Lecture: Health Worker Migration

Global Health BSc

3 November 2011

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Learning outcomes

By the end of this session you will be able to:

- outline the factors leading to attrition of health workers in the public sector and their migration from poorer to richer countries
- demonstrate an awareness of the variety of data sources on health worker density
- recognise the importance of health human resources in a context of inter-national and national inequalities in access to health services
- be able to cite an example of active international recruitment of health workers
- discuss the feasibility of preventing health worker migration
- outline some of the proposed strategies to prevent or mitigate the health worker crises
- demonstrate the relevance of health worker migration for HIV/AIDS

Outline

- What is the evidence?
  - How do we count health workers?
  - How do we evaluate HWM?
- Effects of HWM in origin countries:
  - Potentials: the example of remittances
  - Risks: impact on quality of health services
- Why is it happening?
  - Push factors
  - Pull factors
- Some policy solutions
- HWM and the case of HIV/AIDS pandemic

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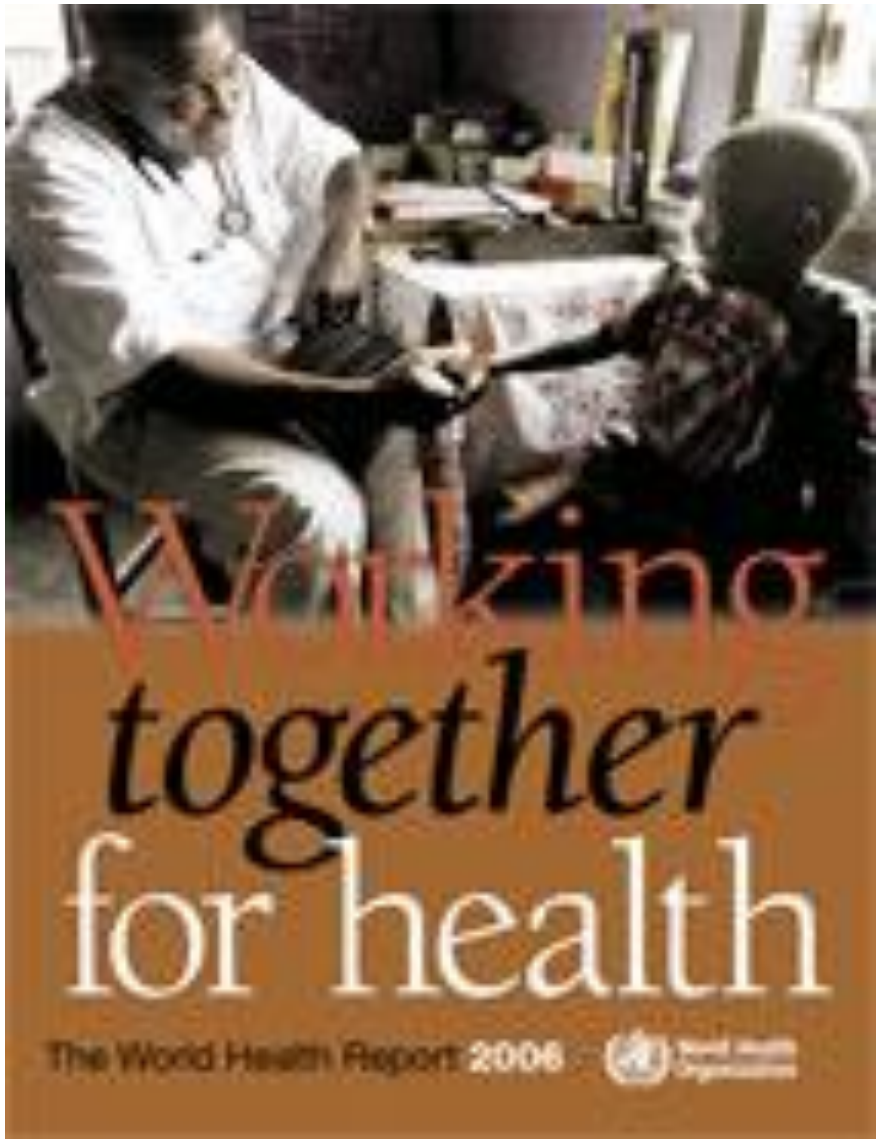
Who Are Health Workers?

"all people engaged in the promotion, protection or improvement of the health of the population"

Adams et al., 2003: 276; Diallo et al., 2003

Counting Health Professionals

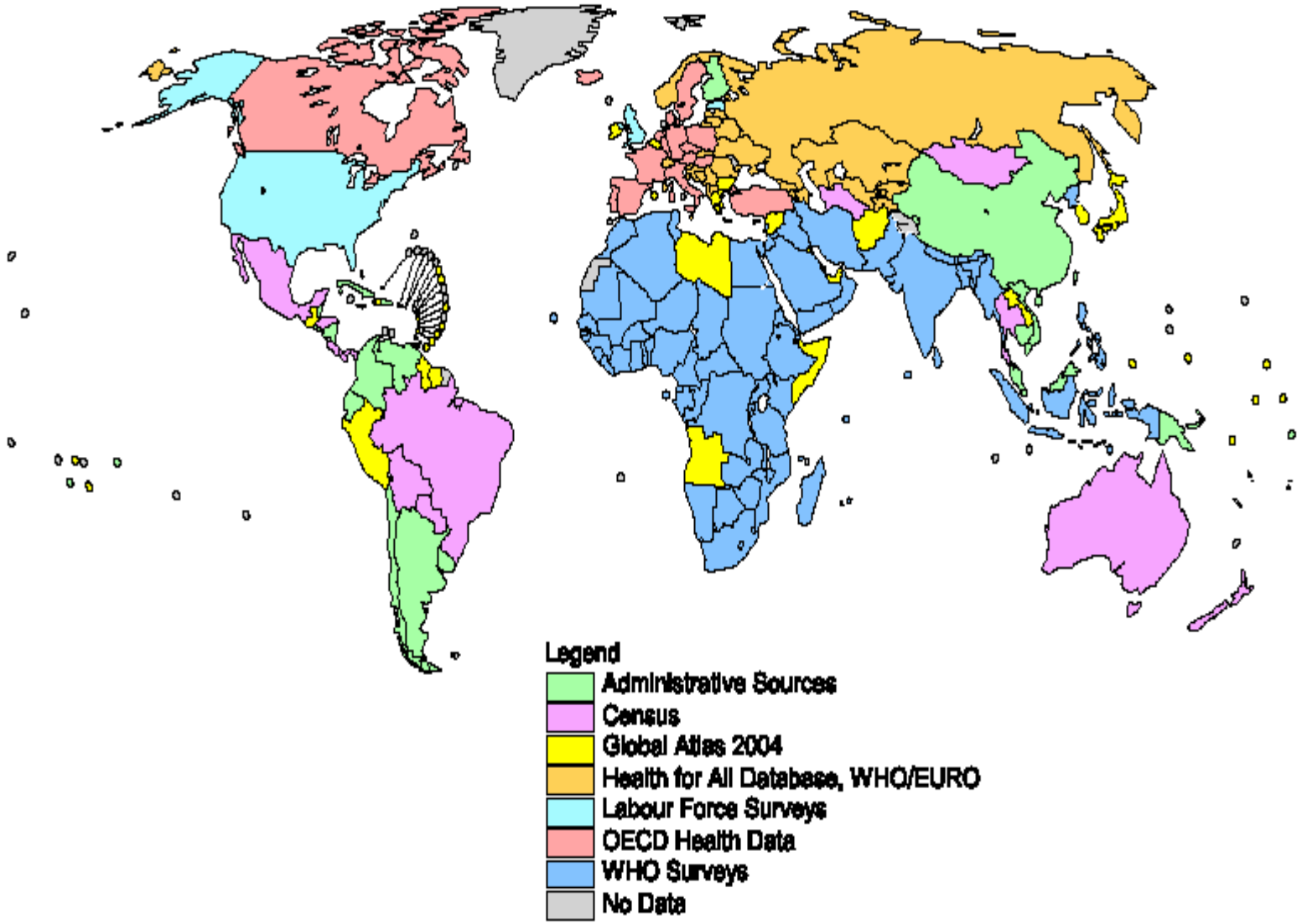


The World Health Report 2006

"Working Together For Health"

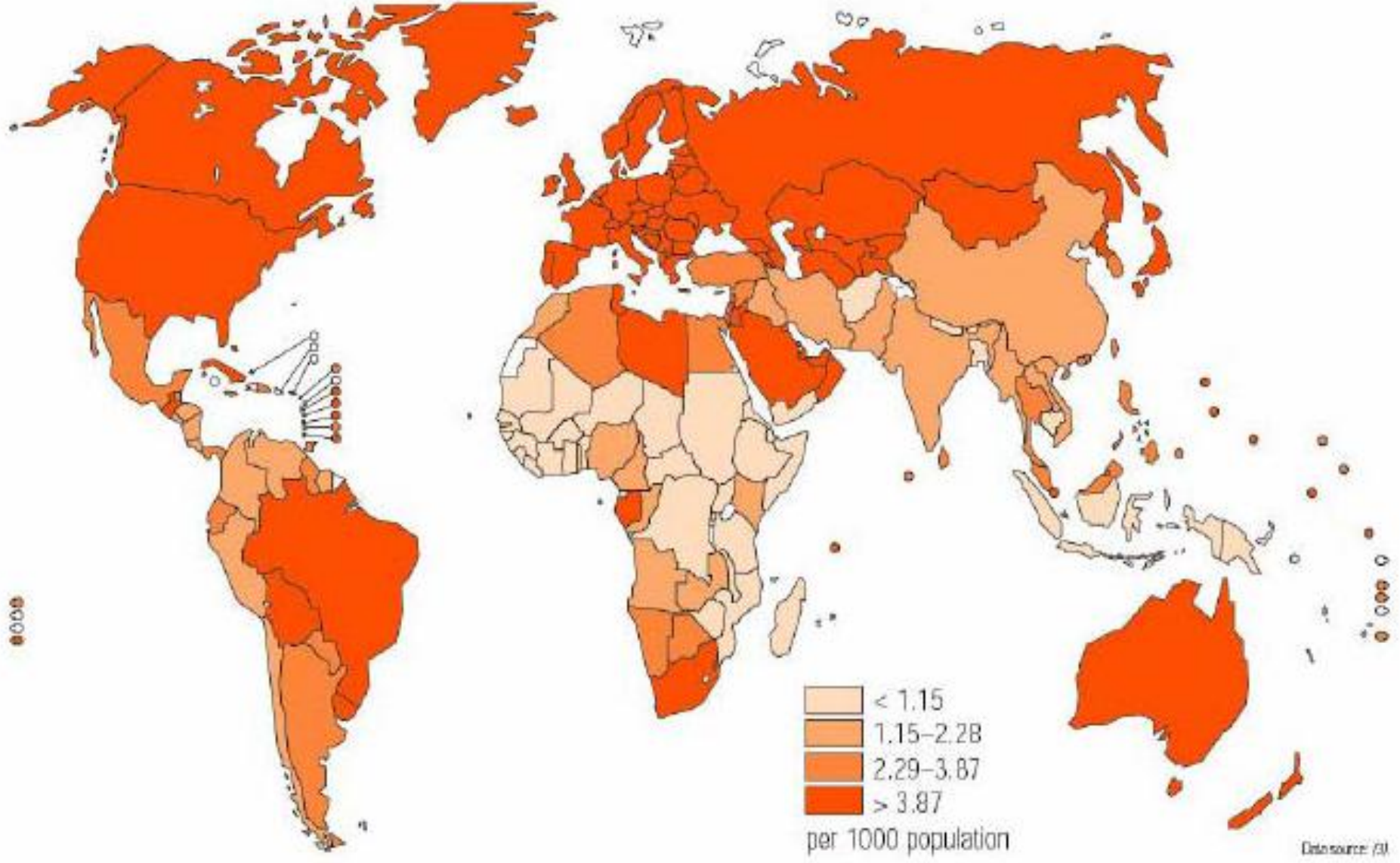
How reliable are our estimates?

