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EUROPE

Recruitment and retention of health workers: Policy options towards global solidarity

The WHO Regional Office for Europe

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Abstract

Report of WHO round table, Kampala, Uganda, 6 march 2008

This constituency meeting was held following the plenary sessions of the First Global Human Resources for Health Forum held in Kampala, Uganda (March 2008), in order to begin planning regional and global action towards policy-making for the concerns of the health workforce, including migration and retention of health resources, and recruitment across boundaries.

Keywords

HEALTH MANPOWER – trends

HEALTH PERSONNEL – trends

HEALTH POLICY

EMIGRATION AND IMMIGRATION

PERSONNEL SELECTION – ethics

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Dr M. Tshabalala-Msimang, Dr A. Alves da Costa and Dr Marc Danzon.

1. Introduction

1.1 Response of WHO to health worker migration

In recent years, the impact of health worker migration has become an issue of special attention for WHO. The World Health Assembly has endorsed two resolutions on the International Migration of Health Personnel (WHA57.19 (Annex 1)) and WHA58.17 (Annex 2). These resolutions urged Member States to develop strategies to mitigate the adverse effects of the migration of health workers and minimize its negative impacts on health systems, and requested the Director-General to develop a global code of practice on the international recruitment of health personnel.

1.2 European commitment to managing migration

At its fifty-seventh session in September 2007, the WHO Regional Committee for Europe adopted a resolution on health workforce policies (EUR/RC57/R1) (Annex 3). The Regional Committee highlighted a consensus on the prevailing crisis of human resources for health, the responsibility of Member States to develop their national health workforce plans and strategies, and the need for collective efforts to tackle international migration. The Resolution gave a high priority to the process of developing policy options for managing migration, including a framework for ethical international recruitment of health personnel.

1.3 Kampala Forum on Human Resources for Health

The first Global Forum on Human Resources for Health, organized by the Global Health Workforce Alliance and held in Kampala, Uganda on 2–7 March, 2008, provided an ideal opportunity for policy-makers from the different WHO regions to examine the latest evidence on effective policy-making on the issue of health worker migration. Over 1500 participants came together in Kampala to share experiences of what is and isn't working in the response to the health workforce crisis and with the intent of building networks, consensus and capacity. The important outcome of the Forum is the endorsement of the Kampala Declaration (Annex 4) and Agenda for Global Action under the banner of "Health Worker for All and All for Health Workers" (Annex 5).

Following up on resolution EUR/RC57/R1, the Regional Office for Europe initiated a dialogue between "source" and "destination" countries and contributed to the Kampala Forum with the round table discussion on policy options for retention and recruitment of health personnel.

2. Overall objective of the round table

The overall objective of the round table organized by the WHO Regional Office for Europe was (a) to promote debate on effective policy options for health worker retention and ethical recruitment, and (b) to foster commitment of all stakeholders to collectively address international migration issues.

2.1 Specific objectives

In addition to presenting the latest evidence from countries and WHO regional offices on policies related to health worker migration, the round table had the following specific objectives:

- to review trends and impact of international migration of health workers on health systems
- to discuss ethical aspects of international recruitment vs. demands of health labour market in receiving countries
- to review the current progress in creating a legally binding multilateral Code of Practice for Health Worker Migration and other initiatives
- to explore policy options for health worker retention in the context of migration
- to forge cooperation and partnerships for action at global, regional and country levels

3. Co-chairs

3.1 A collaborative effort

Two co-chairs, Dr Manto Tshabalala-Msimang, Chairperson of the Health Ministers Bureau, African Union and Minister of Health, South Africa, and Dr Marc Danzon, WHO Regional Director for Europe, opened the round table. Dr Danzon welcomed the participants, especially Ministers and Heads of Delegations comprising the panel, and highlighted the importance of the theme. He referred to the WHO Regional Committee that had requested more action in this area and also thanked the WHO Regional Office for Africa and the African Union for the support they had given to organizing the round table. Honorary guest speaker, the Hon. Mary Robinson, also extended a welcome to participants on behalf of the Ethical Globalization Initiative, Realizing Rights.

3.2 A global problem

Dr Danzon stressed that the issue of health worker migration is a growing theme of concern for Europe as well as for those countries in Africa from which health professionals are moving. Ultimately, health worker migration is the product of poor planning

and resource allocation and, at different times in recent history, the desire by governments to cut health care costs. Evidence everywhere now shows that cutting back on the training of health professionals has proved to be the wrong solution to rising health care costs.

Dr Danzon emphasized that the free movement of people in search of opportunities and a better life has always been a part of the national and international scene. The movement of health professionals is part of a much larger historical tradition of international movement and the problem in not only one of "south to north" migration – within Europe, there is also a movement of health professionals between post-industrial countries, from eastern to western Europe, and with many of the same repercussions for source countries in Europe as those being experienced in Africa. He also pointed out that the last 50 years have seen a continued migration of health professionals from western Europe to North America, Australia and New Zealand for many of the same reasons that are now being seen in the movement of doctors and nurses from Africa to Europe.

3.3 History of the problem

Dr Tshabalala-Msimang, highlighting the history of health care in what had once been colonial countries in Africa, referred to the heavy investments that countries had had to make at a time when they a were facing many other social and economic challenges. Many of those same problems, such as poverty, poor infrastructure, illiteracy and high unemployment, still permeate the region and are a major obstacle to development in Africa. The structural adjustment programmes of the 1980s, which froze recruitment and placed strict and debilitating ceilings on wage structures, served only to worsen the development potential of the region.

