Lecture
Health Worker Migration

Global Health BSc

3 November 2011

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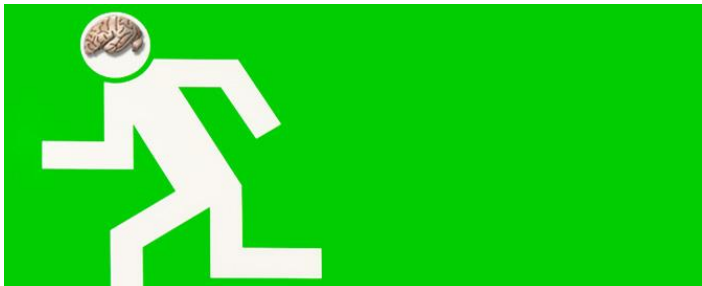
Intended Learning outcomes

By the end of this session you should 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 human resources for health
- recognise the importance of health human resources in a context of international and national inequalities in access to health services
- discuss some of the existing and proposed policies to prevent or mitigate the health worker crises

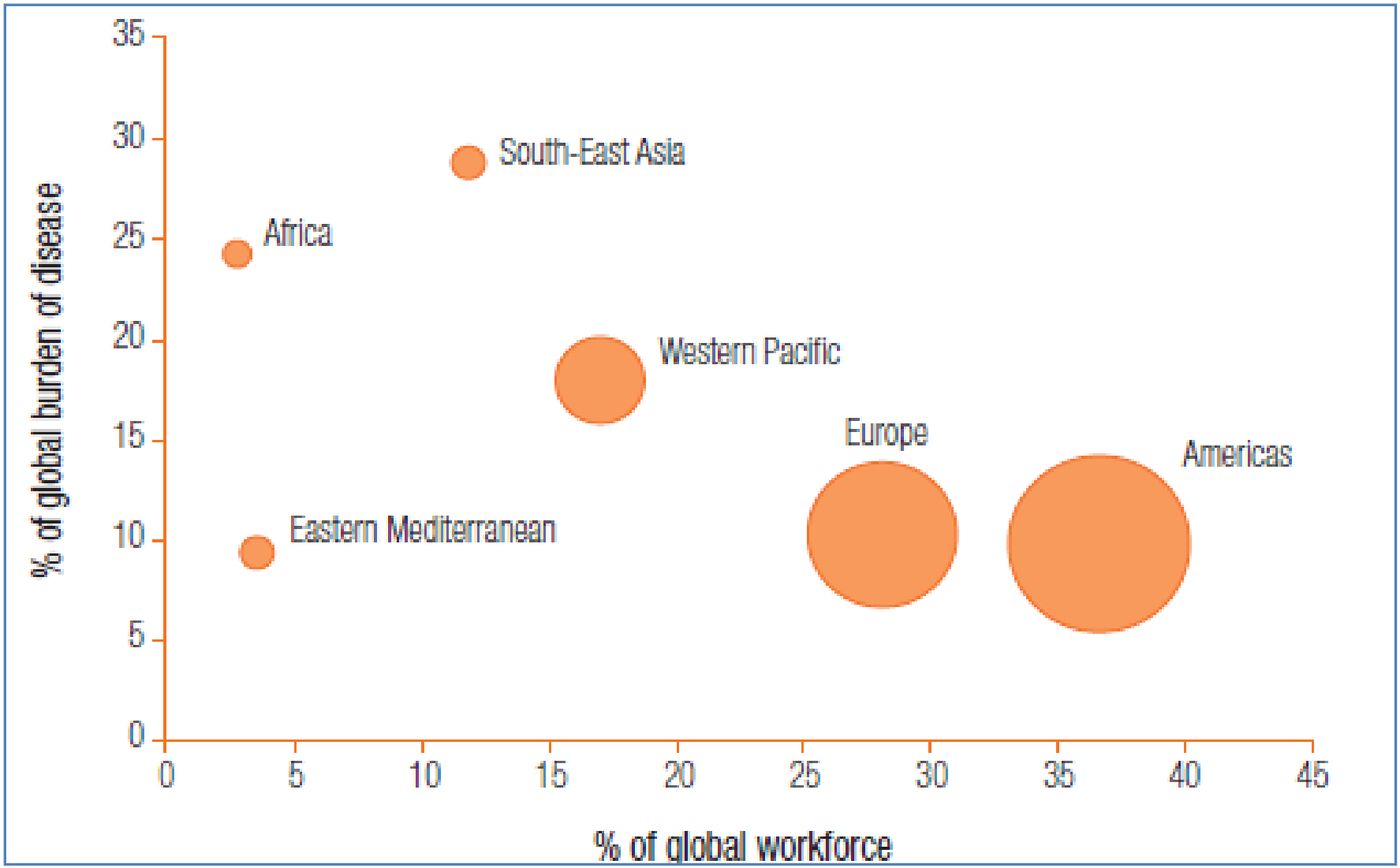
Outline

- What is the evidence for HWM?
- Determinants of HWM: Push and pull factors
- The effects of HWM in source countries
- Why a human rights approach to HWM?
- Existing and proposed policy solutions



Global Inverse Care Law?

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



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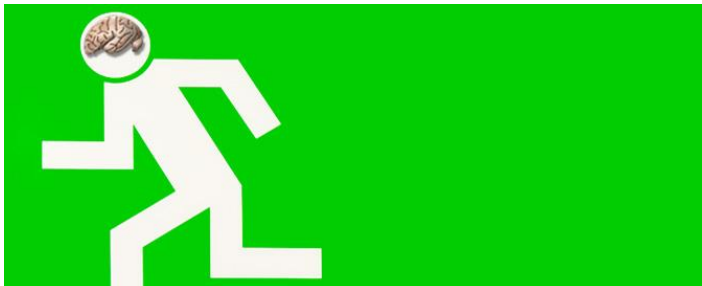
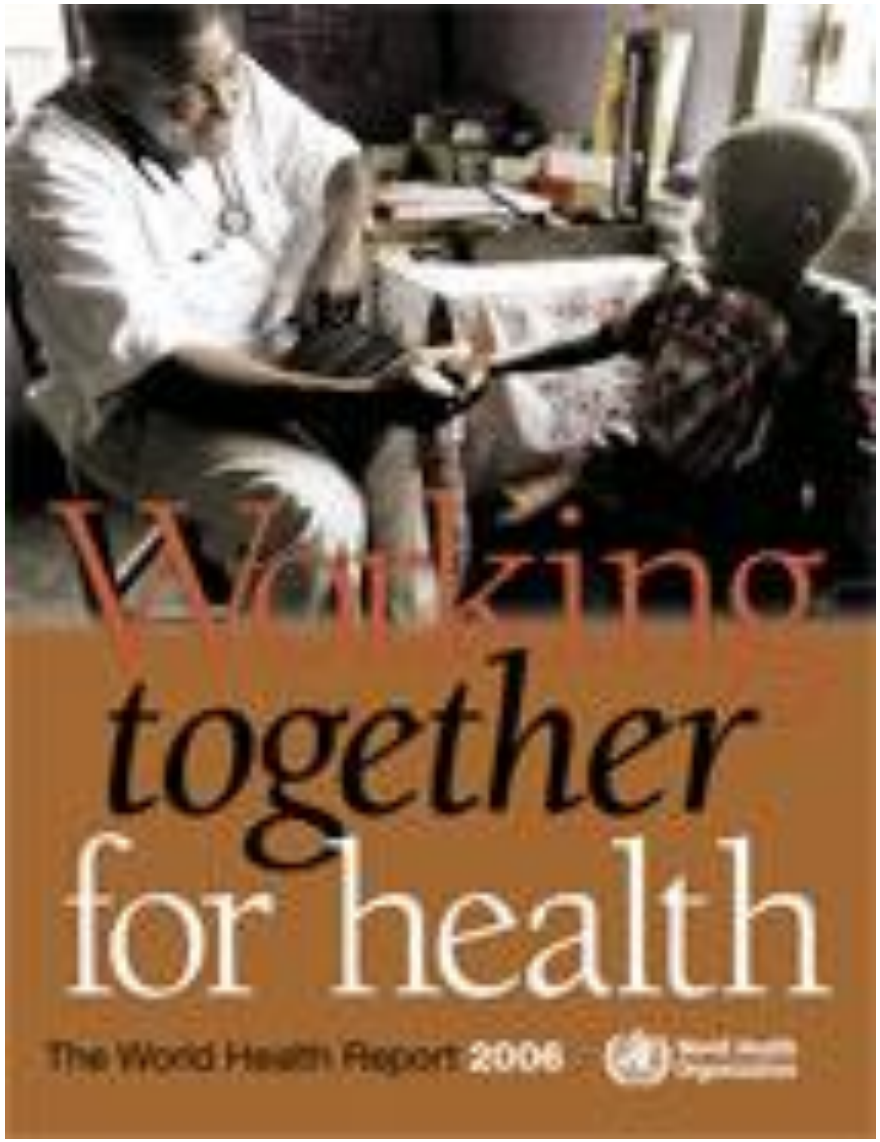


