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Annex 1

GUIDANCE ON WORKFORCE ISSUES

THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

Commonwealth Steering Committee for Nursing and Midwifery

February 2001

GUIDANCE ON WORKFORCE ISSUES

THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

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Commonwealth Steering Committee for Nursing and Midwifery

GUIDANCE ON WORKFORCE ISSUES - THE GLOBAL CRISIS IN THE RECRUITMENT AND RETENTION OF NURSES AND MIDWIVES

1. Introduction

1.1 Many countries are experiencing shortages of nurses and midwives, either generally or in particular specialities or locations (eg rural settings). The effects of shortages may become pronounced, and may potentially threaten the delivery of nursing and midwifery services if they are not addressed urgently.

1.2 The transferability of skills, and possible future opportunities in other countries, may be among the factors which attract people to work in nursing or midwifery in the first place. However, the movement of nurses and midwives to work abroad may be exacerbating nurse and midwife shortages in some countries, including some developing countries which are unable to offer the pay or opportunities available elsewhere.

1.3 Such issues are not unique to nursing and midwifery. However, in the absence of existing international guidelines which can be applied to nursing and midwifery in Commonwealth countries, and in order to address the concerns expressed by Health Ministers, the Commonwealth Steering Committee for Nursing and Midwifery have worked to offer some guidance on the recruitment and retention of nurses and midwives, including international recruitment.

1.4 Not all Member States will have existing co-herent policies on these issues, and this can increase the difficulties in dealing with any concerns which arise between Member States, or with other countries. It is hoped that the provision of these guidelines will encourage all Member States to review their policy/practice on this issue, bearing in mind the legal and ethical considerations involved (both at the national and the international level), so that they develop and implement consistent and justifiable policies and practice.

1.5 Developing policy on this issue is one of the steps which Member States can take in progressing Health Ministers' commitment to identifying and addressing issues affecting the nursing and midwifery workforce, as part of their wider human resources policies (paper HMM(98)7 (Addendum) paragraph 7, adopted at the 12CHMM, refers).

1.6 Readers may also like to refer to the Commonwealth Secretariat's publication "Migration of Health Workers from Commonwealth Countries" (in press) which describes how migration currently affects Commonwealth countries. It also recommends strategies to assist governments to meet the challenge of migration through development of sound human resource policies and practices.

2. Additional background to the problem of nurse and midwife shortages

(Drawing on papers presented to, and discussions at, the 12th Commonwealth Health Ministers Meeting, held in 1998)

2.1 Workforce issues are moving to the top of the agendas of governments and of employers generally, and were a key theme of the Commonwealth Health Ministers Meeting in Barbados in 1998. Issues discussed in papers for that meeting included the migration of nurses and doctors, as well as domestic workforce issues affecting all health workers (eg human resource and capacity building, gender management systems in the health sector).

2.2 These discussions took place in the context of a growing recognition of the vital role played by nurses and midwives, both as a major component of the health service workforce and as those who are very often at the cutting edge in the provision of care to patients. A nurse or midwife may be the only health care provider in a remote area. They know the community and its particular needs, and are in a position to build up ongoing relations with patients and their families, and to gain their trust. This enables them to influence life-style factors affecting public health, as well as, for example, giving treatment or delivering babies.

2.3 Ensuring that the future supply of nurses and midwives is sufficient to meet demand is a matter of concern throughout the Commonwealth, and more widely. The reasons for the projected increase in demand in some countries are related to :

- demography
- advances in medical practices and technology
- the impact of diseases such as HIV/AIDS, and
- changes in public expectations of the healthcare system.

2.4 Factors contributing to problems in recruiting and retaining sufficient nurses to meet that demand include :

- absence of involvement of nurses and midwives in the development and implementation of health care policy
- an ageing current workforce
- insufficient training places, or intake to training courses
- funding problems

- low status of nursing and midwifery
- increased employment opportunities for young women
- out of date working conditions
- increased health risks, including from HIV/AIDS
- lack of family friendly working conditions
- limited opportunities for continuing education, training, development and research

2.5 Specific examples from individual countries include :

- frequent changes of Ministers and/or policies
- nurses pay being frozen at a low level
- poor salary structure
- heavy workloads due to staff shortages
- nursing being seen as "women's work", and so of low status. Nurses being expected to carry out menial as well as professional roles. Parents preferring a girl to marry rather than to work as a nurse or midwife
- threats to the health or well being of the nurse or midwife (including violent attack, medical hazards - including from communicable diseases - unsafe working environment)
- lack of accommodation, or transport
- poor working conditions, including poor building maintenance, shortage of supplies and equipment.

2.6 There are increasing problems for many countries in maintaining the supply of new nurses through traditional routes such as pre-registration training. As a result, many healthcare employers are beginning to pursue alternative strategies through, for example :

- improving the working environment
- better career prospects
- targeting nurses not currently working
- recruitment from other countries.

2.7 Within this context, many nurses and midwives around the Commonwealth, including some from countries which are experiencing temporary surpluses, are seeking employment opportunities abroad which may offer a better standard of living and enhanced career opportunities. Other reasons for nurse and midwives moving to

another country may include the urge to travel and study overseas, or the wish to accompany a family member who is moving abroad, for example in connection with their employment.

