

A critical appraisal on migration of health workers from developing to developed countries

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Introduction

International migration of professionals is a global phenomenon that dates back to the post-colonial era. Since the 1960s, the number of migrant health professional has more than doubled from 75 to 190 million,¹ this is largely due to the quest for a greener pasture or a better source of livelihood as a result of the inequalities in the economic and financial situation between 2 nations. Migration of health workers not only happens from a developing country to a developed one but had been observed even amongst the developed countries, example from Germany to Switzerland.² As at 2012, more than 15% of about a million migrant Doctors practicing in the United States were trained in the developing countries.³

The migration of health workers is associated with consequences especially in the human resource resulting in depletion of both capacity and number of workforce and thus reduced efficiency of service delivery,⁴ though proponents may argue that it has saved some countries from economic down tone from remittances by the health care migrant workers originating from that country (personal communication with Ardee Romello July 2015). This essay highlights the various negative effects of health care workers' migration from developing to the developed countries in the area of human resources for health.

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Reasons for health workers migration

The movements of health care workers are determined by both external and internal factors through a process of push and pull,^{5,6} which can partly be related to increasing globalization.¹ A push from the source countries is largely due to poor economic and financial states resulting in poor remunerations or wages, this have resulted in more than 65,000 physicians of African origin migrating to developed countries within the first few years of their training.⁷ A country like Nigeria for example has more than 4000 of her trained doctors practicing in the US, while countries in Southeast Asia like Indonesia and the Philippines has about 60% of her middle cadre workers abroad.^{8,9} Additionally, the political situations occasioned by violence, increase crime rates and the quest for good health for both parents and children, and improved quality of life are the other factors pushing for migrations.⁵

On the side of the destination countries, the increase in the available vacancies for health workers as it was in Canada for Nurses,¹⁰ a well-managed health system, better retirement policies and the opportunities for further education¹¹ and skill acquisition¹⁰ are the main factors pulling the migrants.

Negative effects of health workers migration

The migration of health workers have led to a drastic shortage in the human resource pool of most developing countries,¹² resulting in most of the source countries not been able to attain the WHO required number for health worker which is 2.28 per 1000 population;¹³ a critical shortage that is affecting more than 57 developing countries.¹⁴ This shortage and sometimes mal-distributions seriously affect service delivery in the different region affected by this disaster. In sub-Saharan Africa for example, a region that has a quarter of all the global disease burden¹¹ of malaria, Tb and HIV, and a rising population, about half of the countries in this region are below the WHO critical shortage for health worker per population, this is accounted for by migration, with only 10% of the global health workforce remaining in this region having poor health indices,¹¹ as oppose to Canada and US who has 37% of all global health workforce with only 10% of Global disease burden.⁹ But surprisingly, more than 25% of the doctors and about 10% of nurses practicing in the developed countries are from Africa,¹¹ this have led to health systems failure in most of the countries with weak health systems.¹³ In the South East Asia however, the story is not much different as the critical shortages of health workers from migration have led to some of the countries hampered from the attainment of the MDGs.⁸

Migration of health workers also creates a vacuum¹⁴ in the training of young health professionals across all cadres, this occurs when the skilled and experienced professionals leaves the training institutions or even the service for greener pastures, the result is the production or training of poor skilled health care worker thereby

compromising the standards of the quality of care given by this group of health workers. In Philippines¹⁵ and Indonesia for example, the growing number of health workers migration has led to a decrease in the quality of training for health workers in those countries.⁸

Similarly, a nation with most of her human resource in health sector practicing abroad is usually at a deficit in her investment for the education of the health workforce lost. Several millions of Dollars would have been spent for their training with nothing in return. To this end, many developing countries have financial deficits of about \$500 million yearly from investments on health education as a result of migration,⁹ whereas the destination countries like United Kingdom could have \$168 million reserved from migrant intake,⁹ this huge financial loss could put pressure on the available resources and demotivate such government in training more especially with the rising economic crisis.