Counting Health Workers



The World Health Report 2006

"Working Together For Health"

Counting Health Workers

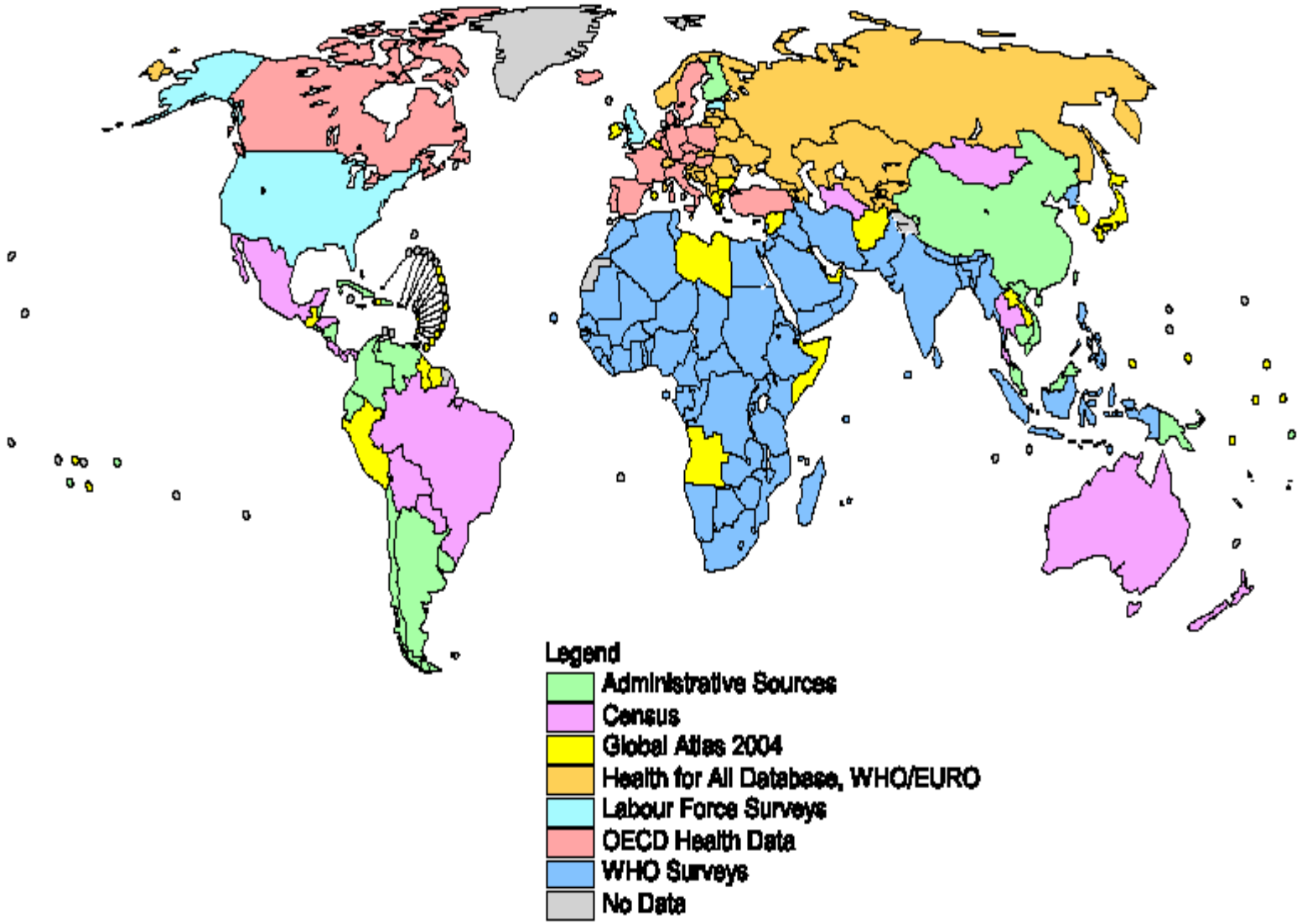
"all people engaged in the promotion, protection or improvement of the health of the population"