2.8 Whilst international mobility has long been a characteristic of the nursing profession and freedom of movement is an important right, the ethical considerations involved in recruiting nurses between Member States have now come to the fore, particularly where local health service provision may be put at risk. Whilst the free movement of nurses and midwives can bring many advantages to both the individual and employer, including broadening of skills and cross cultural expertise, there may be a need to examine these issues and consider ways of addressing them.

3. General considerations for Member States seeking to increase their nursing/midwifery workforce

3.1 Options for dealing with nursing and midwifery shortages for any one country, or one employing unit within a country, will depend on its staffing requirements, available resources and labour market conditions. Each country needs to identify the solutions appropriate to its particular circumstances, and which may help to contribute to maintaining a healthy pool of trained nurses/midwives.

3.2 Whilst pay is an important aspect of dealing with exceptional recruitment and retention problems, a healthy working environment, employment practices, staff involvement in decision-making, and career prospects are all key elements in recruiting, retaining and motivating nursing staff. Nurses and midwives need to both feel valued, and have a real influence through involvement in health policy development and implementation, particularly as there may be increased competition for staff as alternative career opportunities open up for people who might otherwise have become nurses.

3.3 Some more specific points for consideration by Member States seeking to increase their nursing and midwifery workforce follow.

3.4 Comments from nurses and midwives attending the recent workshops organised by the Commonwealth Steering Committee for Nursing and Midwifery in New Delhi and in Brisbane during the year 2000 are summarised at Appendix 1.

Recruitment

3.5 **Workforce planning** is essential. It is too late when the crisis occurs. In some countries many nurses and midwives are due to retire in the next 10 years. There is an urgent need to plan and prepare for effective replacements.

3.6 **Information about the emigration/immigration of nurses and midwives** may need to be collected. (In the survey of Commonwealth countries organised by the Commonwealth Steering Committee for Nursing and Midwifery in 1998, 85% of respondents reported the existence of centralised information about the nursing and midwifery workforce. These databases most commonly hold information on training and recruitment of staff, but information on emigration was less frequently held.)

3.7 **Pay and conditions** are key factors in determining whether people consider nursing as a career.

3.8 **Perks** can also be significant.

3.9 **Start seeking to attract recruits from a young age** - including through work in schools and colleges.

3.10 **Consider alternative entry routes,** such as bridging courses, cadet schemes.

3.11 **Seek to attract qualified staff back to work.** (In England, publicity aimed specifically at nurses who had left for family reasons, coupled with short practice courses enabling them to refresh their skills, brought an encouraging response.)

Retention

3.12 **It is a waste of time and money to recruit nurses and midwives but then fail to retain them.** Dreams and good intentions can be stifled by the overwhelming realities of, for example :

- unhelpful working hours
- low pay
- poor supplies and equipment
- inadequate support systems
- lack of career opportunities.

3.13 **Scope for development and progression is important.** In some countries there had been no promotions for years. This is likely to discourage nurses/midwives from continuing with a career in these professions.

3.14 **Alternative career development opportunities** may need to be considered, as not all nurses and midwives are content to lose direct patient involvement as they progress. In England (for example) new nurse, midwife and health visitor consultant posts enable post holders to spend some 50% of their time in direct patient care, but also to be involved in expert practice, education, development, professional leadership or consultancy.

3.15 **Recognition** of the contribution of nurses and midwives can make a difference, eg the presentation of certificates or other awards. (We all like to feel appreciated.)

3.16 **Retirement age.** Some countries may wish to consider reviewing their current retirement age for nurses and midwives, or adopting a measure of flexibility over the age of retirement.

Improving working lives

3.17 **Family friendly policies** such as flexible working hours, and career breaks are important. Nurses often report that their greatest personal challenge has been to combine being a wife and mother with the pressures of work.

3.18 **Employer/staff partnerships are mutually beneficial** - perhaps with occasional surveys of staff views and needs.

3.19 There must be **equal treatment** of all staff regardless of race, gender, religion etc.

3.20 Employers should take all reasonable measures to provide a **safe working environment** for nurses – safe both from attack and from environmental risks.

4. Principles relevant to international nurse and midwife recruitment

4.1 In developing their policies on recruitment and retention, including international recruitment, countries need to take account of relevant national and international legislation alongside human rights and ethical considerations. A review of domestic legislation may be appropriate if in any case these considerations appear to be in conflict.

4.2 In developing their policies and practice on international nurse and midwife recruitment, Member States may wish to consider adopting principles such as the following.

Rights of individuals

4.3 Like other workers, nurses and midwives should have the right to choose to move to another country to work there.

4.4 There should be no discrimination against a nurse or midwife who is seeking employment in a new country - as compared to nationals of that country - on grounds of race, ethnic origin, religion etc.

4.5 There should also be no discrimination as regards rates of pay, grading, promotion or any other matters relevant to the working conditions or career of a nurse or midwife from another country.

Rights of employers

4.6 Employers have the right to seek to attract individuals to work as nurses or midwives, provided they do so in an open, honest and non-discriminatory manner.

4.7 While not acting in a discriminatory way (see above) employers have the right to take reasonable steps to confirm the comparability of the qualifications and experience of nurses and midwives seeking employment there after moving from another country. Also, that the candidates' language skills and understanding of

practice are sufficient to enable them to practice competently and safely in the country in which they are seeking employment.

5. Good practice principles

5.1 The following are additional principles which Member States may feel it appropriate to adopt, as matters of good practice, in addition to the more fundamental principles outlined in the previous section.