3.4 A growing burden and loss

Meanwhile, she said, the epidemiology of old and emerging diseases in many parts of Africa has continued to place growing burdens on the capacity of countries, especially in the context of population growth and the demand/need for better and more comprehensive health care coverage. At the same time, a weak capacity to recruit and employ health personnel is making it increasingly difficult to meet current and expected needs and demands. She contrasted this with the situation existing in post-industrial regions of the world where poor forecasting and planning have left some countries facing major shortages of both doctors and nurses, but where there is a capacity to attract and recruit professionals from other parts of the world.

Dr Tshabalala-Msimang acknowledged that the push factor is not simply a question of poor salaries, but is rather a far more insidious combination of poor remuneration, poor infrastructure, poor referral capacities, very poor equipment back-up and increasingly run-down facilities that can no longer provide the type of incentive doctors and nurses look for.

Whatever the reason, however, at a global level, the WHO estimate of a shortfall of four million health personnel calls for urgent action, even though there is no "quick fix" she said. She gave the example that between 1998 and 2002 Ghana, one of the major "exporters" of medical personnel, lost £35 million of its investment in training of doctors and nurses while the United Kingdom saved £65 million through "imported" staff.

"no quick fix"

3.5 Emerging approaches

Dr Tshabalala-Msimang referred to some of the ways in which South Africa is seeking to retain its health professionals. For example, special allowances are now being paid to those who are willing to work in rural and deprived areas, and this seems to be having some positive impact. She also said that private/public options are emerging and that, in some locations, doctors in private practice are beginning to donate their weekends and days off to free service clinics, a development that bodes well for the future of South Africa and is demonstrative of the cohesiveness of the medical profession. She also pointed out that technologies such as telemedicine are presenting new opportunities for supporting health personnel in remote areas.

"private-public options"

4. Key speakers

Three key speakers were invited to take the debate forward and present themes such as trends in migration, health worker retention and global codes of practice, that would help serve as a backdrop to the discussion. The key speakers were Professor James Buchan of Queen Margaret University, Edinburgh, Scotland, Professor Sanjoy Nayak of the Royal Tropical Institute in Amsterdam, The Netherlands, and Ms Peggy Clark and Managing Director of Realizing Rights.

Professor James Buchan

4.1 Trends in migration of health care professionals

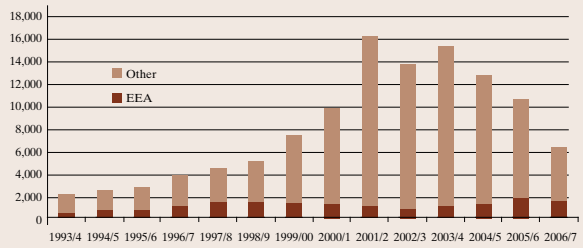
Professor Buchan described some of the main features of contemporary trends in the migration of health professionals. Although human mobility is increasing everywhere, the patterns that are emerging are dynamic and affected by a wide range of forces. Some countries have looked for nurses more than doctors, in others the reverse has been the case, while in others such as Austria, the demand has been for both.

Trends over time have varied considerably, reflecting the labile nature of the market and of the demands and training capacities of the receiving countries. In the United Kingdom, for example, the demand for internationally recruited nurses rose dramatically in the late 1990s, then plateaued for about five years before falling relatively sharply as the United Kingdom began to invest aggressively in scaling up domestic training of nurses to meet its own needs. (Fig. 1)

In Ireland, where the source of incoming nurses has fluctuated over the years, the number of nurses arriving from European Union (EU) countries was consistently higher than the number from non-EU countries until the end of the 1990s. After the turn of the century, this trend has reversed and since 2001 the number of non-EU nursing staff has grown faster than for staff from within the EU. (Fig. 2)

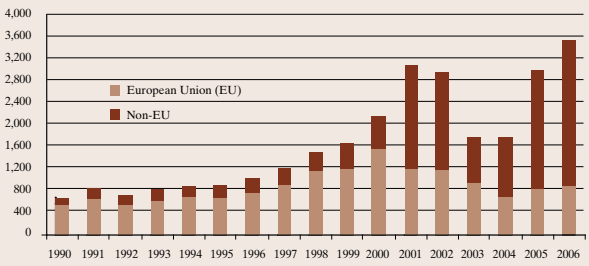
Where health workers move from and where they go to is equally variable. Some countries have proved to be far more important "exporters" than

Fig. 1
UK: new nurses registering from European Economic Area (EEA), and "other" countries 1993-2007



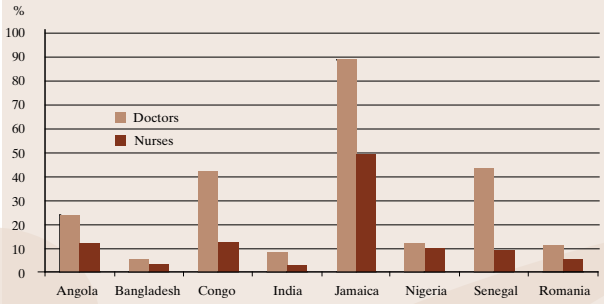
UK Nursing and Midwifery Council, London

