

health workforce

research findings for development policymakers and practitioners

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Could health worker migration bring benefits to Malawi?

Malawi, one of the poorest countries in the world, is losing health professionals to rich countries while its own health system suffers from a critical lack of human resources. Is this movement of medical staff fundamentally unjust, or could it be a 'win-win' situation for both developed and developing countries?

Many see the migration of nurses and doctors from developing countries to the developed world (medical 'brain-drain') as straightforward exploitation of the poor by the rich. However, new research suggests that health sector migration, if managed properly, could become a successful form of trade in services.

Researchers from Kings College London in the UK, and the Ministry of Industry and Trade in Malawi, explored the costs and benefits for Malawi of health sector migration. They looked at recent reports including an analysis by the Malawian Ministry of Health,

which stated an overall health sector vacancy rate of 33 percent (which hid a vacancy rate for nurses alone of 64 percent). Meanwhile, over 100 Malawian nurses and midwives continue to leave the country to work abroad each year, many to the UK, despite recent efforts to improve pay and conditions. This trend outstrips Malawi's current annual training rate of approximately 60 nurses per year.

So what are the effects of this migration pattern? Its costs include loss of public educational investment, fewer and poorer health services and chronic staff shortages. However, remittances (sums of money sent home by those working abroad) are a growing source of foreign exchange in many poor countries. Previous studies from outside Malawi have shown that remittances have a significant impact on poverty. The researchers also found that:

- A major cause of the brain-drain is the huge pay gap between Malawi and other countries, with equivalent salaries for newly qualified nurses and doctors around ten times greater in the UK.
- Without any policy effort, Malawi has shown that it is globally competitive in the training or 'production' of doctors and nurses.
- If migration is temporary, the migrants bring back a 'brain gain' in improved skills and knowledge.

The authors conclude that Malawi can benefit

from 'exporting' health professionals, while providing incentives for some to remain within or return to the domestic health system. However, the current situation, where the cost of training lies with the state while the benefits accrue to the individual working abroad, amounts to market failure. They suggest various policy options:

- Rich host governments could remit part of a tax (such as income tax or national insurance) to the Malawian government for re-investment in public health.

for medical training in Malawi. The debt could then either be written off over a given number of years of public service in Malawi or paid through overseas earnings.

- The state could charge fees for migrants to remit by allowing the holding of foreign currency accounts by Malawians working abroad, and reducing the cost of sending money from the UK to Malawi.

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Removal of childbirth delivery fees

The impact on health workers in Ghana

Ghana has a high maternal death rate and a relatively high rate of unsupervised births. The government recently introduced a childbirth delivery fee exemption scheme with the aim of increasing the use of public health services for deliveries. What impact has this had on health workers and traditional birth attendants (TBAs)?

Little progress has been made to date towards reaching the Millennium Development Goal of reducing maternal deaths by 75 percent by 2015. A major challenge is to boost the number of women receiving antenatal care and births aided by skilled attendants. Worldwide, only 43 percent of women give birth with skilled attendants present. One of the main barriers to giving birth in health facilities is cost, especially of childbirth delivery fees.

The rate of maternal deaths in Ghana is high, with estimates ranging from 214 to 800 per 100,000 live births. Nationally, 45 percent of deliveries are carried out by a skilled attendant. From 2003 to 2005 the government introduced a scheme that exempts women from paying fees associated with deliveries, to reduce financial barriers to using maternal services.

A survey of health workers and traditional birth attendants was carried out by IMMPACT in 2005 to assess the impact of

the new scheme in Ghana. A questionnaire was issued to 374 doctors, nurses, medical assistants, public and private midwives, community health nurses and trained and untrained TBAs in the Central and Volta regions. The questionnaire asked their income, what they thought of the scheme, general motivation and individual and household characteristics. Deliveries in public, at missions and in private health facilities are included, but not those carried out by TBAs.

Findings show that changes have occurred since the scheme was introduced. Some of the negative effects have been balanced out by positive changes.

- Health workers showed a strong commitment to public services, evident in long working hours and lack of private practice.
- Health workers have experienced an increased workload, but this has not seriously affected morale, and they are

able to cope. The number of deliveries per week was not excessive.