5.2 Good practice by Member States/employers seeking to recruit nurses and midwives :

(a) ensuring that domestic policies and practice are as effective as possible in recruiting and retaining nurses and midwives (see Section 3 for some specific points to consider), rather than considering active measures to recruit from abroad as a first option;

(b) as part of the above, considering special measures to recruit from any immigrants who have already settled in the country who may already have had nursing training/experience, or be qualified to undertake it;

(c) if deciding to actively recruit nurses or midwives from abroad :

- considering what principles to apply in selecting which countries to seek to recruit from - for instance in the light of the implications for the countries the nurses and midwives would move from, to avoid exacerbating any shortages there. (See Section 6 below for suggestions for relevant principles.)
- checking that national immigration policies are sufficiently flexible to meet changing needs.

5.3 Good practice by governments in countries which nurses or midwives may move from :

(a) ensuring that they do not breach nurses' or midwives' human rights or rights as workers, if they seek to place any restriction on their movement to work abroad;

(b) in responding to any requests from other countries to recruit nurses or midwives (see Section 6 below) : not discriminating between countries

making such requests, except where this is justified by specific factors (eg agreement to reciprocal arrangements for recruiting by that country, or the relative extent of nurse shortages there).

5.4 Good practice by employers in dealing with nurses or midwives who have last worked in another country :

(a) providing specific induction/adaptation training and/or mentoring for nurses and midwives who have last worked in another country;

(b) providing induction packs for such nurses and midwives, bringing together information helpful to them not only in their job but as people new to the country;

(c) appointing induction co-ordinators for units or groups of units employing nurses or midwives from abroad.

5.5 Good practice by employers : in relation to existing policies and staff

(a) arranging "equality" training for existing staff, and those involved in recruiting, to seek to reduce/eliminate potential discrimination against immigrant nurses or midwives.

5.6 "Just compensation" for international recruitment

There have been suggestions in some quarters that "just compensation" should be paid when a nurse or midwife moves from one country to work in another.

5.7 Two different interpretations of the term "just compensation" are possible, and it is important not to confuse them in discussing the issue :

(a) that immigrant nurses and midwives should receive "just compensation" from their new employers, ie that they should be appropriately recognised and paid, rather than possibly exploited as cheap labour;

(b) the payment of financial compensation by countries importing nurses or midwives to the countries those nurses or midwives came from.

5.8 The first of these interpretations is in line with the principle set out in paragraph 4.5 of this guidance.

5.9 The second interpretation raises a number of issues of principle and of practice which may not be easy to resolve fairly :

- the right of nurses to chose to move to work in another country (paragraph 4.3 refers);

- the absence of any precedent for such a measure in relation to any other group of professionals;

- questions of compatibility with EU and other legislation;

- the extent to which the "exporting countries" may themselves have contributed to the desire of their nurses or midwives to move to work in another country. Contributory factors could include failure to provide adequate pay, conditions or scope for advancement – even taking into account the country's overall financial position. (For example, a country may chose to spend only a comparatively low proportion of its GDP (gross domestic product) on health care, or may fail to take active measures to develop or support the roles of nurses and midwives);

- questions about whether "importing" countries should always make payments to "exporting" countries, or whether additional considerations would apply. For example should compensation be paid even if the "importing" country was a developing country and the "exporting" country a developed country, or if both parties were developing countries (or if both were developed countries)?;

- how any payments could be calculated fairly? For example, could a distinction be made between those nurses or midwives who took the initiative themselves in making a move (ie those not directly influenced to move by the "importing" country), and those "actively recruited" by the "importing" country ?

6. Possible principles for deciding which other countries to actively recruit from (Section 5.2(c) above refers)

6.1 In addition to considering the likelihood of being able to attract recruits from the countries concerned, Member States may wish to consider adopting a priority order in deciding which counties to seek to actively recruit from, or even that they will not actively recruit at all from some categories of countries.

6.2 There are a number of types of criteria Member States could seek to apply in developing their policies. In doing so, they will wish to consider the practicality of obtaining information on which to judge the satisfaction or otherwise of each criteria, as well as its inherent validity.

6.3 The sort of criteria countries might wish to consider using if developing a list of countries they will/will not seek to actively recruit from, or a priority order for recruitment, might include :

(a) recruiting first/only from countries with a surplus of nurses/midwives;

(b) recruiting first/only from developed countries rather than developing countries;

(c) recruiting first/only from countries which had specifically agreed to such recruitment (although recognising that as a matter of law such consent is not necessary for recruitment to take place).

6.4 Such principles could be operated in relation to nursing/midwifery in general, or in relation to particular categories of nurses or midwives (eg at particular levels, or with particular skills).

Factors affecting the recruitment and retention of nurses and midwives : views and experience of nurses and midwives at recent workshops

1. The following notes are based on group discussions at regional workshops organised by the Commonwealth Steering Committee for Nursing and Midwifery, held in New Delhi and in Brisbane in the year 2000.

General

2. Seemingly small factors can swing the balance in determining whether an individual becomes, or remains, a nurse or midwife.

Reasons for leaving nursing/midwifery

3. Several participants knew people who had given up careers as nurses or midwives because of related problems, eg with night duty or their children's education. Many had themselves found it difficult to combine work with family responsibilities, and some had at times thought of giving up their career, citing reasons such as :

- stagnation
- stereo-typing
- lack of autonomy
- family pressures
- poor appreciation of the contribution of nurses
- nursing compared unfavourably with other professions
- they felt their skills were not fully employed.