Fig. 2
Ireland: EU and non EU nurse registrants 1990-2006



An Bord Altranais, Dublin

Fig. 3
"Source" countries: % of doctors and nurses working in OECD destination countries (OECD 2007)



others, reflecting both an institutional capacity for graduating specialized staff while, at the same time, having small populations to serve themselves. For example, the percentage of Jamaican doctors and nurses working in the Organisation for Economic Co-operation and Development (OECD) countries is far higher than that for countries such as Nigeria and India which are typically considered to be the main "exporting" countries. The numbers leaving these countries may be significant, but they are from a much larger home-based "stock". (Fig. 3)

Everywhere, however, there are signs that migration of health personnel is no longer limited to a "south" to "north" movement. Doctors and nurses are moving from developing countries to other developing countries and from post-industrial countries to other post-industrial ones. This is a trend that while largely forgotten is nevertheless a continuation of the trend that characterized the earlier migration of physicians and nurses from western European countries to new world countries such as the USA, Canada, Australia and New Zealand.

4.2 Health worker retention

For many countries, the challenge now is one of retaining sufficient numbers of qualified staff to meet their own domestic needs and thus make training more economically viable. Professor Sanjoy Nayak reviewed this and discussed a number of policy questions and available options. He stressed five directions that call for attention, namely:

(a) encouraging the return of health workers and at the same time promoting the option of circular migration in which professionals would not need to return on a permanent basis (instead, they would be able to return for relatively short periods of time before going back to their destination countries, thus helping meet the needs of source countries and also bringing back new ideas and techniques from the "richer" ones they have moved to);

"encouraging return and circular migration"

(b) "containing brain-waste" of foreign doctors and nurses and reversing a growing trend where foreign-born health care staff – whose qualifications are not "accepted" in destination countries – take on menial jobs that constitute a waste of their talent;

"containing brain-waste"

(c) facilitating the return of remittances to source countries and enhancing what is an already pronounced practice among many migrants, but which is not the case for health professionals who tend to move with families and intend settling and buying homes in their destination countries;

"facilitating remittances"

"an international fund"

(d) creating an international fund that would allow source countries to be compensated and thus permit strengthen-

Professor Sanjoy Nayak

Dr Marc Danzon and Hon. Mary Robinson

ing national health care systems in ways that would make it attractive for qualified professionals to remain in countries of origin;

(e) investing in more research to better understand the dynamics of the problem and seek solutions to the challenge of retention.

"operational research"

Professor Sanjoy said that the challenge calls for a better combination of planning and skill-mix to ensure a rational distribution of health personnel according to needs and forecast needs. This involves a re-visiting of how educational policies and plans are developed, and what international as well as national obligations are taken into account. It calls for national ministries of health, education and finance to work together in novel ways.

"career development and physical and social working conditions"

New approaches to the retention of trained health professionals call for a closer examination of the forces that push them to move. Not all of them move simply because of financial interest and, in this regard, more attention should be given to other incentives such as career development, as well as physical and social working conditions. Much more attention should be given to alternative "bonding" and community service schemes in which health professionals are required to "give back" time and effort as payback for the state and hence tax-payer investments in their training.

At an international level, Professor Sanjoy referred to world trade talks where the notion of a European Blue Card is being discussed and which would permit a much better "control" of how and where and under what conditions health professionals move. He took up the notion of a global solidarity fund which could permit on-going assessments of need and make surpluses of health professionals known to countries in need. Finally, he took up the theme of a global code of practice for ethical recruitment. which could today constitute a major step forward.

"making surpluses known to countries in need"

4.3 Global code of practice

The idea of a global code of practice was taken up by Ms Peggy Clark and Dr Manuel Dayrit, Direc-

tor, Department of Human Resources for Health at WHO headquarters. Ms Clark described the evolving scenario in which the needs of countries are placing complex political as well as human resource challenges on governments and institutions. She said it is a situation in which cross-national attitudes are changing and in which terms such as "poaching" and "stealing" are being increasingly used.

"in 2004, Ghana trained 70 doctors and lost 67 of them"

The migration of health professionals is a special dilemma for countries such as Ghana which, in 2004, trained 70 national doctors and then lost 67 of them to other countries. The reality, however, is that rich and poor countries alike are desperately short of qualified health personnel and the situation is getting worse rather than better. Many countries have simply not foreseen this trend until it was too late.

"Norway projects a gap of 115 000 health workers by 2020 and another 25 000 ten years later"

Norway, for example, projects a gap of 115 000 health workers by 2020 and another 25 000 ten years later. It sees no possibility of scaling up the training of nationals to meet this need, and will have to look abroad for staff. At the same time, countries in sub-Saharan Africa are equally in need of more than one million health workers. The question is how they will satisfy this need while at the same time being asked to share their graduates with other regions.

Principles of free movement, as referred to by Dr Danzon, will have to be respected said Peggy Clark, but she quoted Dr Patricia Santo Thomas, former Secretary of Labour of the Philippines, who has said that "…the primary actors in migration are people, but in the end governments are the key actors…" How governments will respond collectively and individually to the problem is still not clear, but the code of practice could go far in helping because it builds on the concept of a shared responsibility and the role of both source and destination countries.

