is required for advancement;
- routine performance reviews;
- on-time payment;
- a strategy to keep health professionals informed of policy changes within the health system;
- a system that is responsive to complaints by health care workers and gives reasons for decisions;
- regular contact from supervisors and the central health system, particularly in rural areas.

To retain health workers, countries may also consider moving towards a performance-based reward system that rewards health workers for good performance in improving patient outcomes, or in meeting health needs at the community level. Performance-pay systems should be carefully tailored...
to ensure that improvements are evidence-based, rather than based on selective reporting or choice of patients. Workplace systems that take account of individual workloads in planning the distribution of health workers between facilities, which offer flexible working hours, and which encourage workers to develop their own solutions to local problems, can also contribute to a positive working environment where health workers feel supported and motivated (Box 14.4). Strategies to reduce the time that health professionals spend on activities that do not require their professional expertise may also increase efficiency and motivation.

**Box 14.4: Human resource management strategies: an example from Kenya and Guinea**

**Decentralizing task management**

In 1999, Kenya and Guinea trialled a COPE (Client-Oriented, Provider-Efficient) model of human resource management within eight intervention sites in the two countries. The programme was supported by simple tools and was based on a philosophy of participation and teamwork, transferring decision-making power to the local, on-site team, maintaining a focus on clients’ rights and needs, cost-consciousness and efficiency. An evaluation of the programme found that both skills and performance were enhanced through the programme, attendance at clinics increased, as well as immunization rates and quality of care. The evaluation found that local staff were able to resolve a range of problems without outside assistance, including small renovations, improving staff working conditions, and service-delivery issues – such as long waiting times, and poor record-keeping and referral systems. These improvements were validated by exit interviews with clients. Core features of the COPE model include the autonomy and independence of the local team, shared responsibility for actions, and a focus on improving systems and developing staff capacity: these helped to create an enabling environment in which local staff felt empowered to act and to assume responsibility for problems and their solutions.

A safe working environment, including adequate facilities and equipment, are essential to health worker retention (Box 14.5). Minimum safe working conditions include clean water, a safe electricity supply, and adequate office space, equipment and supplies. Physical violence may drive workers to leave their positions, particularly female nurses in rural areas. National law must ensure that employers respond swiftly to reports of workplace violence and that employees who complain are protected from retribution or discrimination. Health workers require protective equipment, including gloves and containers for the safe disposal for needles and blood products. Health workers should also be immunized and have access to post-exposure prophylaxis for HIV infection in case of a needle-stick injury.

Sufficient pay is another factor that is essential to improving retention in the public health sector (Box 14.5). Low wages are often a motivation for leaving the public health care sector, particularly in developing nations. However, raising salaries – or seeking to compete with private sector salaries – is not the only way of increasing remuneration. Incentive programmes may include vehicle and education subsidies, hardship allowances, housing, travel allowances, paid vacation, preferential placement for advanced training opportunities and even access to good quality Internet services (Box 14.5).
### Investing in safe working conditions

The loss of staff from public sector health clinics to the private sector has long been a problem in Haiti. However, Partners in Health (PIH) has turned its rural clinics into the most sought-after residency sites in the country despite offering lower pay than private clinics. Programme directors attribute the high retention levels in these clinics to the quality of the clinic facilities, which are stocked with essential medicines and technology so that health workers are not frustrated by their inability to provide care. Although PIH is an externally funded operation, its success in increasing retention of local workers is instructive.

### Increased pay and incentives

Even with wages lower than the private sector (though higher than government positions), PIH recruits top candidates to its rural locations because it offers them transport back to cities to visit their families, and provides lodging and food. Often-cited is the satellite Internet service that PIH provides, which enables doctors to communicate with their families and professional colleagues and gives them access to extensive medical reference material and patient management systems. PIH also offers opportunities for Haitian medical professionals to collaborate with researchers worldwide, publish in academic journals and speak at conferences.

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### REFERENCES


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1 All references were accessed on 1 May 2016.


26 Health Insurance Act 1973 (Cth) (Australia).