Reasons for continuing as a nurse or midwife

4. Key motivators in their own decisions not to leave had included :

- commitment to the profession
- promotion/increased salary
- professional development.

Practices helpful to recruitment/retention

5. Practices which participants felt were/could be helpful in the recruitment and retention of nurses and midwives or improving their working lives, included :

- re-registration
- the nurse practitioner role
- job sharing
- counselling
- in service education
- better career structures
- appropriate pay
- continued professional development.

Commonwealth Steering Committee for Nursing and Midwifery : background

1. A Steering Committee for Nursing and Midwifery was set up, and a Commonwealth Action Plan for Nursing and Midwifery developed, at the request of the 9th Commonwealth Health Ministers Meeting (CHMM) in 1989.

2. The remit of the Steering Committee has been renewed by subsequent CHMMs. Most recently, at the 12th CHMM in 1998, Ministers adopted recommendations for action to further develop nursing and midwifery in Commonwealth countries, including the continuation of the work of the Steering Committee for Nursing and Midwifery in order to co-ordinate, progress, and evaluate the contribution of nursing and midwifery to the achievement of Ministers' objectives.

3. Membership of the Steering Committee is constituted by the Commonwealth Secretariat. In addition to the Chair (currently Professor Anna Maslin, International Nursing Officer, Department of Health, England) membership currently includes :

   - the board members of the Commonwealth Nurses Federation
   - a number of invited national chief nurses/other senior nurse leaders
   - representatives of the Commonwealth Secretariat, the Royal College of Nursing, the International Council of Nurses and the International Confederation of Midwives.

4. The Steering Committee provides regular written reports on its work to Commonwealth Health Ministers Meetings.

Annex 2

Suggested indicator data on migration of health professionals[1]

Indicators	Possible information sources	Remarks
1. Vacancy rates for professionals in public health services	Public Service Commission, MOH Personnel Units	May indicate low supply of health workers or low leaver rates
2. Expatriate employment rates	Registration bodies, MOH Personnel Units	As above
3. Resignation rates (health professionals compared with professionals from other public services)	MOH Personnel Units/Civil Service Authority	Quite a good indicators but may also measure *internal brain drain* to private sector or other professions and sectors
4. Salary levels compared to the cost of living index	Ministry of Econ Planning/Finance	A good "push" factor indicator
5. Compare specialist/generalist vacancy rates	MOH Personnel Units	May reflect training policy or remuneration policy. High specialist vacancy rates important
6. Perceptions of service benefits by health workers	Surveys, Unions, Professional Associations	May have other "confounding factors"
7. Organisational environment – *"Bureaucracy Index"* (time for processing promotions, delays in appointments of new recruits)	Surveys, time and motion studies	Important indicator to assist other indicators when finding solutions
8. Vacancy rates of lecturers/trainers in health professions	Medical schools, Training schools	Especially trends showing vacancies increasing over time
9. Trends in average age of specialists/postgraduate staff	Surveys	May reflect training and replacement policy/efforts
10. Trends in doctor: nurse population ratios	Statistics Bureau/ MOH Personnel Units	Usually good indicator but may reflect high population growth rates and a slow training policy
11. Trainee return rates from external courses	WHO, MOH-HRD	Good indicator
12. Unemployment rates (graduates, other technical staff)	Surveys, analysis of applications	? Measure of "push" level and over-production?
13. Number of health workers registered to migrate (e.g. "Good Standing" certificates, J-1 visa clearance requirement rates) pa	Regulatory bodies/councils, MOH Personnel Units, Labour Departments	Good indicator of "intent" and maybe actual actions

Other factors such as inappropriate placement of staff (e.g. technical staff in administrative positions, over-specialisation at the expense of primary care staff training, inappropriate orientation of health trainees to tertiary hospital systems rather than primary health care etc) are more difficult to measure and need more qualitative assessment.

The indicators will also need to be further evaluated. What "benchmark" levels will indicate a problems? (e.g.: 10% vacancy or 20%? Are established staffing levels too high/too low?)

[1] ***Source***: Dovlo DY. Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African states. A report prepared for the Commonwealth Secretariat; 1999 (unpublished). Appendix 2.

Annex 3

African region: Summary of main factors influencing migration in Africa and Recommendations on policy directions

Extracts from the report on the African region[1]

Summary of the main factors influencing migration in Africa[1]

These may be summarised as

- Low salaries (ranging from "relatively low" to "ridiculously low") in an increasing free market environment.
- Limited administrative and human resources planning capacity of Ministries of Health, resulting in delays and frustrations of professionals.
- Some have cited "over-production" of physicians and nurses as a problem for countries contributing to the migrant labour. (In Ghana, however, a severe shortage is worsened by frequent recruitment of nurses by agents in the UK).
- Inappropriate training raises expectations of the health worker that may only be met in the richer countries.
- Inaction by recipient developed countries and the helplessness of dispatching countries to come up with acceptable and workable policies.

Recommendations on policy[1]

Policies should aim at resolving the underlying issues and root causes of the brain drain.