"bilateral agreements… have met with some success because they explicitly engage the two partners"

The search for options is moving fast and to date three types of international codes have emerged that could be relevant to the question. The Commonwealth Code is a multilateral approach that has been found effective in providing the broad lines needed in terms of parameters and principles, but these have been difficult to implement and enforce. Regional codes and agreements such as the Caribbean Single Market Code or the Pacific Code are limited by their very nature to the regions in which they were developed. Bilateral agreements between countries on the other hand have met with some success because they explicitly engage the two partners, both the source and destination countries.

"engage all the actors and in doing so provide a truly participatory approach"

Dr Manuel Dayrit took up this theme and talked about the vision of the code of practice that was being proposed. The code, he said, offers a "shared responsibility" theme that could engage all the actors concerned and in doing so provide a truly participatory approach to the challenge. It recognizes the global nature of the problem rather than allowing the debate to continue erroneously focusing only on a few countries.

The code is composed of ethical recruitment guidelines such as have been developed by the International Council of Nurses; technical assistance such as the Department for International Development's (DfID) support to South Africa's programme for strengthening the health professional workforce; circular migration and return migration principles such as have been enunciated in the Caribbean Single Market Economy; self-sufficiency in health worker orientation; monitoring of health worker flows; on-going monitoring and assessment including the evaluation of the code's effectiveness.

The key to the code as now envisaged is that WHO Member States will gradually engage in and be responsible for its formulation. It is seen, moreover, as a flexible instrument that can be open to change as needs and opportunities emerge, and that allows for "soft laws" to be taken up by the partners. The code builds on the experience that WHO and other agencies have gained in areas such as tobacco control, and allows for the involvement of the private sector as an equal partner in broaching a problem which is already a theme for both the private and public sectors.

5. Debate

Led by facilitator Ms Zoe Mullan of *The Lancet* medical journal, who was later joined by Ms Peggy Clark of Realizing Rights, members of the panel and the audience engaged in an open debate in response to the presentations and a number of key questions.

5.1 Is it wrong to recruit health professionals from other countries?

This question generated a discussion that highlighted the complexity of the problem and the need to accommodate the demand and supply sides of the problem.

Dr Nick Banatvala from the United Kingdom pointed out that not only has the United Kingdom gone forward to develop a Code of Practice for itself, but also has moved to ensure that it can meet many of its human resource requirements through educating and training its own domestic doctors and nurses.

In reply to frequently asked questions about the ethics of systematic recruitment as opposed to voluntary spontaneous movement of health professionals, Dr Bjørn-Inge Larsen of Norway reminded the group that in one way or another all countries eventually engage in the process. Thus, as countries lose some of their personnel to out-migration, they turn to other countries in search of personnel to replace those they have lost. He added that his ministry estimates well over 135 000 medical personnel may be needed over the next twenty-odd years.

Canada's delegate, Mr Bentley Hicks, emphasized the fact that in his country as well as many others, there is a structural problem whereby domestic demand is growing rapidly at the same time as the capacity to educate and train new national staff is decreasing because medical faculties are ageing and training institutions are run down.

Dr Lola Dare, CHESTRAD, from Nigeria said she welcomed the concept of managed recruitment of health personnel and that, from the perspective

of many health professionals, migration offers the most open pathway to career development as well as recognition of worth. She questioned criticisms of so-called active recruitment, saying that advertisements are to be found in almost all technical medical journals – recruitment agencies are not the only ones engaged in this practice.

This same theme was taken up by a delegate from Kenya who stated that students in medicine and nursing – just as in other sectors – go into their studies with expectations and ideals which, when not met, push them into considering options in other countries. This, he declared, calls for a much deeper analysis by sending countries of why they are not able to do more to retain their graduates.

"why are developed countries unable to attract the necessary number of medical and nursing students?"

The discussion nevertheless served as a good reminder of the many facets to the problem. From South African delegates came the question of why is it that developed countries seem to be unable to attract the required number of students into medicine and nursing, and thus begin to meet their own needs.

In response to the theme of managed migration, the United States delegate appealed for greater respect for the individual in the equation and noted the fact that recruitment and service will always be a one-to-one relationship between employer and employee.

5.2 Can there be international agreements on the strengthening of human resources in source countries?

In response to this question, a number of countries indicated that this is not only desirable but in fact already underway. For example, Mr Hicks remarked that Canada had been doing this for some time through its foreign assistance programs and that this would always, from a Canadian perspective, be more acceptable than providing financial compensation to sending countries and entering into transactional agreements.

Dr Marc Danzon argued that in all these matters it will be always be better to foster international and institutionalised ways of responding to the needs of source countries, while at the same time trying to satisfy the needs of post-industrial countries. Whatever is done, he said, must be transparent and planned in ways that allow for all concerned to prepare for the future and benefit equally from the movements that will inevitably continue to take place. An international vision is called for that recognizes the facts of the phenomenon as well as its truly global nature.

The delegate from South Africa, Dr Phetsile Dlamini, reminded the panel of the Memorandum of Understanding that has been signed by her country and the United Kingdom and which, as Dr Danzon said, provides a transparent base for recruitment and reciprocal relationships. She nevertheless added that the problems facing Southern Africa are enormous and that unless the movement of health

professionals is contextualized, it will be impossible to understand the problem and respond to it. She called for greater contributions by donor countries together with a greater national investment in social services aimed at reducing food insecurity, illiteracy and poor infrastructure – unless rural areas can be made attractive, she argued, it will always be difficult to get doctors and nurses to work there.