Sources of the global health workforce database



Countries with lowest relative need have highest numbers of health workers

Density of health care providers (doctors, nurses and midwives)



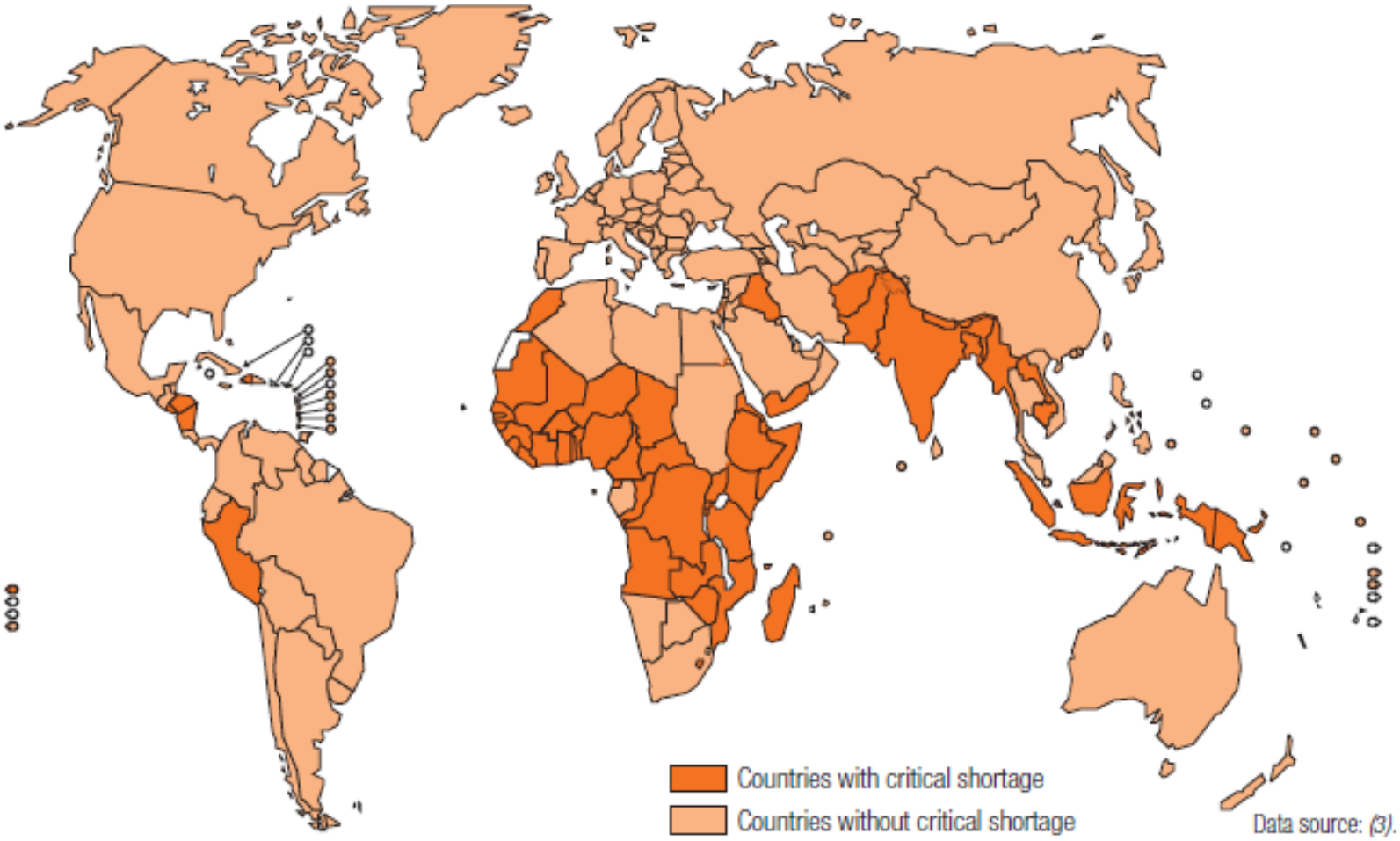
“Critical Shortage”

57 countries had critical shortage of HWs

- Defined as:
  - Density < 2.5 health care providers (doctors, nurses & midwives) /10,000 population
- Many countries failed to meet:
  - 80% skilled attendance at delivery
  - measles coverage
- Gap:
  - Estimated 2.4 m extra doctors, nurses and midwives needed globally to meet the coverage rates (4.3 m more if we estimate for **all** health service providers)

Map of countries

Countries with a critical shortage of health service providers (doctors, nurses and midwives)



Shortages of HW

WHO region	Number of countries		In countries with shortages		
	Total	With shortages	Total stock	Estimated shortage	Percentage increase required
Africa	46	36	590 198	817 992	139
Americas	35	5	93 603	37 886	40
South-East Asia	11	6	2 332 054	1 164 001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312 613	306 031	98
Western Pacific	27	3	27 260	32 560	119
World	**192**	**57**	**3 355 728**	**2 358 470**	**70**

Estimated critical shortages of doctors, nurses and midwives, by WHO region (WHR 2006)

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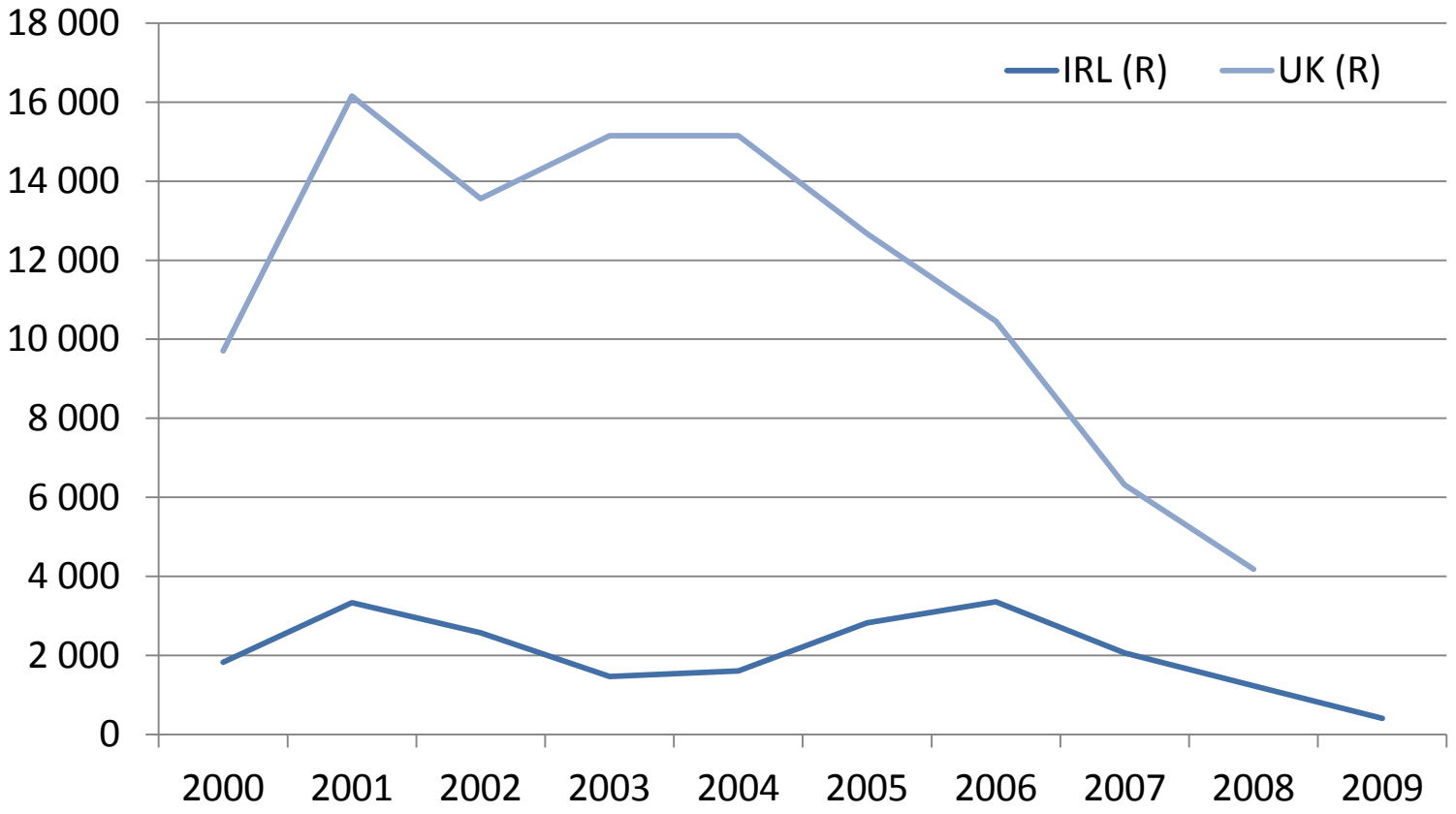
Movements of HW