Adams et al., 2003: 276

Diallo et al., 2003

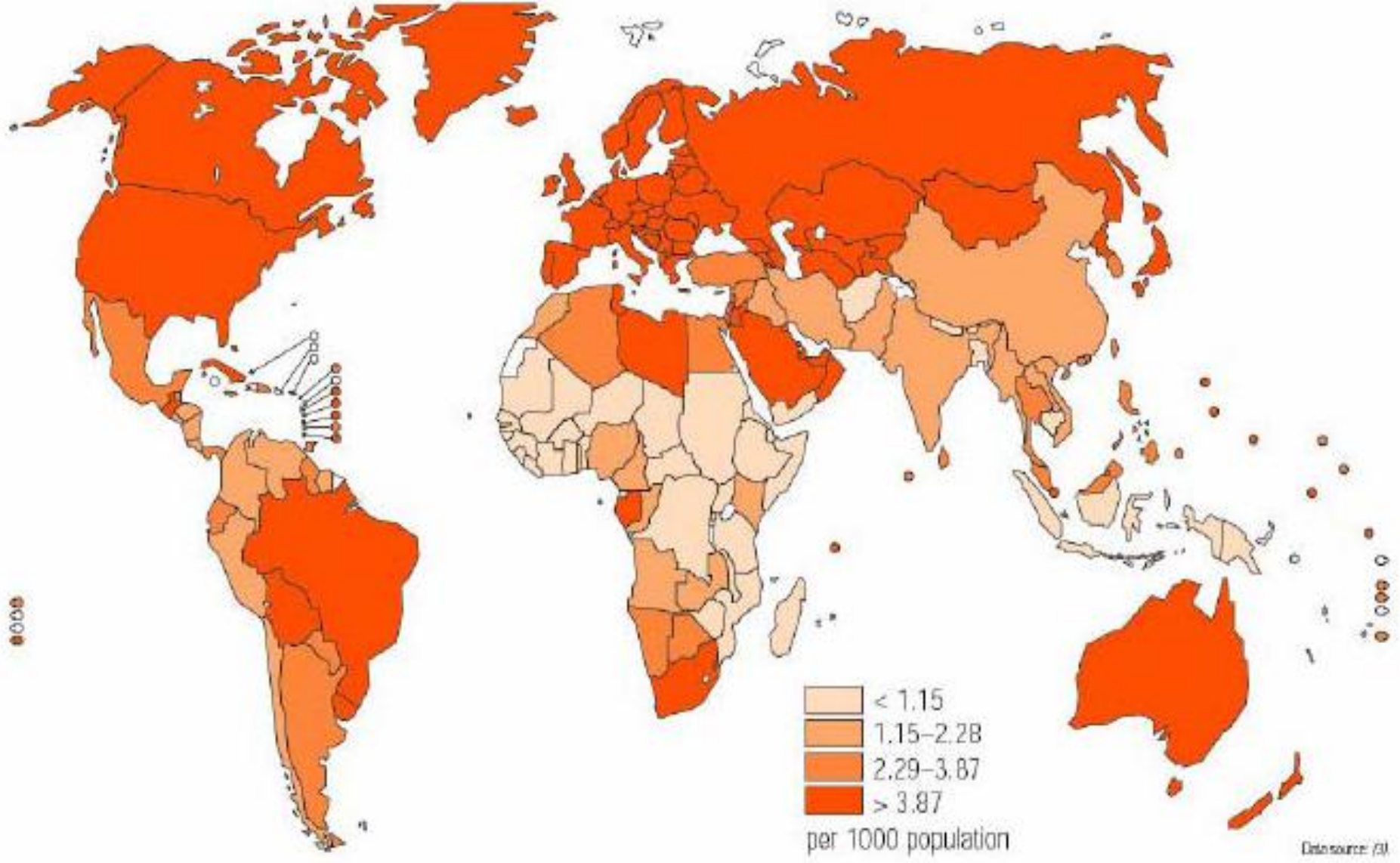
How reliable are our estimates?