5.3 Can health professionals be encouraged to return?

This had been proposed by a number of governments and agencies. Dr Anita Davies reported that the International Organization for Migration (IOM) is one of the organizations that are working to make the idea of return attractive by facilitating periodic preparatory visits that enhance the decision to eventually go back. In Israel, there have also been attempts to make return following study periods abroad attractive through incentive packages which include allowances for housing and other benefits.

5.4 Can health professionals be encouraged to stay?

Again it became evident that many countries are thinking about solutions that can be acceptable to all stakeholders.

Mr Muhammed Hussein, the Ethiopian delegate, referred to a Human Resource Plan for 2020 that is being developed and in which the basic premise is that, when the national government invests in the training of health care professionals, it can rightly expect them to "pay back" in kind and contribute a period of their time to the national health system. A scaling up of some of the ways this can be done in Ethiopia is already planned.

"not only retaining graduates but making better use of the ones countries already have"

From Brazil's Professor Geraldo Cury came the argument that the issue is not simply one of keeping health professionals at home, but of making better use of the ones that are already there. The number of health personnel in Brazil is relatively high and could meet many of the country's needs, but the

Dr Marc Danzon and Hon. Mary Robinson

problem is one of distribution. Many of the geographic areas calling for more doctors and nurses are not attractive to new graduates, and it is difficult to encourage them to go there even for short periods of time.

In South Africa where maldistribution is also a problem, the problem of retention is an even more critical challenge. The South African delegate asked for a regional strategy that would open up the possibility of countries sharing expertise, facilities and personnel, and would allow for new options for retention to be explored at a regional level.

"the costs involved call for international initiatives and support"

How international organizations view the problem is important in terms of the support they can give, and the OECD delegate pointed out that the management of health resources, be it in terms of retention or the planned movement and sharing of staff, calls for a level of financial investment that can only come with the involvement of external international organizations such as the EU. Cooperation policies and programmes are called for that will constitute a source of support to countries as they embark on this route of action.

The Sierra Leone delegate, Ms Patricia Abu, contributed that her country faces the challenge of one of the world's highest maternal and infant mortality rates at a time when medical and nursing graduates are busy leaving the country. It is not that Sierra Leone has not developed policies on the matter, but that the task of implementing and enforcing them is

proving too difficult. The earning power of graduates in Sierra Leone is simply so low that, without outside assistance to rectify this, little can be done to change the situation.

"the drain is not only abroad but also into other sectors in source countries"

Much the same problem is faced by other countries in the region, added Dr Stephan Malinga from Uganda, but part of the problem is not simply that doctors and nurses are leaving, but that many of those that stay end up moving into other areas of work where they can earn more. The leakage of trained health professionals into the private business sector, for example, is high and countries must try to match what the private sectors offer.

This same theme of "brain waste" was taken up by a delegate from Ethiopia who highlighted the fact that, after 40 years of investment in the training of doctors and nurses, the country currently has fewer than 1000 nurses in place. Many have left the country, but many have also gone into other professions where they earn more than they would as nurses. The problem in Ethiopia, as in Canada, is that they are also losing medical faculty and hence the capacity to scale up their training if that is the answer.

"countries need to emphasize the patriotic aspect of the solution and challenge doctors and nurses"

Looking for public-private partnerships may well offer an answer said Dr Tshabalala-Msimang, speaking as Minister of Health of South Africa, and referring back to one of her opening statements. Countries need to emphasize patriotism and challenge doctors and nurses who have gone into the private sector to help – she added that such initiatives may present many more opportunities than have previously been considered possible.

6. Realizing rights

A global code of practice promises new opportunities for all the stakeholders involved in this growing challenge, said Ms Peggy Clarke as she and Ms Mullan posed key questions to the panel. The last year has seen a "tectonic shift" in how countries are viewing the problem and for the first time there seems to be a true alliance emerging between source and destination countries.

From Malawi came news that, in a country whose health system has been devastated in great part by the loss of health professionals, steps have been initiated with the help of DFID and Norway to improve working conditions and stem the flow. Quality housing is being built for doctors and nurses, and schools are being provided for their children.

"by monitoring flows it has been possible to evaluate and protect"

The example of the Philippines, which is one of the most important source countries for doctors and nurses, offers a baseline from which to work. Ms Patricia Santo Tomas described some of the many steps that have been taken over the years by the Philippines based on their growing experience and in response to the many risks as well as advantages health professionals face. Regulatory mechanisms have been put in place to protect those who move and those who stay, but most important of all is the fact that by regulating and monitoring flows, the Philippines has been able to evaluate and serve all the stakeholders in ways that are ethical, rational and in keeping with national and international realities.

From the Norwegian delegate, Dr Bjørn-Inge Larsen, came the pointed question of what does "self-sufficiency" in health resources management really mean. Does it only mean expanding national training to meet predicted needs or does it mean also working with potential sending countries in ways that are evidence-based and fair to all partners?

Ms Peggy Clark

"a Global Code should not obviate bilateral and regional initiatives"

In summing up the debate, Dr Tshabalala-Msimang pleaded for concerted action in what is a massive challenge, but she also declared that she hoped a global code would not obviate the many bilateral and regional approaches that are also needed in her region and elsewhere. This is especially true given that many stakeholder governments have already begun to discuss the need for better cooperation and assistance, and where the traditional historical links between some of the countries concerned are being used to forge creative alliances.