- The increase in workload for public sector health workers has been matched by an unrelated pay increase. Doctors are very well paid compared with other workers in Ghana. TBAs reported a drop in client numbers and pay. The impact on private midwives was mixed.
- Health workers expressed positive and negative attitudes toward the scheme. They appreciate that it has increased deliveries in health facilities, especially among poor people, but are concerned about unreliable government payments that are jeopardising sustainability.

These findings show that a fee exemption scheme, that increases demand for public health services while maintaining health worker salaries and morale, is feasible if managed well. This applies even in countries such as Ghana where human resources are restricted. However, this may be linked to the fact that Ghana's public health workers are generally paid well compared to the average government employee.

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Regulation of dual job-holding doctors in Peru

It is becoming common practice for doctors working in government facilities to hold at least one second job in the private sector to supplement their relatively low public sector income. This dual practice is open to unethical behaviour and corruption yet is difficult for governments to regulate. What options exist for effective regulation of these activities?

Doctors choosing to work simultaneously in the public and private sectors for financial reasons are often confronted by a blurring of the boundaries between their two positions. Many become exposed to corrupt and unethical practices such as misappropriating public sector resources and diverting patients from a public to private health facility. Dual practice also has some positive benefits, such as increasing the potential to retain public sector practitioners. In many instances, regulation that bans these activities would be inappropriate and ineffective.

A study by the London School of Hygiene and Tropical Medicine in the UK, Cayetano Heredia University in Peru, and the George Institute for International Health in Australia, investigates the nature of dual job-holding by public sector medical practitioners in Peru and considers options

for appropriate and effective regulation. The researchers interviewed 20 city-based practitioners in Lima using a cross section from the private and public sectors, clinical practice and policy making. It presented the following findings:

- Dual practice is widespread, acknowledged by doctors and carried out mainly by young male doctors. However, as it is not covered explicitly by health sector regulations, its legality is unclear.
- The main reason why doctors decide to hold more than one job is to increase income. They generally remain in their public sector roles for economic security and skills development.
- Medical professionals agreed with the need for greater regulation of dual practice but views differed over who should control the regulation. Some doctors believed dual practice should be banned while others were more tolerant, recommending an approach that minimises harm.
- Due to the highly competitive nature of the market in Peru, dual practice does not guarantee extra income. These pressures are the result of deregulation of the medical labour market, lack of workforce planning (and a flood of graduates) and poor economic conditions.

A major finding of the study is that any changes to the regulations dealing with dual practice will need to link with Peru's broader economy and the relevant reforms.

The report suggests that regulation:

- has a role in bringing together the medical profession's collective interests and wider policy objectives such as retaining public sector medical staff and ensuring quality
- would need to recognise dual practice activities, set standards of quality and clearly demarcate public and private activities
- could include greater control of the supply of medical practitioners, measures to reduce financial pressures caused by poor economic conditions, and tighter control of dual practice doctors

- should ensure medical practitioners perceive a 'win-win' situation, so that they are willing to enable successful implementation
- could control income, yet broader regulation of medical education and workforce planning will be required to tackle the external pressures causing dual practice services.

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'The Role of Regulation in Influencing Income-Generating Activities Among Public Sector Doctors in Peru', *Human Resources for Health*, 5(5), by Manuel Juma, Stephen Jan and Anne Mills, 2007

Many dual job-holding doctors become exposed to corrupt and unethical practices such as misappropriating public sector resources

Health worker responses to health sector reforms

In the past 20 years, a number of developing country governments have attempted health sectors reform to improve performance. These reforms often failed to include participation of the health workforce in planning and decision-making. Both Bangladesh and Uganda have attempted many such reforms, aiming to improve performance and delivery of care.

Both countries have very low per capita spending on health and both face challenges in meeting the Millennium Development Goals. In 1991, Bangladesh became a democracy after 20 years of military rule and launched a wide programme of reforms. Uganda introduced a series of reforms in the early 1990s in an attempt to rebuild the health sector after its collapse in the 1970s.