- Rural to urban
- Public to private (including NGO sector)
- Between countries:
  - Least developed to developing /developed country
  - Developing country to developed country
  - Developed to developed countries

HW stock in OECD countries

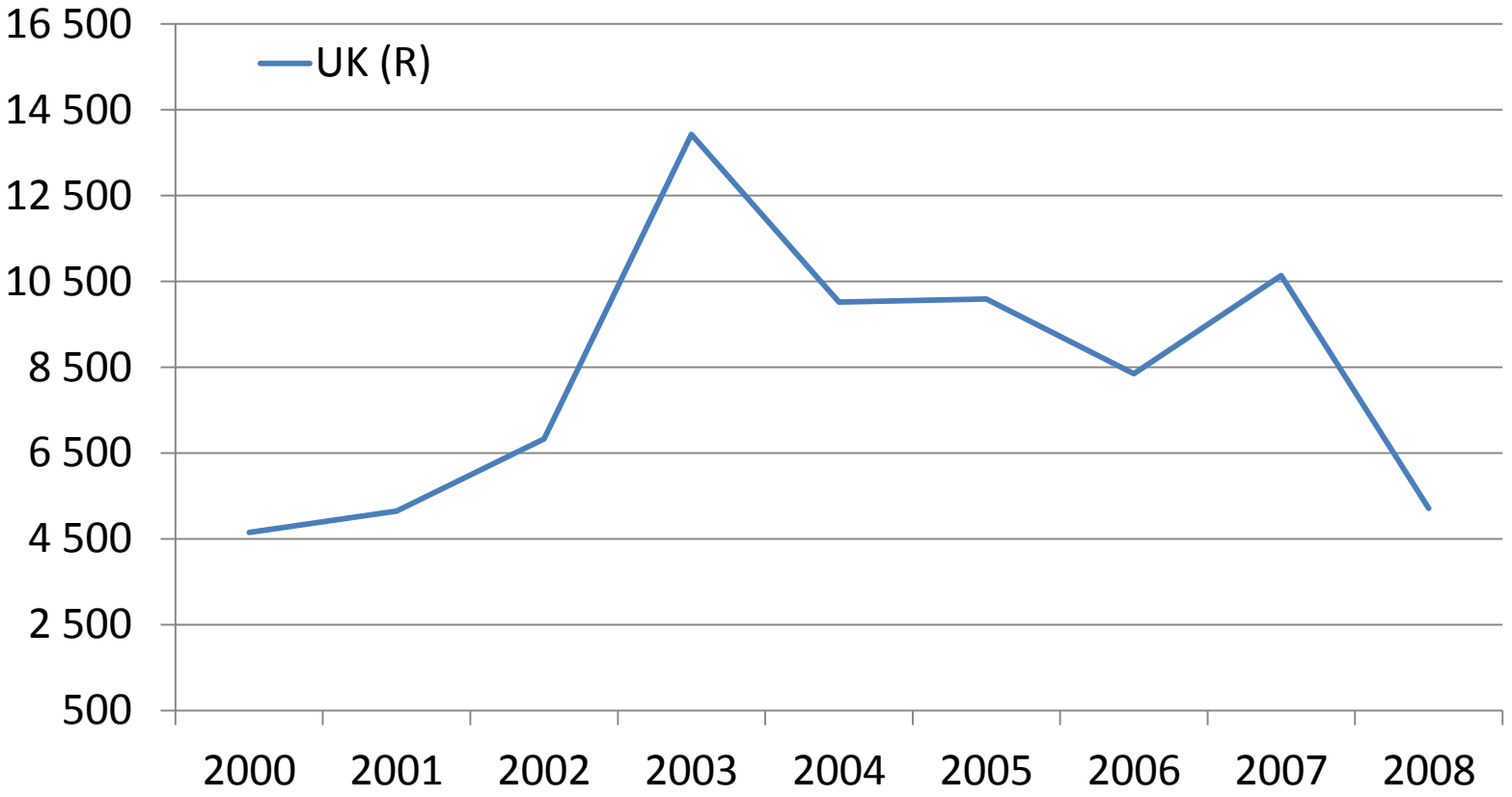
- 1970s and 1980s: prolonged growth in physician and nurse density in response to increased demand
- Early 1990s: Cost-containment policies and slower growth
- 2000s: shortages of doctors and nurses – efforts to increase national training

HWM to the UK - nurses



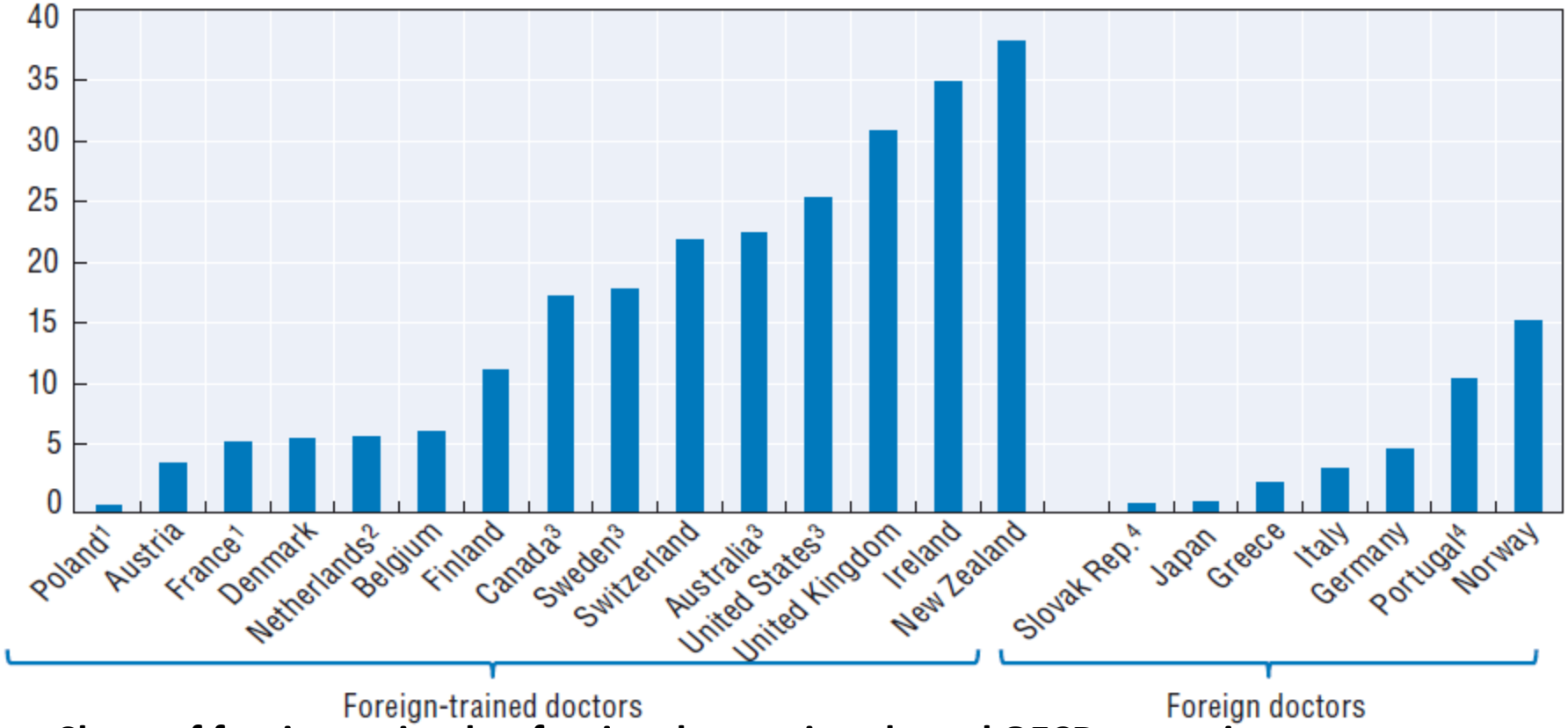
Migration flows of nurses to selected OECD countries, 2000-2009 :UK and Ireland
Available at: www.oecd.org/health/workforce

HWM to the UK - Drs



Migration flows of doctors to selected OECD countries, 2000-2008

Foreign-trained or foreign doctors in selected OECD countries



Share of foreign-trained or foreign doctors in selected OECD countries in 2008 (or latest year available) Percentage. 1. 2005. 2. 2006. 3. 2007. 4. 2004. Source: www.oecd.org/health/workforce.