Dr Marc Danzon presented the conclusions of the debate to Mrs Mary Robinson, and highlighted what he saw as the critical elements that had emerged in the debate. The first and most important theme he said is that we must be guided by ethical principles and, unless we accept this, there will continue to be chaos and dangerous imbalances. At the same time, there must be respect for the human rights of all people and for the right to move and seek a better life if necessary.

"the aggressive recruitment of doctors and nurses from countries that can ill afford to lose them cannot be accepted"

Dr Danzon carried on by stating that there must also be a fundamental respect of the people who move. Their rights in destination countries have to be protected and vigilance must be exercised to ensure that they are not exploited and made second class citizens in the evolving global health care marketplace. At the same time, he argued that aggressive recruitment of doctors and nurses from countries that can ill afford to lose them cannot be accepted. It will lead to a worsening of the situation in source countries and will create global imbalances in health that will become irreparable.

"global solidarity must become both our goal and one of our central planning principles"

In all of this, Dr Danzon continued, good stewardship by governments is essential. They must assume greater responsibility and become true partners in a process that cannot be turned back but only improved. Among other things, the planning of health systems and services calls for improvement and, in addition, new approaches to both national and international health development need to be identified, hopefully through multilateral mechanisms. Only through the principle of global solidarity will our goal of equity in health be attainable.

In responding to Dr Danzon and Dr Tshabalala-Msimang, Mrs Mary Robinson thanked the WHO Regional Office for Europe for an extraordinary and highly productive event. As we enter the 21st century, she observed, the right to health must be given teeth and cease being a platitude. The right to health means having access to quality care and we must all work together to achieving this goal as soon and as effectively as possible. In doing so, we must look back and learn from the many mistakes and neglected issues that have brought us to where we are today with its unacceptable inequities in health and health care. We must insist on accountability for the past as well as for the future, but it is to the future that we must look with a new vision and commitment.

Annex 1

WHA57.19 International migration of health personnel: a challenge for health systems in developing countries

The Fifty-seventh World Health Assembly,

Recalling United Nations General Assembly resolution 2417 (XXIII) of 17 December 1968;

Recalling United Nations General Assembly resolution 58/208 on International migration and development, and the decision therein that, in 2006, the General Assembly will devote a high-level dialogue to international migration and development;

Further recalling resolutions WHA22.51 (1969) and WHA25.42 (1972);

Noting that the African Union declared 2004 "Year for Development of Human Resources in Africa";

Taking note of the Commonwealth Code of Practice for the International Recruitment of Health Workers, which was adopted at the meeting of Commonwealth health ministers (Geneva, 18 May 2003);

Noting the work in progress on international labour migration in the International Organization for Migration, the Global Commission on International Migration, and in other international bodies;

Recognizing the importance of human resources in strengthening health systems and in successful realization of the internationally agreed goals contained in the United Nations Millennium Declaration;

Noting with concern that highly trained and skilled health personnel from the developing countries continue to emigrate at an increasing rate to certain countries, which weakens health systems in the countries of origin;

Being aware of the work undertaken in United Nations organizations and in other international organizations with a view to strengthening the capacity of governments to manage migration flows at national and regional levels, and the need for further action to address, at both national and international levels, as an integrated part of the Sector Wide Approaches and other development plans, the issue of migration of trained health-care personnel;

Noting further that many developing countries are not yet technically equipped to assess adequately the magnitude and characteristics of the outflow of their health personnel;

Recognizing the significant efforts and investment made by developing countries in training and development of human resources for health;

Further recognizing the efforts made to reverse the migration of health personnel from developing countries and aware of the need to increase these efforts;

Concerned that HIV/AIDS, tuberculosis, malaria and other such communicable diseases are placing additional burdens on the health workforce;

1. URGES Member States:

(1) to develop strategies to mitigate the adverse effects of migration of health personnel andminimize its negative impact on health systems;

(2) to frame and implement policies and strategies that could enhance effective retention of health personnel including, but not limited to, strengthening of human resources for healthplanning and management, and review of salaries and implementation of incentive schemes;

(3) to use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration;

(4) to establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin;

2. REQUESTS the Director-General:

(1) to establish and maintain, in collaboration with relevant countries, institutions or organizations, information systems which will enable the appropriate international bodies to monitor independently the movement of human resources for health;

(2) in cooperation with international organizations within their respective mandates, including the World Trade Organization, to conduct research on international migration of health personnel, including in relation to trade agreements and remittances, in order to determine any adverse effects and possible options to address them;

(3) to explore additional measures that might assist in developing fair practices in the international recruitment of health personnel, including the feasibility, cost and appropriateness of an international instrument;

(4) to support Member States in strengthening their planning mechanisms and processes in order to provide for adequate training of personnel to match their needs;

(5) to develop, in consultation with Member States and all relevant partners, including development agencies, a code of practice on the international recruitment of health personnel, especially from developing countries, and to report on progress to the Fifty-eighth World Health Assembly;

(6) to support efforts of countries by facilitating dialogue and raising awareness at the highest national and international levels and between stakeholders about migration of health personnel and its effects, including examination of modalities for receiving countries to offset the loss of health workers, such as investing in training of health professionals;

(7) to mobilize all relevant programme areas within WHO, in collaboration with Member States, in order to develop human-resources capability and to improve health support to developing countries by setting up appropriate mechanisms;

(8) to consult with the United Nations and specialized agencies on the possibility of declaring a year or a decade of "Human Resources for Health Development";

(9) to declare the theme of World Health Day 2006 to be "Human Resources for Health Development";

(10) to include human resources for health development as a top-priority programme area in WHO's General Programme of Work 2006–2015;

(11) to report on implementation of this resolution to the Fifty-eighth World Health Assembly.