To date there has been little research on the mechanisms through which health sector reforms either enhance or discourage the workforce's motivation and performance. This study, conducted in 2004, considers the effect of such reforms on health workers. It examines the context of reform objectives and the response of health workers to workplace changes in Bangladesh and Uganda. Interviews were held with 700 individual health workers. Focus groups and key interviews were held with health managers, institutions and professionals. The study found that:

- Reform planners in both countries failed to take context into account, assuming that health staff would passively implement the reforms.

Nurse in a hospital's mother and baby clinic in Bangladesh.

Barbara Klass / Panos Pictures

- Unification efforts in Bangladesh resulted in a power struggle and led to mistrust between the former family planning and health divisions, with the family planning staff believing they had 'lost out' to health staff.
- The workforce felt positive, hoping that changes in payment schemes meant salaries would be paid more promptly.
- Rapid decentralisation with poor human resources management left Ugandan health workers insecure. Local authorities in power were influenced by resource shortages and nepotism.
- Closer ties to community leaders had a positive effect on health workers. Leaders could lobby the government on their behalf for financial and human resources.

The researchers reported that while staff may have been demoralised and resources short, shifting authority and supervision to the rural districts affected communities positively as they assumed an active role in shaping health service provision. The study makes five key recommendations:

- Reform planners should design reform objectives that improve community health services by encouraging a favourable response from the workforce.
- Reform planners should carefully analyse the health system context when designing reform objectives, to identify elements that either support or block reform initiatives.
- Reform programmes should be flexible



so problems can be easily identified and resolved.

- Health workers should be involved in all stages of the reform process, and should understand the purpose of change and have confidence in the consultation process on which it is based.
- In evaluating the impact of reforms, an important criterion is that health workers' motivation and performance are affected by their perception of their relationship with the community.

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For further reading

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Motivating Tanzanian primary health care workers

Local primary health clinics are widespread in Tanzania. However, patients often prefer to go straight to hospital specialists because primary health care in the country is of such a poor standard.

The Tanzanian government has tried to improve health services throughout the country. Primary health care was decentralised in 1992. At the same time on-the-job training was provided for health workers and some received housing support. According to government guidelines, health workers should be supervised every three months. Nevertheless the quality of care remains poor.

Tumaini University in Tanzania together with the London School of Hygiene and Tropical Medicine in the UK talked to primary health workers in northern Tanzania to find out what problems they face and how their jobs could be improved.

One of the problems is a lack of staff. Health workers often have to handle cases for which they are not trained. A nursing assistant may have to do the work of a pharmacist and doctor: dispense drugs, give injections, dress wounds and help in the labour ward. The shortage of staff also means doctors often have to do non-medical work, such as cleaning.

Primary health workers' skills would improve if they received feedback on the patients they referred to the district hospital. For example, specialists could visit the clinics to discuss frequently referred cases. Health workers would also be able to update their skills if they returned to hospitals to work after a two-year placement in a rural clinic.

Workers feel they are gambling with patients' health because they have no laboratory to carry out tests on blood

Workers feel they are gambling with patients' health because they have no laboratory to carry out tests



and urine samples. Despite government regulations, health workers are not supervised regularly, are criticised rather than encouraged and receive no feedback from their appraisals. Workers are entitled to promotion and a pay rise after three years. However many have

worked for more than ten years without any promotion. Junior staff who join the health service at a later date receive higher salaries. Although the workers feel demoralised, they continue to work because they believe they are 'working for God'. The study found that health workers want:

- regular supervision and support from managers
- the procedure for promotion to be more transparent
- better facilities and training
- to receive feedback on referrals
- a rotation system in place so they can update their skills.

While decent salaries for health workers are important, other issues also matter if workers are to remain motivated.

Nurse Melifa Mphasa listens to the pregnant belly of a patient in the labour ward at Bwalia 'Bottom' Hospital in Lilongwe, Malawi. She says 'The salaries have been increased but school fees and rent take up most of my earnings. Transport is very expensive. I want to serve my nation but we need better salaries to meet the cost of living.'

Abbie Traylor-Smith / Panos Pictures 2007

The study recommends that health workers:

- are properly supervised and supported. Supervisors will need to be trained to do their job effectively
- have their work assessed and receive regular feedback
- are given a clear career structure with straightforward procedures for promotion.

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