Doctors trained in sub-Saharan Africa working in OECD countries

Source country		Doctors working in eight OECD recipient countries[a]	
	Total doctors in home country	Number	Percentage of home country workforce
Angola	881	168	19
Cameroon	3 124	109	3
Ethiopia	1 936	335	17
Ghana	3 240	926	29
Mozambique	514	22	4
Nigeria	34 923	4 261	12
South Africa	32 973	12 136	37
Uganda	1 918	316	16
United Republic of Tanzania	822	46	6
Zimbabwe	2 086	237	11
Total	82 417	18 556	Average 23

a. Recipient countries: Australia, Canada, Finland, France, Germany, Portugal, United Kingdom, United States of America. **WHR 2006**

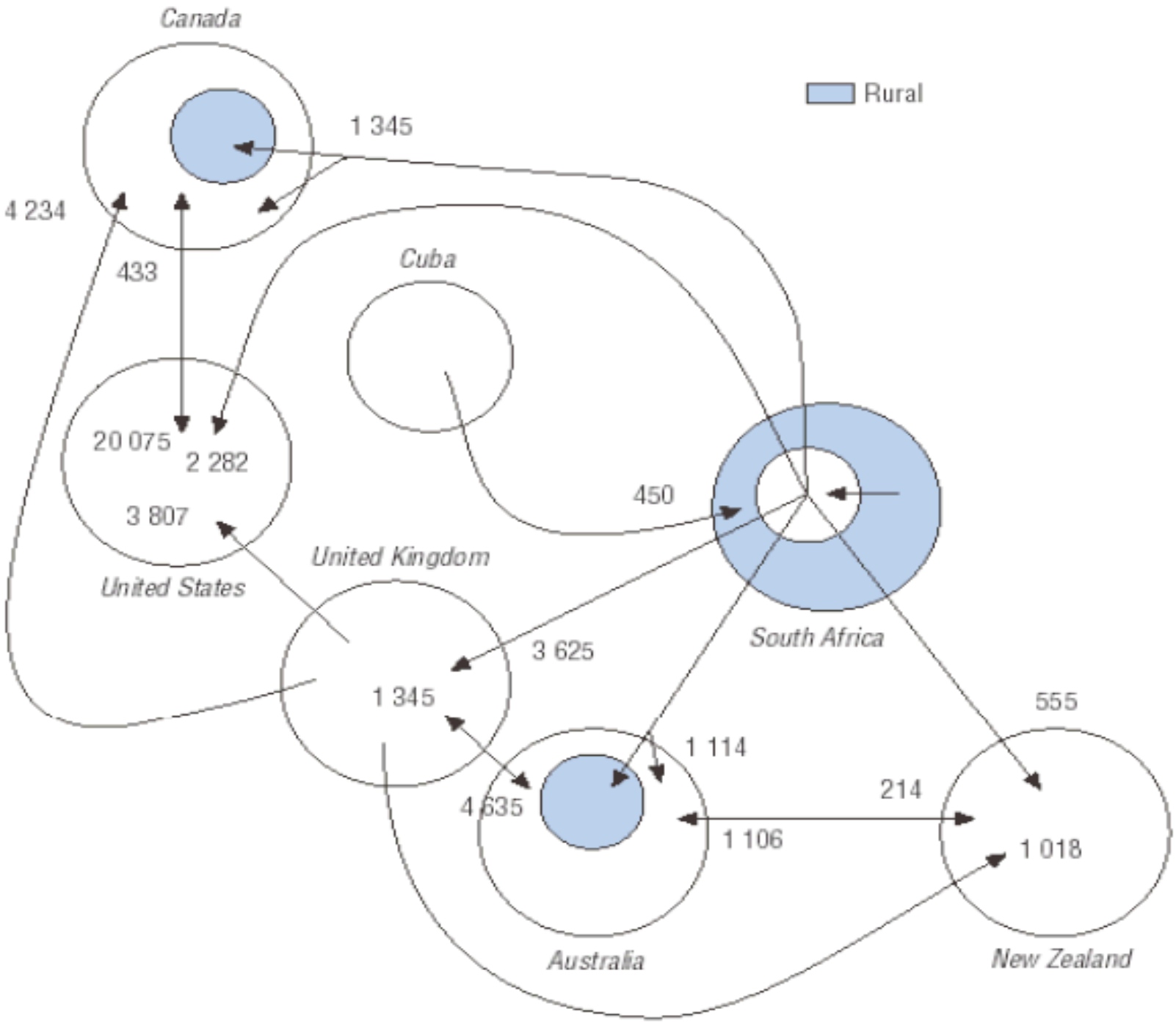
Table 5.3 Nurses and midwives trained in sub-Saharan Africa working in OECD countries

Source country	Total nurses and midwives working in home country	Nurses and midwives working in seven OECD recipient countries[a]	
		Number	Percentage of home country workforce
Angola	13 627	105	0
Botswana	7 747	572	7
Cameroon	26 032	84	0
Ethiopia	20 763	195	0
Ghana	17 322	2 267	13
Guinea-Bissau	3 203	30	0
Kenya	37 113	1 213	3
Lesotho	1 123	200	18
Malawi	11 022	453	4
Mauritius	4 438	781	18
Mozambique	6 183	34	0
Namibia	6 145	54	0
Nigeria	210 306	5 375	3
South Africa	184 459	13 496	7
Swaziland	4 590	299	7
Uganda	17 472	21	0
United Republic of Tanzania	13 292	37	0
Zambia	22 010	1 198	5
Zimbabwe	9 357	3 183	34
Total	616 204	29 597	Average 5

[a] Recipient countries: Canada, Denmark, Finland, Ireland, Portugal, United Kingdom, United States of America.

Note: Data compiled by WHO from various sources.

Are HWM metrics reliable?


Canada
Rural
1 345
4 234
433
Cuba
20 075
2 282
3 807
United States
450
United Kingdom
South Africa
3 625
1 345
555
1 114
214
4 635
1 106
1 018
Australia
New Zealand

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Effects of HWM

- **Costs of health worker migration**
  - Worse health outcomes?
  - 'beheading' of system
  - Extra pressure on others in the health systems
  - Creates further pressure for migration
- **Benefits of health worker migration**
  - remittances
  - circular migration may mean new skills are introduced into the system
  - puts pressure on government to respond to wage/health system reform demands
  - puts pressure on government to do more efficient substitution of skills

A potential Benefit of HWM: Financial Remittances

- difficult to estimate
- benefit may be smaller than costs to donor health system

Aluwihare, 2005

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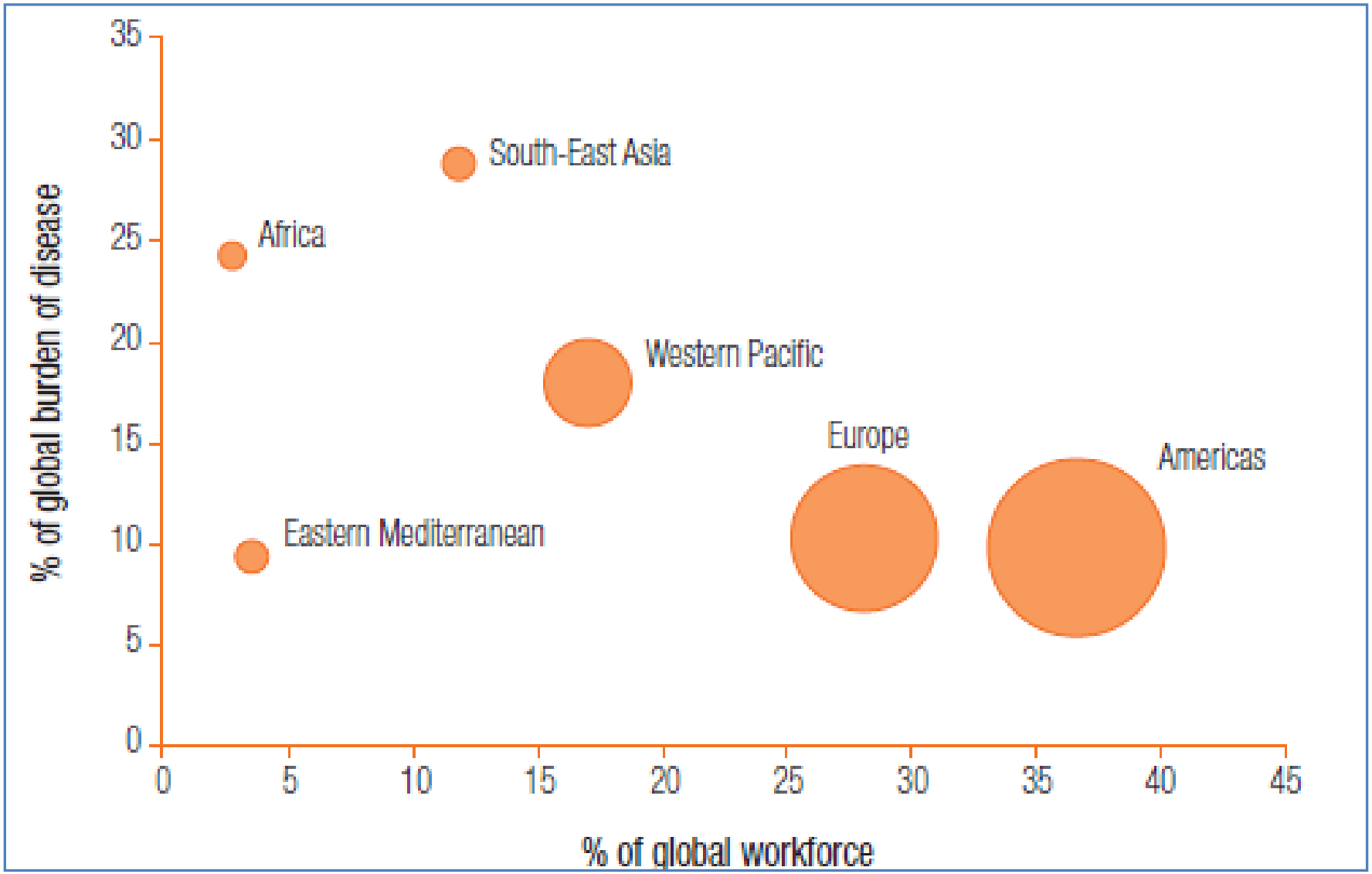
Global Inverse Care Law?