Strengthening capacity and systems for personnel administration: Complex and frustrating bureaucracy seems a major factor in many Commonwealth countries affected by migration. The situation should be assessed and documented, and information systems developed to help build new and efficient administrative systems. In many countries, this will include enhancing the decentralization of personnel administration. Improved transparency and consensus in managing Health Professionals (e.g.; Postings, Scholarships & other learning opportunities, Promotions and Appointments,). Confidence in a fair system is likely to play an important role in migration decisions where economic situations are more stable. (e.g.; In Lesotho, some cite political interference in appointments etc., as reasons for migration[2])

Developing Human Resources Policies, Strategies and Plans: The WHO-AFRO has initiated a programme for assisting countries to develop HR Policies and Plans. However this will also be influenced by building the capacity of HR managers and Policy Makers to develop and implement appropriate strategies. The lack of plans causes [a] the lack of knowledge on the situation, [b] the continued over-production of expensive staff types or inappropriate skills, [c] inability to match staffing types with services and costs. Effective planning and implementation alone will not limit or remove mobility of health professionals but will assist to understand the situation and take actions that minimize rather than worsen migration. Strategies must be comprehensive, incorporating the key areas of Human Resources development, training and management.

Promoting and funding professional links between Institutions in developed and developing countries: The developed countries can assist by building links with scientists and professionals in developing countries. (An example is cited of the links and funding support between Hughes Institute and Russian scientists that enables them to carry out research at home and possibly improves retention[3]).

Strategies for improving communication between professionals using new technology such as Email, Telemedicine and radio linked methods also help to prevent or reduce "professional isolation" which is often mentioned as a reason for migration of intellectuals[4].

The Commonwealth can assist to support such organizational linkages (possibly already available) that allows senior academics and practicing professionals to exchange ideas and participate in conferences and meetings. Such interactions even with and between neighbouring countries can be less expensive and can be supported financially by even the poorer countries.

Developing local Postgraduate and Specialist Training Systems: Lack of opportunity for higher training is often as a reason for migration of the younger professionals in Ghana[5] and possibly in other countries. Support for early postgraduate training for doctors can be used to attract them into deprived areas for a period and thus reduce deployment difficulties. Examples from Indonesia[6] show that these strategies can be successful if faithfully implemented and relatively early specialization occurs. However, specialization incentives must also assure that the right types of specialist are produced otherwise post specialization brain drain occurs. The development of local and relevant courses is important either within countries or as part of regional cooperation strategies. It is suggested[6] that targeting scholarships to persons from specific deprived communities and groups may influence retention and the likelihood of the professional working in his/her home locality. However, we must recognize that acquisition of highly demanded qualifications may rather enhance mobility and the risk of migration.

Offering specialist training to older and more settled personnel (e.g.; through example of Philippines "Step ladder" system) may reduce the likelihood of migration when a family is already built and other demands and responsibilities reduce migration.

Bilateral or Multi-lateral "Brain Export/Exchange" agreements: In many countries, the target countries for brain drain are few (usually one or two main target countries responsible for over 60% of movements of professionals). Agreements on managing the process and on numbers permitted as well as the involvement of the sending countries in the recruitment and selection process can assist improve the situation as well as ensure some remittance of earnings. It can also involve technical and financial support from receiving countries to assist develop health systems in the poorer country. Ghana's MOH has entered into agreements with MOH Jamaica and recruitment agencies from the United Kingdom aimed mainly at restricting numbers recruited so as to avoid collapse of services, to ensure return after a period (and allow others to go) and also to ensure adequate conditions of service for its citizens. A standard system and process of considering these agreements could be developed to assist countries extract as much benefit as possible from exporting their well trained health professionals. A system which allows health workers to rotate in turns to work outside might be a good strategy.

Other incentives and motivations factors: Pay systems and methods for professionals in countries where mobility is high and remuneration is a factor, need to be reviewed. Some countries have experimented with "Extra Duty", "Rural", "Hardship", "Mountains" and

other allowances to encourage distribution and retention of health workers. Ghana has proposed introducing intra-Mural private Practice in public hospitals for specialists to help enhance their incomes, and "hardship" and extra duty allowances for other health workers (especially in rural areas.).

Other motivational issues in the poorer countries relates to retirement and its benefits. Social services are poor and low salaries generate very low pensions. This social security issue remains an important reason for migration which must be dealt with either by creating additional trust funds to support retiring or elderly health practitioners.

Development of new career options for health workers is an important motivational factor. The lack of clear career options remains a factor in many countries where careers are limited to routine promotion with new titles every few years. General and family practitioners as well as public health practitioners have limited opportunities and often lack the recognition given to the clinical specialties. New career schemes should provide incentives to encourage relevant and needed cadres.

Skills Delegation/replacement: Many countries have utilized various distinctive cadres to carry out functions originally reserved for doctors or other professionals in the face of shortages and expanding services. Examples given the text include the Assistant Medical Officers of Tanzania, Field Surgeons in Ethiopia, Nurse Practitioners in many countries, Midwives with extra Life Saving Skills in Ghana, etc., . This has a two fold benefit of [a] Service providers trained at lower costs, [b] Obtaining the services delivered (also possibly at lower costs than doctors would provide them) and [c] Motivated staff due to new and respected responsibilities given them and [d] Staff who are much less mobile because of registration difficulties outside the country of origin.