Migrant workers have tendency for increased rate of destitution, or professional nurses relegated to hospital aides in some countries,¹⁶ largely because of licensure barrier, consequent of which may be a waste of talents leading to uptake of unprofessional jobs,¹⁷ resulting in substandard payments of the professionals and occasionally high rates of mental illnesses,¹⁸ and poor quality of life from inability to access quality health care services and absent health insurance cover.

Positive effects of health workers migration

Though the negative outweighed the positive effects, the source countries receive large sum of money from their migrant health workers in form of remittance, this has been shown to improve the revenue drive of the source country, and the remittances sometimes may be more than some countries budget. In 2011 alone, the percentage remittance of health workers to developing countries was about \$35 billion.¹⁴ The Philippines and Indonesia are the world largest exporters of health professionals and, therefore, attracts more remittances.^{12,19} World Bank report in 2000 showed that 2% and 10% of GDPs per capital in India and Philippines respectively were from remittances of their migrant workers and that over a million Filipinos working abroad have at a point save their country's economy from dwindling increasing it GDP by 10% in 2010.¹² Even with these huge remittances, critics have argued that monies transferred does not get directly to the governments for translation into useful health systems development and service delivery,⁹ rather it just improve the income of few individuals and families. As part of their mission for migrating, health workers have the desire to gain more experience and knowledge so that they could make a difference or even breakthrough in their fields, such knowledge acquired or the breakthrough successes are to the glory of their countries, occasionally attracting funds for research or investments which will ultimately lead to the economic growth of their country. Similarly, the return of the migrant worker brings about the transfer of technology, skills and expertise. But others may argue that because of the wide gap in technology and development, the knowledge and skill transfer may not possible.⁹

Conclusions

Even though migration of health workers cannot be permanently prevented, some strategies can be employed to reduce the influx especially from the developing world where the impact is

high: Collaborative programs between the health institutions in source and those in the destination countries will help in building capacity of the health workforce, research networks can also be formed and access to learning materials provided as it is done by Fogarty international in India and Cuba,¹¹ or funds can be channelled to address the decayed infrastructure in the health sectors of the source nations to serve as a motivating factor for retention and the return of the migrant health workforce to their home countries,³ This form of collaboration will equally provide solutions to the unavailable human resources in most of the source countries. An example of these collaborative partnerships is seen in Mbarara, Uganda and the University of Bristol in the UK.¹¹ Similarly, 13 African universities in Ethiopia, Zambia, and Nigeria are also into this partnership through the Medical Education Partnership Initiative.²⁰ This will aid retention, build skill and knowledge of the health workers and, therefore, prevent migration.

Efforts must be made by source nations in improving remunerations, provision of slots for further training both within and outside the country and the provision of additional incentive for senior staff, this was done in Malawi between 2004 and 2009 with great success.²¹ Similarly, political ties can be developed between the countries so that a limit can be put to the number of years immigrant health worker can stay in the destination country like the short term visa stay, as seen in the Caribbean where maximum stay for migrant is 3 years.¹⁰

Additionally, source countries should be encouraged to develop curriculum for providing middle and low cadre health workforce to fill the gaps created by the shortages, this middle or lower cadre can be trained in their local languages, this will bring a huge barrier to migration faced by workers that are non-English speakers.¹² A similar programme was developed and executed in Cambodia and Laos republics.⁸ Lastly, the process of task shifting as was done in Mozambique can be put in place to address the areas with critical shortages thereby providing good outcome at a lower cost.²²

Migration of health workers has remained a big challenge to the human resources sectors of most developing countries, with negative effects more than the positive, supportive measures must be put in place to address the push and pull factors through adequate remunerations, subsidised accommodation, insurances²³ and collaborations, this will help in minimizing the movements since absolute measures against migration may affect fundamental human rights of the health workers.

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