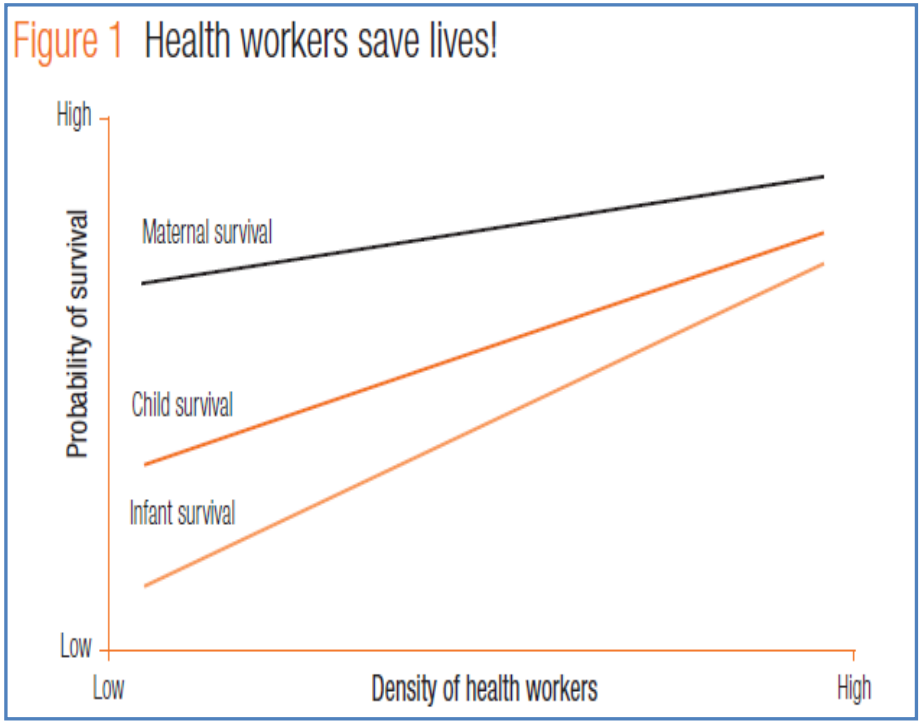
Health worker distribution by level of health expenditure and burden of disease, WHO regions



Effects of HWM towards OECD countries: types of origin countries

- Large origin countries (eg. China, Russia):
  - small percentage of expatriation
- Smaller countries with a policy to train HWs and export them (e.g. Philippines):
  - Maintaining high levels of HWs at home
- Smaller countries with >50% expatriation rates (small island states in Caribbean & Pacific and 5 African countries: Mozambique, Angola, Sierra Leone, United Republic of Tanzania and Liberia)

Two opposing views



Physician Density and Basic Health Indicators (WHR 2006)

"Children do not die in rural Mozambique primarily due to a lack of cardiologists and nurse practitioners; they die principally from lack of oral rehydration during diarrhea, lack of malaria prophylaxis, and lack of basic primary treatment for acute respiratory infections. None of these require highly trained personnel to deliver. ... why is it that no staffing or public health effects due to emigration per se are observable even across countries that have lost half or even two thirds of their health professionals to emigration?"

Clemens 2007:38

See also Anand and Baernighausen, 2003

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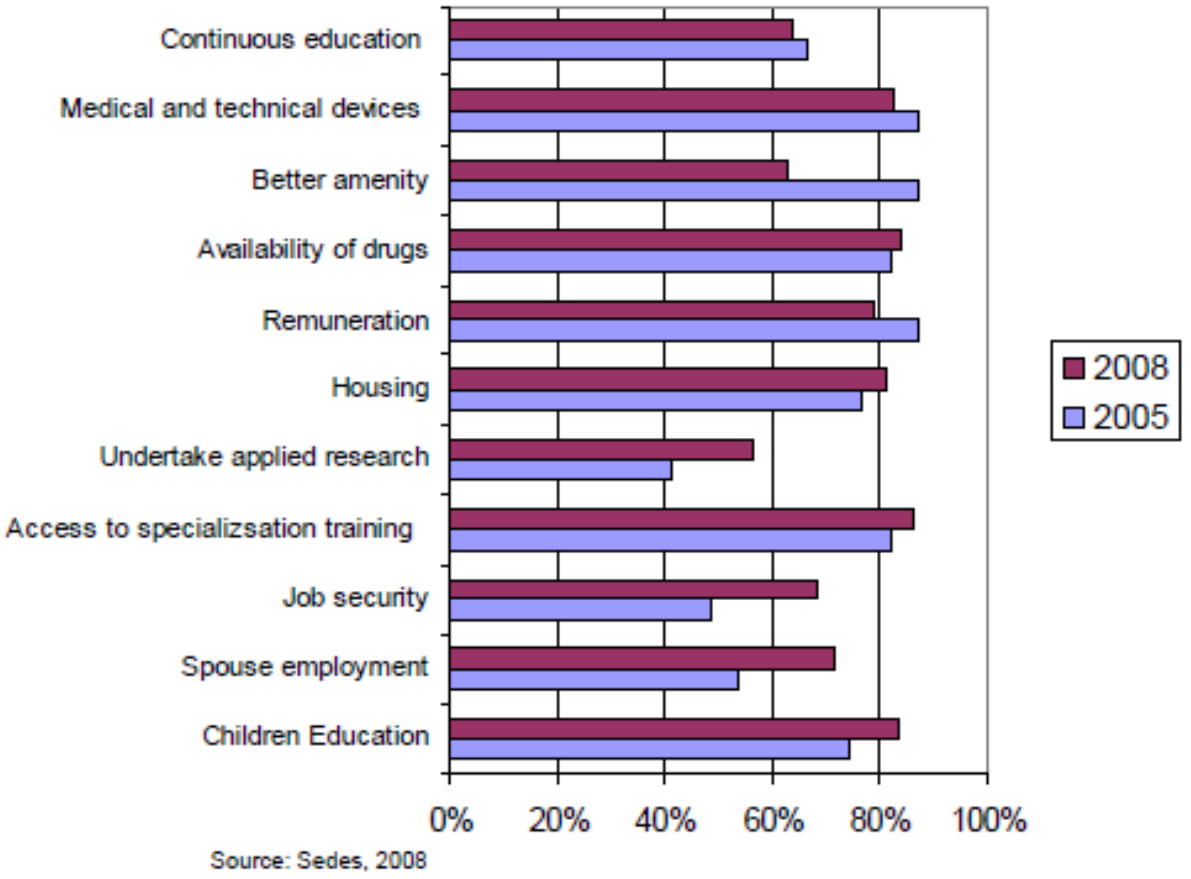
Factors related to decisions to relocate to stay or leave rural and remote areas

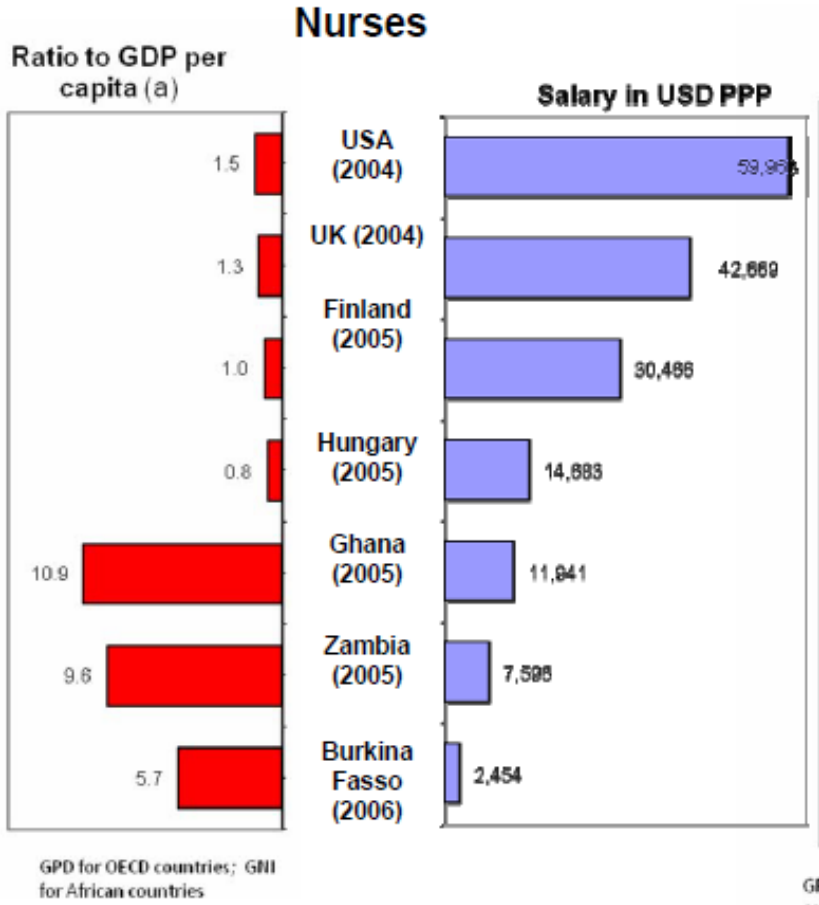
Factors affecting the decision to go to or stay in rural areas:

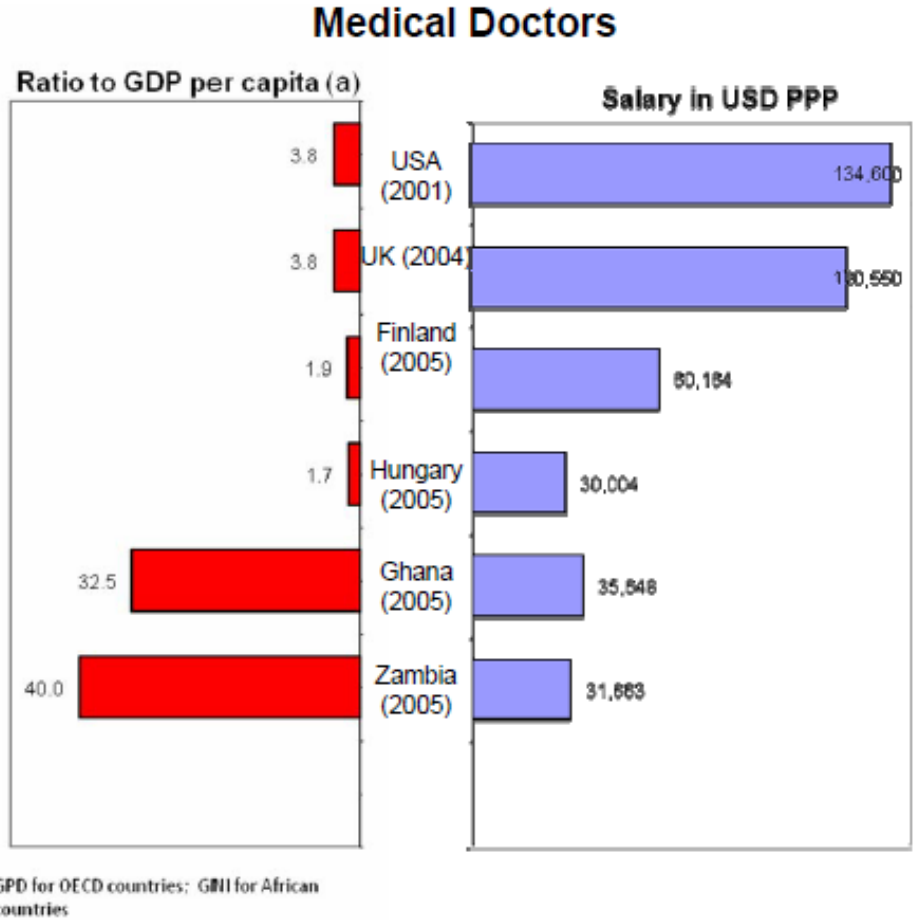
- Personal factors
- Professional environment
- Social and local environment



Working in rural areas in Niger: Health professionals expectations

Nurses and Doctors' salaries: OECD and African Countries: US Dollar Purchasing Power Parity comparison





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Pull factors
Decreasing barriers to migration

- cheaper air travel
- greater access to the internet enabling independent searching for job opportunities.
- proliferation of private recruitment firms facilitating the process of crossing borders

(see Mensah 2005 and Mensah et al 2005)

Pull factors?