Recruitment of Expatriates: Almost all countries in the Africa region have expatriate health workers either as volunteers, representing NGO[7] service providers, or recruited by the government services from neighbouring countries. Some have arrangements to receive VSO[8] or BESO[9] volunteers to work in the health services. No formal inter-government agreements were elicited in the region except for arrangements with the Cuban government for doctors made with a number of countries including Ghana, South Africa, Namibia and the SADC[10] arrangements in southern Africa. Language difficulties are often a problem with Spanish speaking Cuban doctors but can be reduced by efforts made to provide language lessons to such expatriates. Agreements also can assist both the receiving and dispatching countries to better plan the numbers and reduce detrimental effects on either country of flooding of migrants to recipients or a collapse of service in the dispatching country.

Health Sector Reforms: Funding human Resources needs (beyond sponsorship for postgraduate training etc.,) is generally neglected as part of Sector Reforms. Adjustments in many countries have meant projected reductions in the wage proportions of budgets, limiting the options for providing and retaining professional health workers. Can approaches to Health Sector reforms find new ways of supporting Human Resources Investment in health along similar lines as for infrastructure and funding arrangements to support retention of priority staff and encourage deployment to the areas of greatest need?

Donors and partners are reluctant to support funding of wages which is seen unsustainable expenditure where eventual withdrawal may even worsening motivation problems. Targeted and indirect support aimed at providing non-monetary incentives to workers in unpopular locations or difficult jobs may be considered including supporting staff to obtain additional

qualifications and supporting communication and links with professional and academic institutions to reduce the phenomenon of professional isolation.

Ministries of Health will need to debate and restructure the balance between personnel costs and other recurrent and capital costs. Human resource costs will necessarily be relatively high if equipment, logistics, infrastructure and other resources are to be efficiently utilized. In addition, substantial investments into training of health professionals should not be wasted by allowing migration due to low wages. This has to be countered against having significant salary raises that leave little funding available for service delivery.

Overall, the issues of good governance, efficient economic management, transparent and efficient staff administration systems are the underlying important issues affecting the success of any strategies that are implemented.

References and notes to Annex 3

1. This annex comprises two extracts from Dovlo, D.Y. *Report on issues affecting the mobility and retention of health workers/professionals in Commonwealth African states.* A report prepared for the Commonwealth Secretariat: 1999 (unpublished). *Summary of the main factors influencing migration in Africa* is from p.30; *Recommendations on policy directions* is from p. 33-35. Numbering of the references have been changed to make the Annex freestanding.
2. Wireko TB. *Brain Drain in Lesotho.* A consultancy report sponsored by Commonwealth Secretariat CTFC with assistance from UNDP; 1997 (unpublished)
3. Agovino T. 'Stemming the brain drain from the former USSR.' Lancet. 11 July 1998; 352(9122): 125
4. Schlegel M. Brain 'Drain with regard to Africa.' Available on-line from www.sas.upenn.edu/african_studies/articles_gen/menu_articles_gen.html [Accessed 28 February 2001] Article discussing information technology systems and means to help scholars on the continent keep updated and in touch with colleagues.
5. Dovlo D and Nyonator F. 'Migration by graduates of the University of Ghana Medical School: a preliminary rapid appraisal.' *Human Resources Development Journal* 1999; 3(1) [Electronic Journal] Abstract available on-line from www.moph.go.th/ops/hrdj [Accessed 26 February 2001]
6. Martineau T and Martinez J. *Human resources in the health sector: guidelines for appraisal and strategic development.* Health and Development Series, Working Paper No. 1. Brussels: European Commission; 1997. p.14. Available from www.liv.ac.uk/lstm/hrdcover.html [Accessed 6 February 2001]
7. NGO – Non-Governmental Organisation.
8. BESO – British Executive Service Overseas
9. VSO – Voluntary Service Overseas
10. SADC – South African Development Community

Annex 4

Caribbean region: Recommendations at both policy and strategic level

Extract from the report on the Caribbean region[1]

The following recommendations to be implemented at both policy and strategic levels are based on findings from the literature review, professional experience and expertise, as well as the results of the returned questionnaire survey of ten of the fourteen Commonwealth Caribbean countries which was conducted as part of this study.

A regional goal should be to reduce the 'brain drain' by paying greater attention to conditions of employment/service and conditions of work including dysfunctional workplaces, enhancing job satisfaction and teamwork.

1. Policy orientations and strategic planning are required for the strategic placement of human resource within the context of national health sector development.
2. The level/grade structure and classification of health workers be reviewed and a more equitable system among categories introduced. The resulting levels/grades be reduced, with appropriate number of steps introduced accordingly.
3. Introduction of new categories of health workers. Several impacting forces as well existing occupational skill deficiencies point to the need for introduction of new skill types within the health service.
4. "The countries need to review the process of human resource management so that health personnel are able to deliver acceptable, effective, and efficient health care in a satisfactory work environment, despite the marked contraction of resources available to health. These goals imply quantitative and qualitative changes in the patterns of service delivery, along with improved management skills and a systematic framework of information, which are both valued and used by leaders and decision-makers. Development of the latter is perhaps the single most important challenge facing the health system"[2]
    - Review and improve personnel management functions such as appointments, performance appraisal, promotion, disciplinary process, and leave allowances.
    - Create mechanisms that will give the health professionals the opportunity to be innovative, expand their professional roles and develop excellence in management and clinical practice.
    - Introduce structural changes in staffing patterns, which entails skill mix.
    - Distribute health workforce on the basis of health service requirements.
    - Emphasize substitutions within the different professional groups, introducing auxiliaries as appropriate and arriving at a mix of staff that is cost-efficient and of high quality.
    - Increase nurse workforce supply through:

        - appropriate ratio of professional to non-professional nursing personnel
        - substitution of one type of labour for another
        - efficient allocation and utilization patterns and appropriate mixes of nursing personnel
    - Provide and maintain incentive programs such as:
        - more flexible shift system
        - improved local transport arrangements
        - day care facilities at place of work
        - low cost housing schemes
        - educational opportunities
        - improved career mobility.
    - Change from vertical, hierarchical command organizational structures to comparatively flat responsive structures.
5. Reform the regulations particularly those dealing with hiring, promotion, and disciplinary measures, and delegate to the work sites as appropriate.
6. Given the spiraling cost of health technology and the limited demand for some services, the English-speaking Caribbean countries must continue to explore opportunities for selective specialization and for sharing services among themselves to overcome discrepancies between the available workforce and the needs of the health sectors.

According to Buchan[3], "...the real challenge to management and planners is not identifying potential solutions to recruitment and retention difficulties (which by now are well documented); it is identifying which solutions are appropriate to their circumstances, and evaluating the effectiveness of these solutions".

The commitment of the governments in identifying solutions and their implementation is imperative.

References and notes to Annex 4

1. This annex is an extract from Reid UV. *Human resource development for health project: Commonwealth Caribbean*. A report prepared for the Commonwealth Secretariat: 1999 (unpublished). p.28-30.
2. PAHO/WHO *Health conditions in the Caribbean. Scientific Publication no. 561*. Washington DC: PAHO/WHO: 1997. p.88-89.
3. Buchan J. 'Nursing shortages and human resource planning.' Journal of Advanced Nursing 1993; October: 469

Annex 5

Pacific regions: Discussion and recommendations

Extract from the report on the Pacific region[1]

Alterations to existing processes in order to reduce emigration of health personnel should be built around sound human resource management and development practices. It must be recognised that a quality health service is dependent on the personnel providing that service, and that investment in the selection, education, monitoring and training of those people in association with appropriate rewards for their expertise, skills and dedication, is the only way to further develop the health services in a sustainable and affordable manner.

All Ministries of Health will benefit from enhanced human resource management and the further development of workforce plans. These plans can only be developed by skilled health planners working collaboratively with the government, Health Ministry and consumers. For this essential criterion to be possible, health planners must be employed in each Ministry of Health and recognised appropriately by that Ministry, so that their expertise is not recruited by other Ministries or other countries.

The first task, should be to identify the goals and objectives of the Health Service within what are for every country, finite budgets. Strategies must then be developed for the achievement of those goals and objectives. Part of the business plan which will arise will involve the identification of the mix of skills which are required at each level of the health service, and the best method of delivering those skills through the identification of the personnel who will be required. It is important to emphasise that the health service must meet the identified needs of the population to be served based on the primary health care model, and not merely be an imposed solution which is reached by well intentioned, but unrealistic assessments and recommendations from external consultants.

It is important to state however, that over emphasis on the primary health care approach may send the wrong message. It is not intended that health services be provided on artificially low budgets which are sufficient to employ only semi-skilled personnel. The aim must be to have staff who are all of a high calibre regardless of the level of the health service where they are engaged. There must in each country be well funded secondary and tertiary referral hospitals and a commitment by government to adequately fund the health services and not to rely on donor aid for every development initiative.

The importance of a well documented health service development plan is emphasised. This "National Health Plan" and the associated health workforce plan should form the basis for discussions and negotiations with the Public Service Commission, Treasury and other government ministries for securing a greater percentage of resources for health service training programmes.

Once the numbers and types of staff required have been identified for each level of the health service, consideration must be given to the education and training required for the existing school leavers to attain those skills and education. It is considered that education should meet the identified requirements.

For these reasons it is considered that the health services will to a large extent be dependent on the nursing staff, who along with their undoubted compassion, commitment to service

and expertise, are prepared to work in remote rural areas and to function as part of the community which they are serving. The developments taking place in nurse education for the production of "specialist nurses" or "nurse practitioners" are applauded, as this would seem to be an appropriate way to strengthen health service delivery at the local level.

It is important that in the rural health services, the special challenges for health service staff be recognised by government. Augmentation of salaries for these personnel may be appropriate so that their take-home-pay is higher than that offered to urban personnel of equivalent skills and position grade.

As far as is possible within financial efficiency considerations, health worker education should be provided in-country, or certainly within the region at existing tertiary education facilities such as the University of Papua New Guinea, the University of Samoa, the University of the South Pacific, the Fiji School of Medicine and the Fiji School of Nursing. The World Health Organization and donor governments should be encouraged to change their support from scholarships to countries such as Australia, New Zealand, and the United Kingdom to support for education within the home country or within the region where such educational opportunity exists.

Consideration should be given to ensuring that pre-service health worker education is provided under the auspices of the Ministry of Education in "main-stream" institutions, rather than in Ministry of Health institutions which may be compromised in educational terms by the co-existing need for service delivery to patients. To achieve this desirable objective there will need to be a greater commitment by governments to health service funding and to training of health service personnel. Service delivery should not be dependent on personnel whose primary objective is to obtain their basic qualification.

Health service staff who wish to obtain specialist qualifications, should if such qualifications meet the identified needs of the population, be supported to study and practice only in countries of the region. This means that there should be processes in place for better matching of skills with needs, stronger incentives for personnel to upgrade their basic skills, more professional management and planning of human resources, and active commitment given to the retention of professionally and technically qualified people within the public health service.