(Eighth plenary meeting, 22 May 2004 – Committee A, third report)

Annex 2

WHA58.17 International migration of health personnel: a challenge for health systems in developing countries

The Fifty-eighth World Health Assembly,

Having examined the report on international migration of health personnel: a challenge for health systems in developing countries;1

Concerned that migration and recruitment of health personnel, particularly highly trained and skilled health personnel, from developing to developed countries continue to be a major challenge for health systems in developing countries;

Recalling the requests directed to the Director-General in resolution WHA57.19, and noting with satisfaction that the Director-General has taken steps to address some of them;

Noting that there are additional areas related to international migration of health personnel, within the context of resolution WHA57.19 that require further attention by the Director-General;

Bearing in mind the high-level debate to be held at the United Nations General Assembly in 2006 on international migration,

1. EXPRESSES GRATITUDE to the Director-General for the steps he has taken to implement some of the requests directed to him in resolution WHA57.19;

2. REQUESTS the Director-General:
(1) to intensify his efforts to implement fully resolution WHA57.19;
(2) to strengthen WHO's programme on human resources for health by allocating to it adequate resources, in particular financial and human resources;
(3) to report on implementation of this resolution to the Fifty-ninth World Health Assembly;

3. DECIDES to include, as a substantive item on the agenda of the Fifty-ninth World Health Assembly, "International migration of health personnel: a challenge for health systems in developing countries".

(Ninth plenary meeting, 25 May 2005 –Committee B, second report)

Annex 3

EUR/RC57/R1
Health workforce policies in the European Region

The Regional Committee,

Recalling World Health Assembly resolutions WHA57.19 and WHA58.17 on the international migration of health personnel: a challenge for health systems in developing countries that urged Member States and requested WHO to develop strategies to mitigate the adverse effects of the migration of health personnel in order to minimize its negative impacts on health systems; and resolutions WHA59.23 on the rapid scaling up of health workforce production that urged Member States and requested WHO to facilitate the activities to scale up the production of a competent health workforce in countries; and WHA59.27 on the strengthening of nursing and midwifery that urged and requested Member States and WHO to establish comprehensive programmes for the development of a highly skilled and motivated nursing and midwifery workforce;

Recalling also its resolutions EUR/RC50/R5 and EUR/RC55/R8 on cooperation with countries and strengthening European health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs" that urged Member States to ensure that appropriate attention is paid to the quality and skills of human resources;

Acknowledging that educated and well-trained health workers save lives, that the functioning of health systems depends on the availability, efforts and skill mix of the workforce and relies on their knowledge, skills and motivation;

Recognizing the crucial importance of human resources in strengthening health systems, managing and delivering health services, and ensuring the quality of their performance;

Recognizing that the health workforce should be appropriate to people's health needs and that social, demographic, epidemiological and economic circumstances remain a challenge for the attainment of health for all;

Recognizing the diversities that exist in the composition, distribution and dynamics of the health workforce within and between countries in the Region; and the influence of ageing of both the population and the health workforce, and of technological innovations and environmental changes on health workers;

Noting with concern the geographical and skill-mix imbalances in the health workforce and the increased migration of health workers in the Region;

Having considered document EUR/RC57/9 on Health workforce policies in the WHO European Region;

1. ENDORSES the recommendations contained in the report;
2. URGES Member States:

(a) to improve and expand the information and knowledge base on the health workforce at country level, where appropriate in order to strengthen information systems, encourage research and build capacities in policy analysis, planning and implementation related to human resources for health;

(b) to develop, embed and mainstream policies concerning human resources for health as a component of health systems development, and to take responsibility for the development of human resources plans and strategies relevant to the needs of the country including a balanced distribution of the workforce within countries, ensuring their implementation;

(c) to assess the trends in and impact of health workforce migration in order to identify and act on effective migration-related policy options, including establishing agreements with other countries to address the movement of health

workers, based on the principles of transparency, ethics, fairness and mutual benefits;
(d) to orient, where appropriate, workforce planning towards achievement of health for all, in primary health care as a first step;

3. REQUESTS the Regional Director:

(a) to cooperate with and support Member States in their efforts to improve their health workforce;

(b) to continue to build and support capacities in health workforce policy development, planning and management at national level and in the WHO European Region as a whole, and to facilitate and promote the harmonization of health workforce data and the use of standard indicators and tools to improve quality and comparability;

(c) to develop a core set of health workforce indicators to be used for monitoring and evaluation of the current situation and trends at national and WHO European regional levels, and to facilitate the exchange of knowledge, information, experience and evidence in effective health workforce development and management among Member States and partners;