Foreign doctors 'must be trained to work here': Watchdog steps in as fears over patient safety grows

By FIONA MACRAE

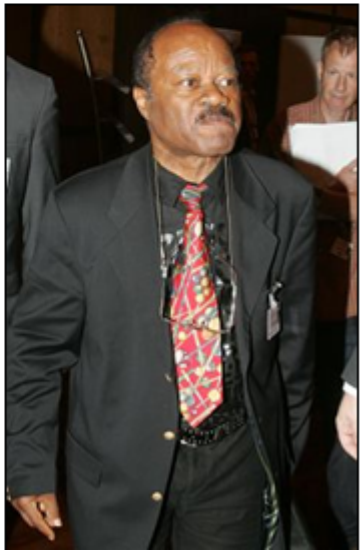
Last updated at 7:53 PM on 16th September 2011

Foreign doctors should complete a basic training course before starting to work for the NHS, the medical watchdog has ruled.

Many overseas doctors arrive with 'little or no preparation' for working in the UK and need more support to practise safely, said the General Medical Council.

It is to run induction courses for all doctors new to the Health Service, including graduates from British medical schools and those arriving from abroad – including the continent.

There is growing alarm that patient safety is being put in the hands of overseas doctors whose training is not up to scratch.



The case of the UK:
Active recruitment in early 2000

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- **Source countries**
  - address the push factors making health professionals leave
  - train more health workers
  - substitute skills: produce non-exportable workers
  - carry on exporting!
- **Destination countries**
  - aim for self-sufficiency
  - apply an ‘ethical recruitment’ policy
  - shut the door – deny visas and posts
  - give more aid for health systems to address push factors
  - compensate?
  - encourage collaborative links with source country health systems: allow circular migration; send your own doctors
  - carry on importing!

Solutions?

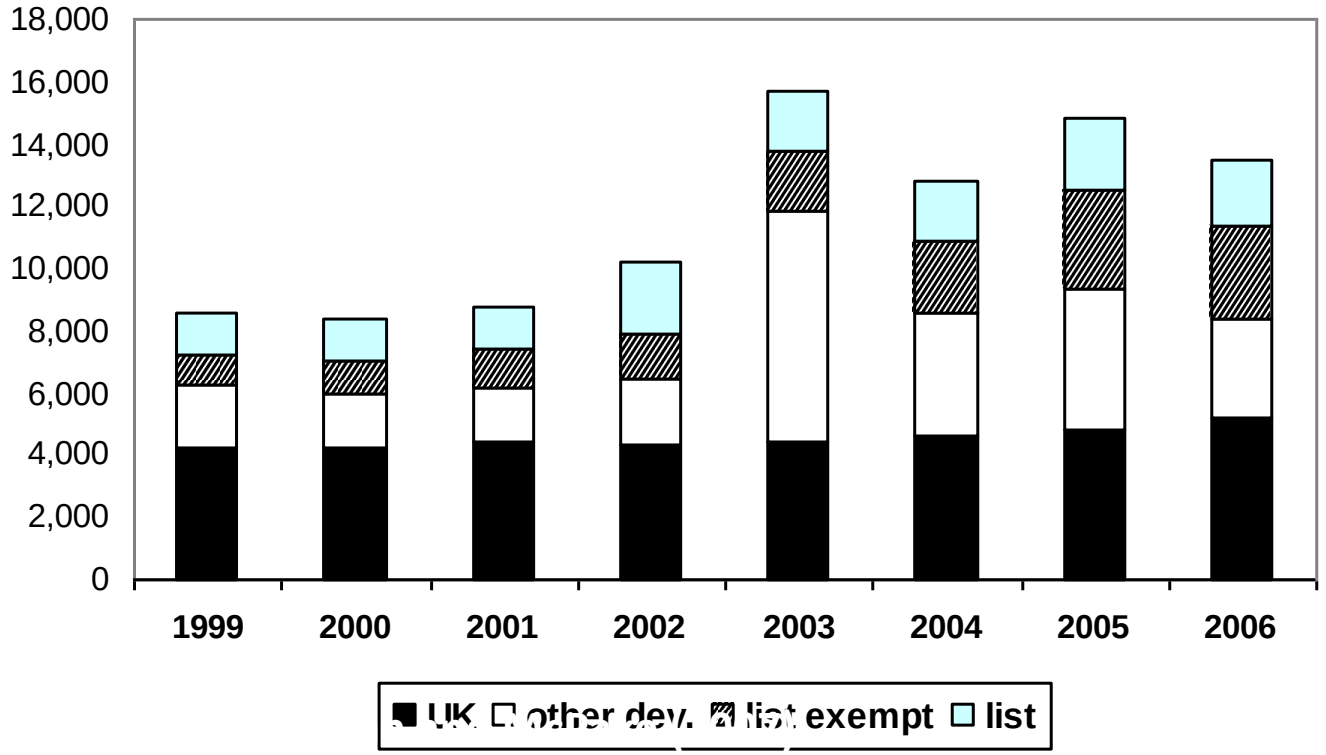
- Codes:
  - national (e.g. UK)
  - International (WHO)
- Financial retribution to country of origin
- Skills recirculation

International Policy Initiatives

Year	Policy Initiative
2001	**International Council of Nurses (ICN) expressed position statement on ethical recruitment**
2002	Public Service International (PSI) launched a campaign addressing the issues of ethical recruitment of health care workers
2002	Active positions expressed by Realising the Rights: the Ethical Global Initiative
2003	Commonwealth Secretariat initiated Code of Practice in international recruitment of health professionals
2004	World Health Assembly Resolution (WHA57.19) requested for code of practice on the international recruitment of health personnel
2005	World Health Assembly discussed the effects of the migration and promotion of fairer recruitment tactics
2005	International Labour Organisation (ILO) launched a programme: 'The International Migration of Health Service Workers: The Supply Side'
2006	International Organisation for Migration (IOM) organisers seminar on 'Migration and Human Resources for Health: From Awareness to Action'
2006	Establishment of the Global Health Workforce Alliance (GHWA)
2007	The Health Worker Migration Policy Initiative organised by Realizing Rights: the Ethical Globalization Initiative and GHWA
2009	Discussions of the Global Code of Practice initiated by the World Health Organisation
2001	**International Council of Nurses (ICN) expressed position statement on ethical recruitment**

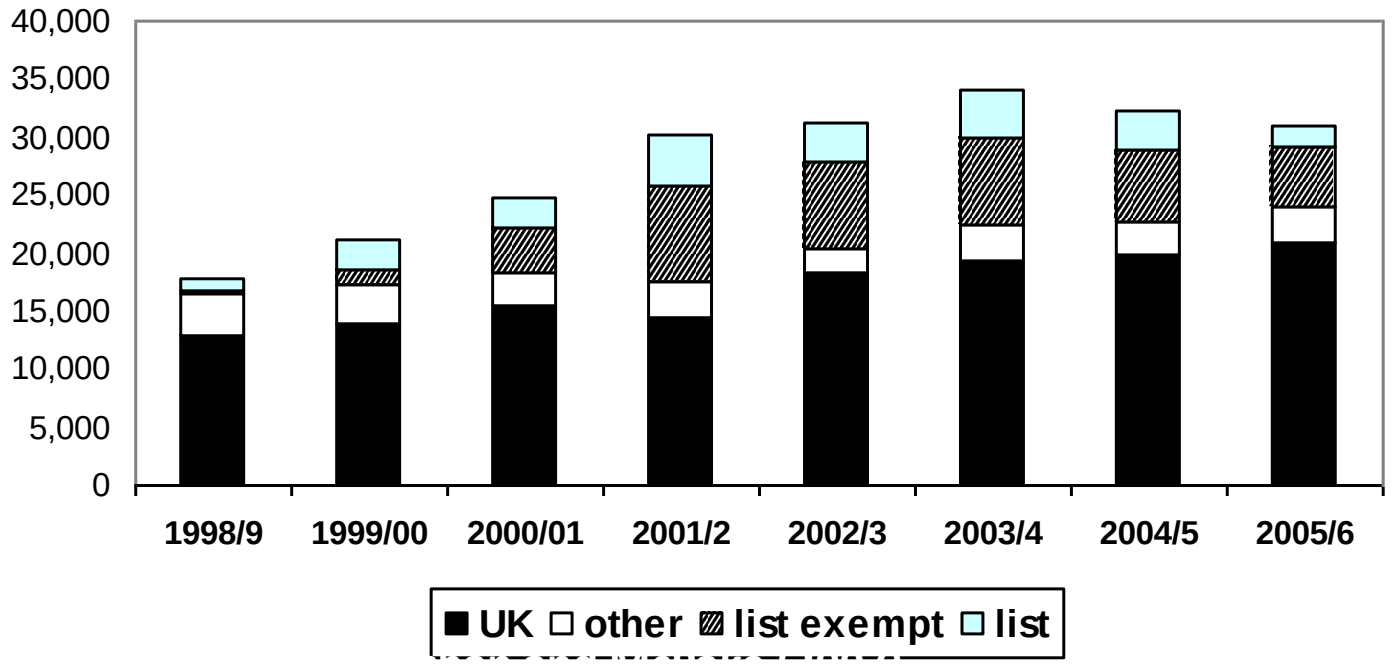
The UK response to HWM

Fig 1: Doctors: New GMC Full Registrants- from UK, other developed countries, list but exempt countries, and other list countries, 1999-2006