All staff (and indirectly the patients) benefit from involvement in quality improvement processes. Health Ministries should ensure that personnel are deployed and co-ordinated in a fair and rational manner, and appropriately monitored so that further improvement in their skills and performance can be supported through first identifying the need, and secondly through providing the opportunity. Such processes should not be punitive in nature, but be positive in intent so 'as to achieve quality in outcome. There must be supportive supervision of personnel at all levels of the health service.

Strategies to provide support to continuous quality improvement are important. Such strategies could include government financial support to continuous professional development (CPD) programmes which are developed and provided by the various professional organisations. In addition, performance-based rewards for health

personnel would provide further incentive for a best-practice approach which achieves optimal patient outcomes.

Health workers can frequently become discouraged due to seemingly insurmountable difficulties such as shortage of equipment or drugs, poor facilities, unrealistic community

expectations, or working in a sole practitioner environment. The result is a loss of morale with absence from the work post which may commence as short-term and then progress to permanent absence or to a decision to emigrate. The solution to these difficulties is a combination of solving the apparent problems, supportive supervision associated with constant motivation of staff to high levels of performance.

It is crucially important for staff to be able to derive satisfaction from their work, and the Health Ministry must ensure that processes are in place which enable satisfaction to be attained whether the employee is in a remote rural location, or in a central (national) hospital. Satisfaction is dependent upon selection of the right person for each job, so that the health worker is personally fulfilled through the existing activity level, and not over-educated for the level of service to be provided. Linked to satisfaction is some form of career progression, and appropriate recognition through salary structure of the health worker's importance to the development of the country as a whole.

There are periods of difficulty and self questioning for all health workers. It is important that all are encouraged in their continued commitment to the attainment of the health goals. The National Health Plan should be focused on attainable health goals which are finance and time reasonable, and those goals should be collaboratively reviewed in a continuous manner so that health workers feel part of the process of improving health for the entire community.

If these recommendations were easy to implement then they would already be occurring, and there would be no need for this review. The practicality is that such processes are difficult to implement and are dependent not only on the availability of money, not only on political will, and not only on reallocation of entrenched interests, but on active communication with all involved in health, without the difficulties which come from artificial professional barriers and from entrenched interests.

It is proposed to now suggest a series of questions for health ministries, which will provide a focus for human resource development within each country:

How can we increase the prominence and our commitment to human resource development?

- How can we improve the present practices in relation to management of human resources?
- What processes and methodologies should we use in our particular situation?
- How can we sustain a momentum of development?
- How can we bring about real co-operation with the private arid non-government (NGO) sectors?
- How can we integrate the efforts of all health workers? .
- How can we resolve the series of existing imbalances?
- How can we further mobilise our training and educational institutions?

These questions form a structural basis for initial analysis prior to establishing a detailed human resource plan. The plan should incorporate estimated workforce needs, which are accurately costed so as to provide information to government on the future budgetary implications. There is no point in establishing a comprehensive plan on paper, if the expenditure implications preclude it from ever being implemented.

The human resource development plan needs to be of a practical nature timed over a period it is suggested of twenty years. Population trends and economic development indicators will be necessary to place the plan in a context of overall country development.

Having established the human resource development plan, it is then necessary for the Ministry of Health to constantly monitor that plan and to assess progress towards meeting the various targets. As information changes, so too should the plan be altered and up-dated. At definite periods of approximately five years, the plan should be extensively reviewed and adjusted along with current staffing issues and on-going skills needs analysis.

Some countries are investigating the provision of health services in association with fee-for-service or cost-recovery principles. It is considered that such processes should be carefully developed in order to avoid over-servicing. In addition, attention to the actual allocation of funds raised is an important process for further health service development. It is recommended that cost-recovery revenue be distributed in a three way process to provide funding to local health services, local staff salary enhancement and to central health service administration.

The development of appropriate networks for health can also be important in assisting countries to meet the challenges posed by the need to deliver health services within finite budgets. There is considerable scope for the non-government provision of health services.

These may be private-practice based and could include dental, medical and pharmacy services. Associated with such development comes the necessity to provide regulation and monitoring in order to ensure quality health service delivery and to prevent over- activity (which in developed countries may be known as doctor-induced demand).

Such regulatory, monitoring and inspection processes become a new demand for the Ministry of Health and cannot be left to regulation by market forces if consumers are to be adequately protected.

Traditionally, not-for-profit agencies such as non-government-organisations (NGOs) and church-based organisations are able to provide quality health services to people in need, particularly to those in rural locations. Examples from this study are church organisation hospital services in Papua New Guinea and in the Solomon Islands. The Ministry of Health should continue to have the role of co-ordinating the government and NGO sectors in the provision of optimal health care for the population in each country.

In addition, consideration should be given to the development of some part-time appointments to work in the government service. The remainder of time would be spent in providing health service through the non-government sector. This concept of part-time private practice could initially be investigated in dental, medical and pharmacy services

Reference and note to Annex 5

1. This annex is an extract from Rotem, A. and Bailey, M. *Health personnel migration within Commonwealth countries in the Pacific Region.* A report prepared for the Commonwealth Secretariat by the School of Medical Education Faculty of Medicine, the University of New South Wales: 1999 (unpublished). p. 29-34.