(d) to develop recommendations to set up systems for stimulating and motivating the health workforce to work in remote and rural areas, as well as mechanisms for professional development;

(e) to give high priority to monitoring health worker migration and policy interventions at national and international levels through the continuing analysis of country reports and the publication of annual regional syntheses of those reports;

(f) to facilitate the development of an ethical guide/framework for international recruitment of health workers into and within the European Region;

(g) to ensure that the health workforce remains a priority of the WHO Regional Office for Europe, in the context of strengthening health systems, and to mobilize resources to support countries in the area of health workforce development, in line with the WHO Medium-term strategic plan;

(h) to continue building and strengthening networks and partnerships that contribute to establishing sustainable human resources for health in the Region, and to advocate with national stakeholders, development partners, international agencies, donors and all relevant programmes within WHO that more effective investment should be made in health workforce development and better resource coordination;

(i) to put health workforce policies on the agenda of the WHO European Ministerial Conference on Health Systems in 2008;

(j) to report back to the Regional Committee at its fifty-ninth session in 2009 on the progress made.

Annex 4

Health Workers for All and All for Health Workers

The Kampala Declaration and Agenda for Global Action

Declaration

We, the participants at the first Global Forum on Human Resources for Health in Kampala, 2-7 March 2008, and representing a diverse group of governments, multilateral, bilateral and academic institutions, civil society, the private sector, and health workers' professional associations and unions;

Recognizing the devastating impact that HIV/AIDS has on health systems and the health workforce, which has compounded the effects of the already heavy global burden of communicable and non-communicable diseases, accidents and injuries and other health problems, and delayed progress in achieving the health-related Millennium Development Goals.

Recognizing that in addition to the effective health system, there are other determinants to health;

Acknowledging that the enjoyment of the highest attainable standard of health is one of the fundamental human rights;

Further recognizing the need for immediate action to resolve the accelerating crisis in the global health workforce, including the global shortage of over 4 millions health workers needed to deliver essential health care;

Aware that we are building on existing commitments made by global and national leaders to address this crisis, and desirous and committed to see immediate and urgent actions taken;

Now call upon:

1. Government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing political momentum to the process.

2. Leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans.

3. Governments to determine the appropriate health workforce skill mix and to institute coordinated policies, including through public private partnerships, for an immediate, massive scale-up of community and mid-level health workers, while also addressing the need for more highly trained and specialized staff, .

4. Governments to devise rigorous accreditation systems for health worker education and training, complemented by stringent regulatory frameworks developed in close cooperation with health workers and their professional organizations.

5. Governments, civil society, private sector, and professional organizations to strengthen leadership and management capacity at all levels.

6. Governments to assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workforce.

7. While acknowledging that migration of health workers is a reality and has both positive and negative impact, countries to put appropriate mechanisms in place to shape the health workforce market in favour of retention. The World Health Organization will accelerate negotiations for a code of practice on the international recruitment of health personnel.

8. All countries will work collectively to address current and anticipated global health workforce shortages. Richer countries will give high priority and adequate funding to train and recruit sufficient health personnel from within their own country.

9. Governments to increase their own financing of the health workforce, with international institutions relaxing the macro-economic constraints on their doing so.

10. Multilateral and bilateral development partners to provide dependable, sustained and adequate financial support and immediately to fulfil existing pledges concerning health and development.

11. Countries to create health workforce information systems, to improve research and to develop capacity for data management in order to institutionalize evidence-based decision-making and enhance shared learning.

12. The Global Health Workforce Alliance to monitor the implementation of this Kampala Declaration and Agenda for Global Action and to re-convene this Forum in two years' time to report and evaluate progress.

Annex 5

Health Workers for All and All for Health Workers[1]

An Agenda for Global Action, chapter 5

Managing the pressures of the international health workforce market and its impact on migration
Poorer countries are most affected by the loss of their already scarce health workforce to countries with better conditions and higher salaries. There are increasingly competitive, cross-border pressures in the health sector. These include the growing demand from national health systems in rich countries as well as the growing trade and private commercial investment in health services. In these circumstances, there is a need to find ways to stabilize the health workforce market and reduce the negative impacts of the high mobility of health professionals, thereby improving retention.

Individuals have the right to leave any country, including their own[1], in search of better opportunities, but health workers trained with public resources have obligations as defined by individual countries.

1.1. Governments will monitor health workforce flows in and out of countries, making such data transparently available and using this information to inform policy and management decisions.

1.2. The World Health Organization will accelerate negotiations for a code of practice on the international recruitment of health workers. This code should be a tool used by countries, regions and health professionals to negotiate agreements. Consistent with the agreed code of practice, destination countries should commit to supporting and enhancing the education and training of health workers both at home and in source countries. Actions should also be taken to realize the untapped potential of the health worker diasporas for improving health services in source countries.

1.3. All countries will work collectively to address current and anticipated global health workforce shortages. Richer countries will give high priority and adequate funding to train and recruit sufficient health personnel from within their own country.

1.4. National governments will be supported to develop coherent policies and build capacity to analyse the implications of trade agreements on the mobility of the health workforce. This effort will be informed by stakeholder consultation mechanisms within and outside government.

1.5. Stakeholders will test and evaluate innovative interventions in the international health workforce market to assist retention.

1 Full text of the Agenda for Action (http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf).

2 Article 13, Universal Declaration of Human Rights, 1948.