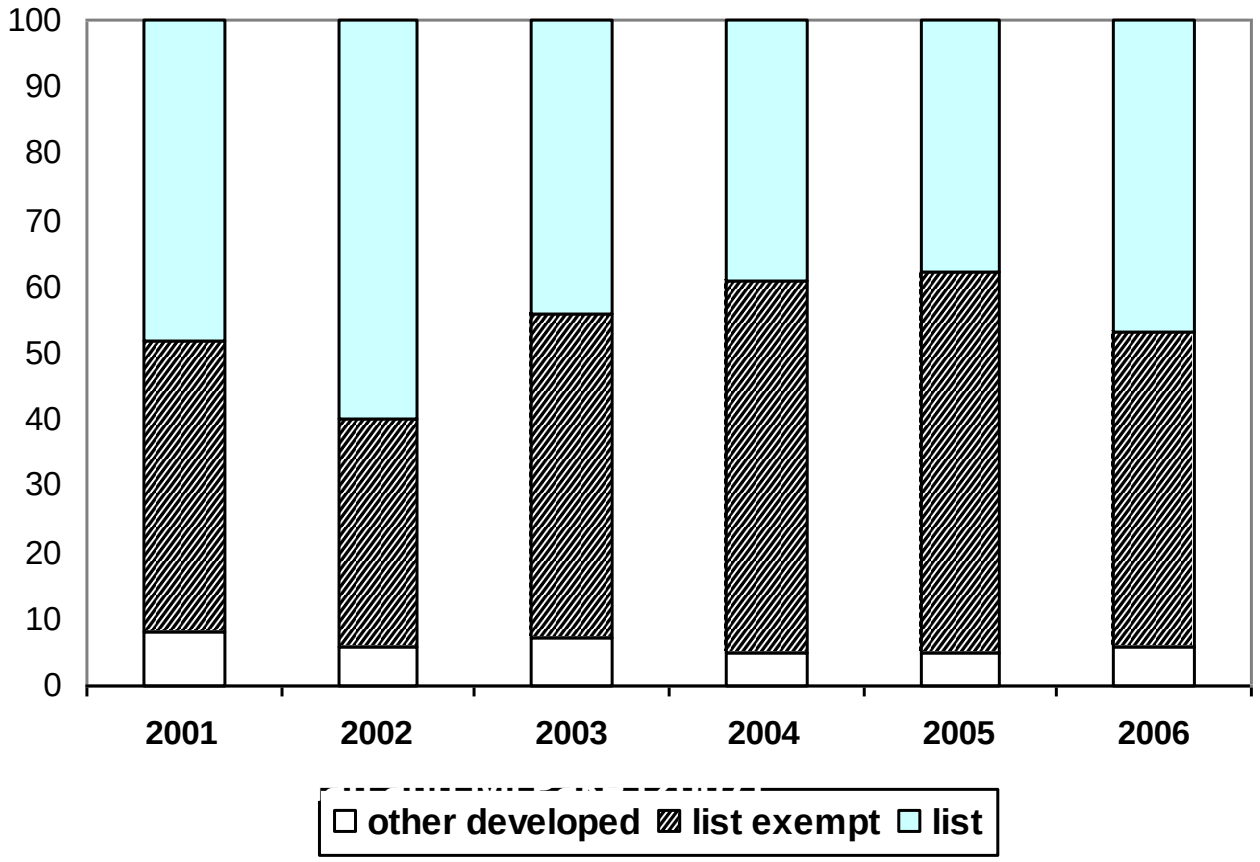
Is the UK Ethical Recruitment Code Effective?

Fig 2 :Nurses: New Registrants- from UK, other developed countries, list exempt countries and list countries, 1998-2006



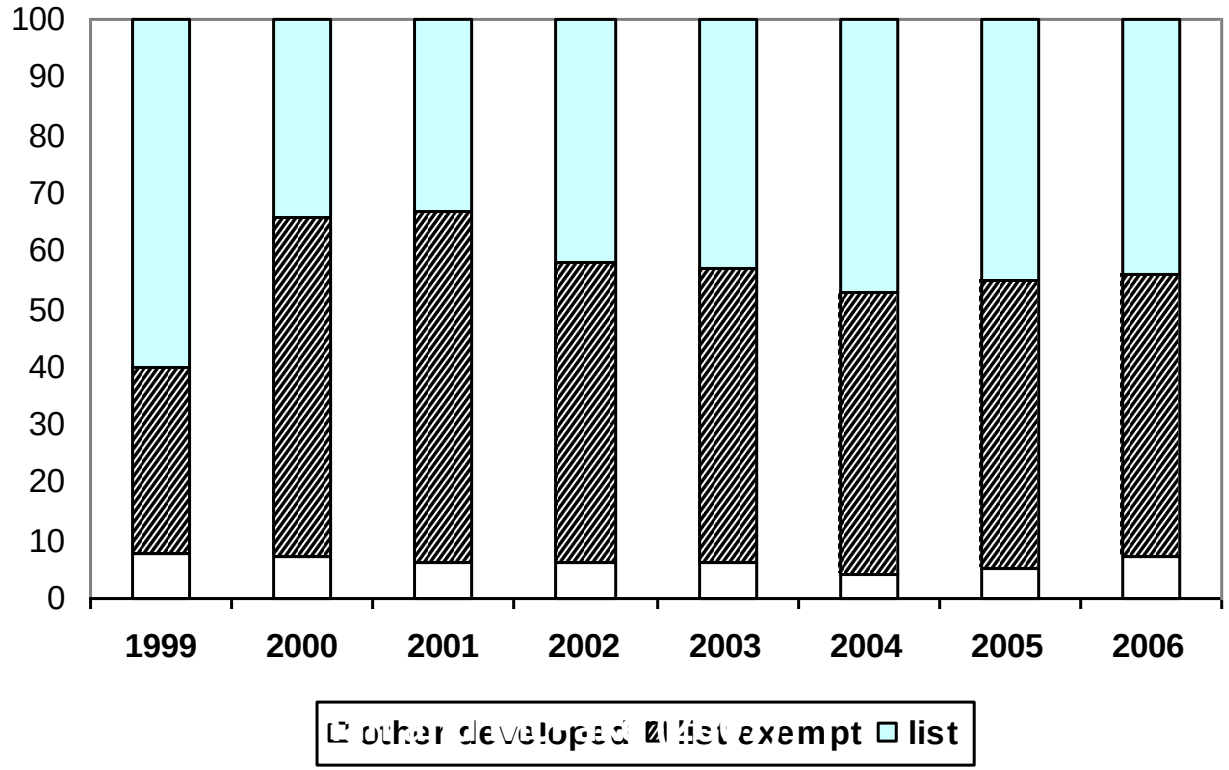
Is the UK Ethical Recruitment Code Effective?

Fig 3:Work Permits Doctors: % allocation by type of country 2001-2006



Is the UK Ethical Recruitment Code Effective?

Fig 4: work permits issued to nurses % by type of country 1999-2006



High-value migrants

Tier 1 (General)

- Eligibility
- Supporting evidence
- Applying
- Applications by dependants
- Refusals
- Settlement
- Cost
- Processing times
- Change of circumstances form

TIER 1 (GENERAL)

This section explains whether and how you can apply for permission to extend your stay in the UK as a highly skilled worker under Tier 1 (General) of the points-based system.

Do you have a biometric residence permit?

If you hold a biometric residence permit (formerly known as an identity card for foreign nationals), or have held one in the past, we want to hear your views about it. Please take part in our 5-minute survey.

Read more

DO IT ONLINE

Calculate your points using the points-based calculator

MORE NEWS AND UPDATES

'Apply online' service restored

Changes to the list of English language tests

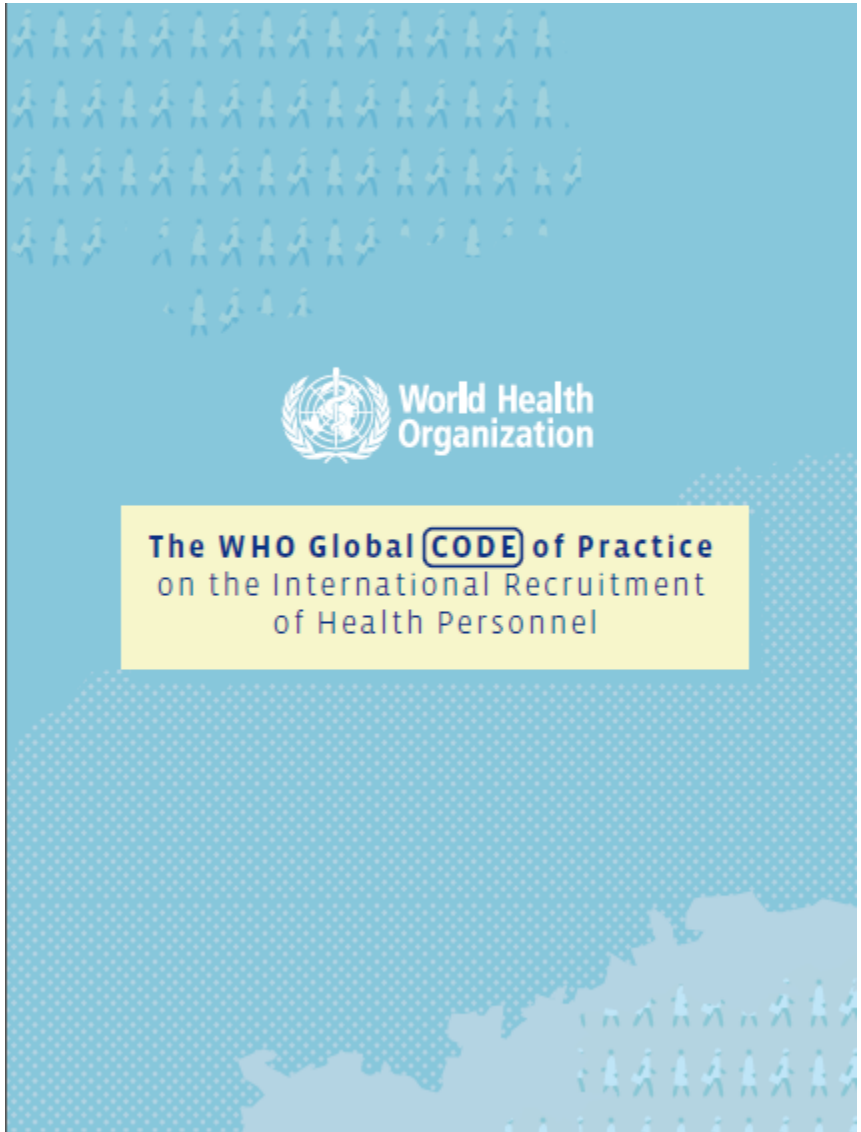
One week to go on family consultation

Consultation on the work routes leading to settlement closes on the 9 Sept

More news

News feeds

WHO Global Code of Practice on the International Recruitment of Health Personnel



Skills recirculation

- Imperial College London-Rwanda Link: Reducing mortality among sick children in Rwanda by Emergency Triage/Treatment Course and improving care pathways. (large grant)

The case for restitution payments From the UK to SSA

Training costs saved by the UK by employing HWs from Ghana:

- £103 million

Training costs saved by the UK by employing HWs from sub-Saharan Africa as a whole:

- £2.5 billion

Reflection

The perverse subsidy is worsening global health inequality –should it be re-paid through compensation?

J. Int. Dev. 18, 757–770 (2006)

The case for restitution payments

HWM = substantial flow of perverse subsidy from poor to rich countries

- further widens existing global gulfs in health and well being
- contravene many high-income countries' treaty obligations in the field of human rights
- Morally wrong

Restitution payments as an opportunity for recipient-centred aid

(McIntosh et al, 2005)

Rights-based approach

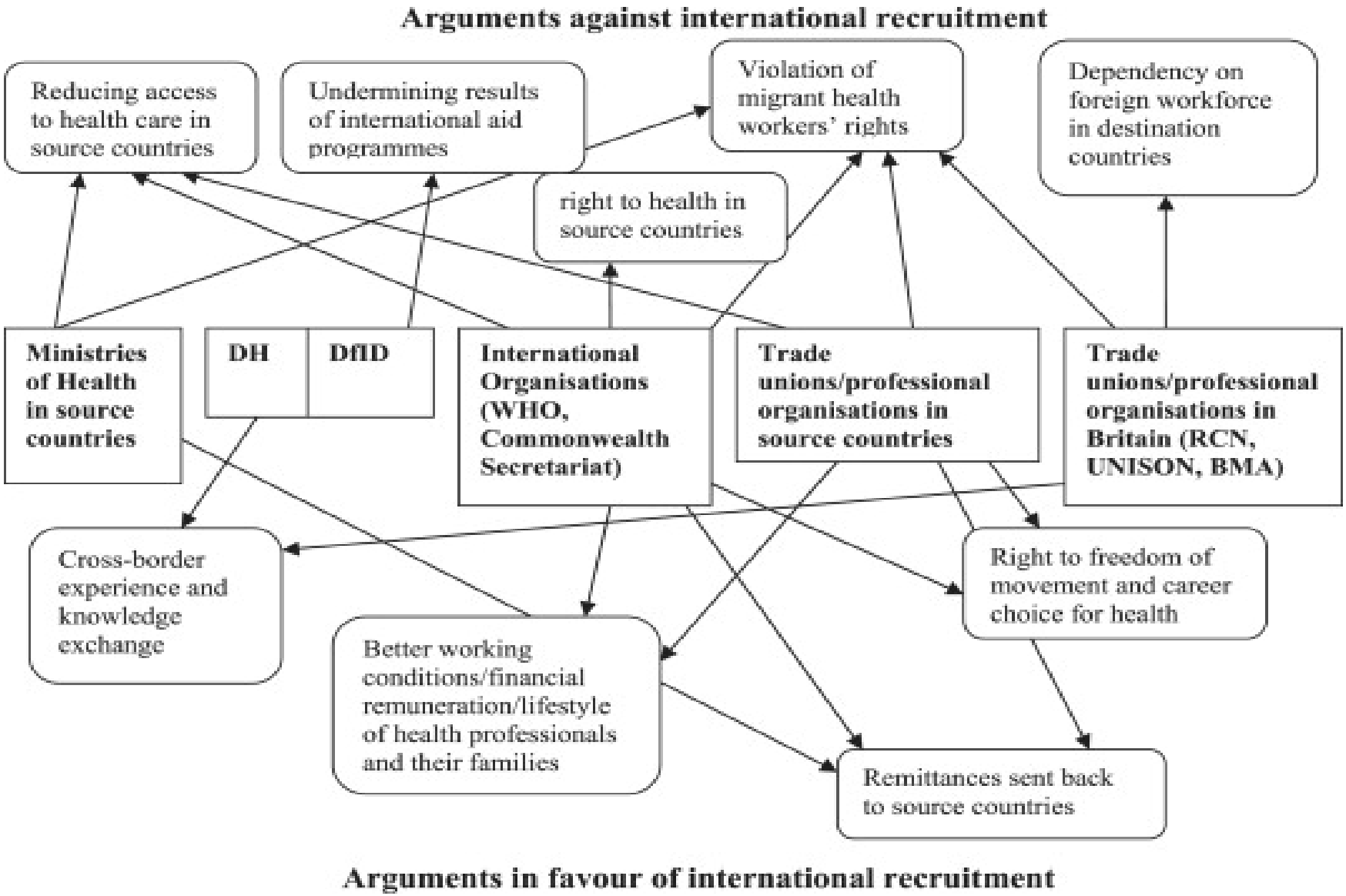
3 rights under international and regional human rights law:

- the right to health (affecting individuals in countries of origin and destination)
- labour rights (affecting health workers)
- the right to migrate (affecting health workers)

non-discrimination and equality (cross-cutting)

(deMesquita 2005:6)

The HWM Debate - The Main Actors



Reflections

What is the appropriate response to HWM?

Other potential future directions ...

- Long Term
- Short term

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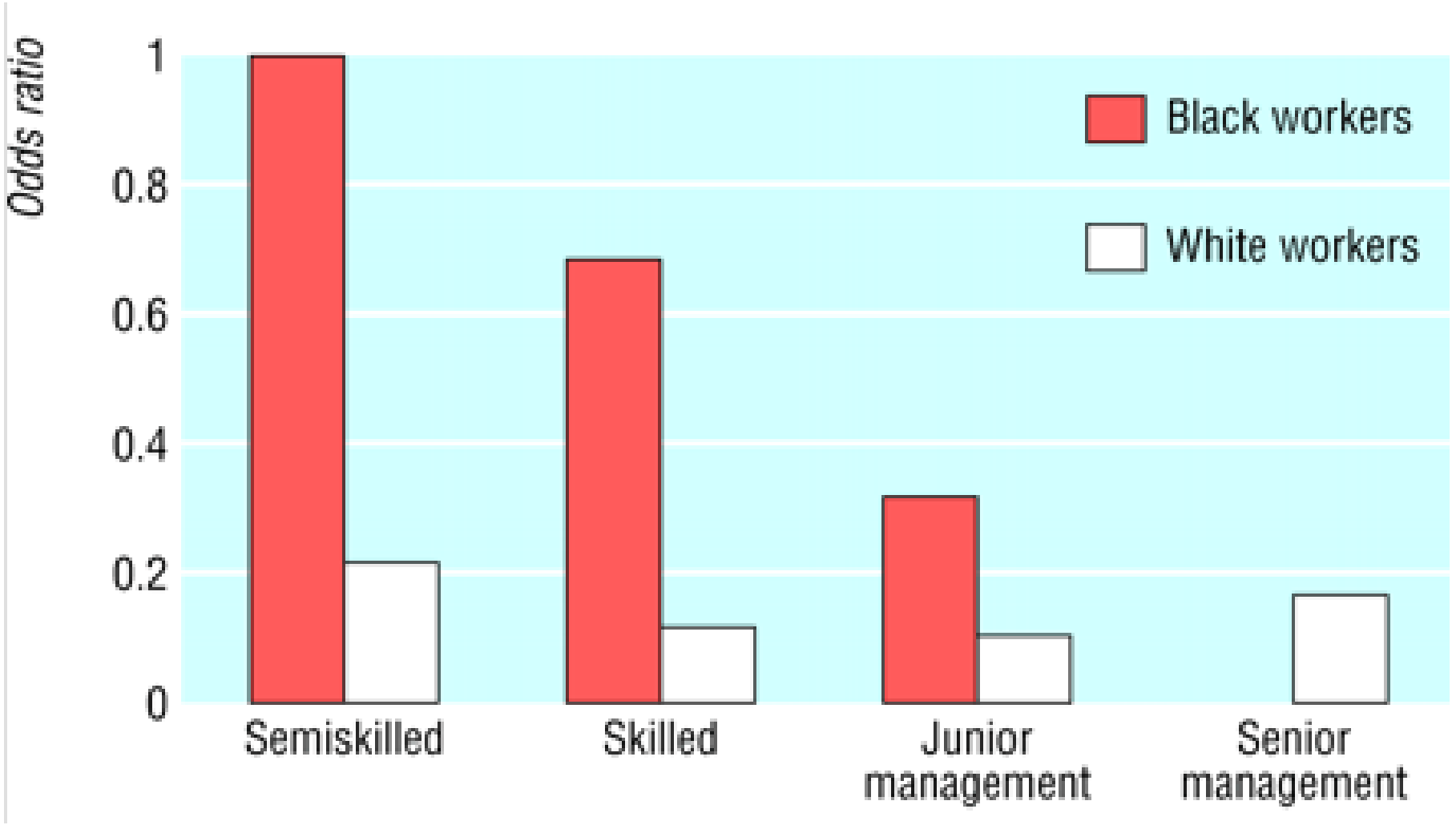
Shortages of HW and HIV/AIDS

- shortage of health workers to treat HIV/AIDS (HAHW) in SSA caused by:
  - Low education rates
  - High emigration rates
- Human resources is one of the main constraints in scaling up ART

How does the HIV pandemic place strain on health workers?

- increased testing and counselling, treating of opportunistic infections
- Provision of antiretroviral treatment (ART)
- Increased mortality and morbidity amongst health workers >> increased workload and underqualified labour

Odds ratios of HIV seroprevalence among employees in South Africa



Seminar

- http://rockhopper.tv/programmes/318

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