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”

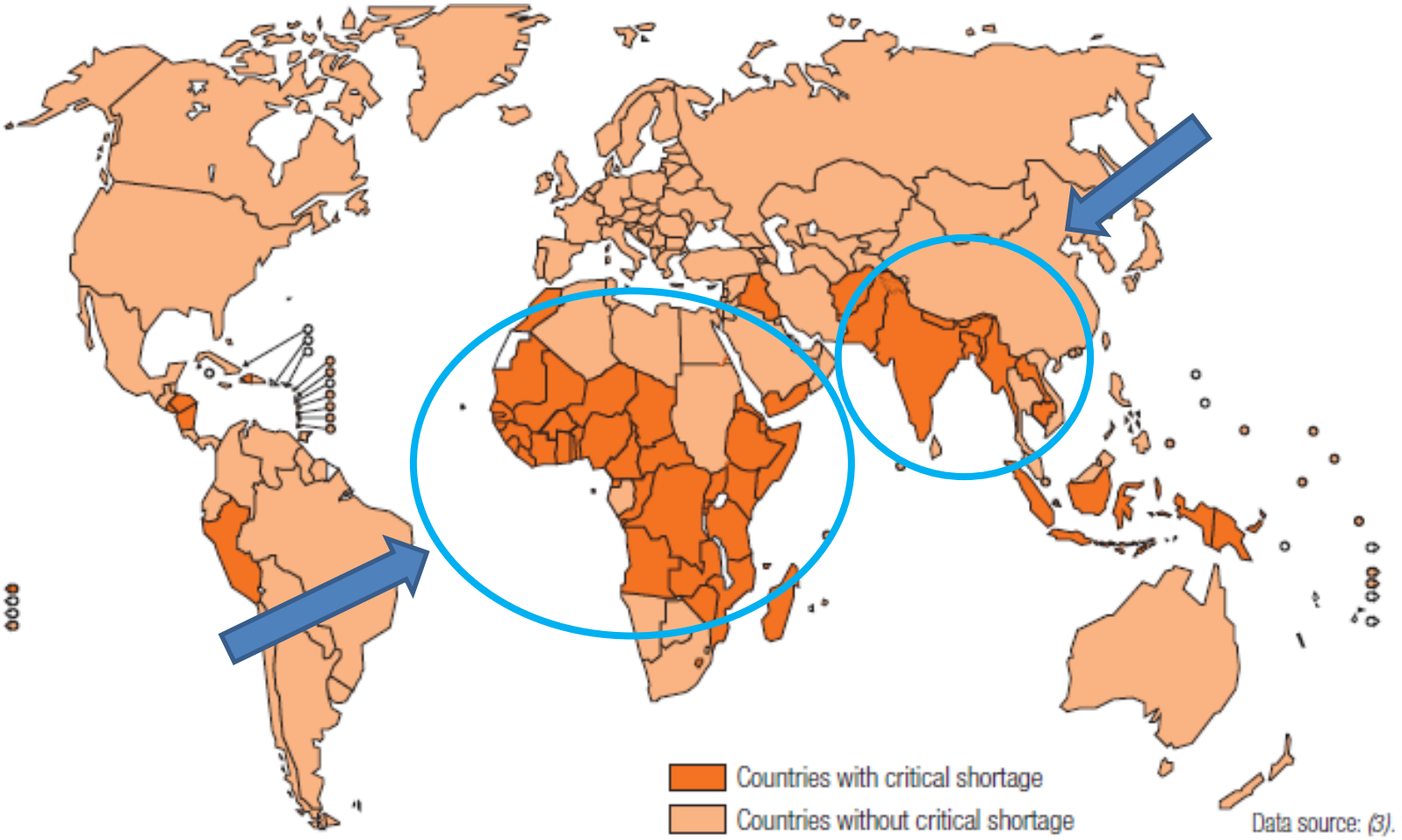
57 countries had critical shortage of HWs (WHR 2006)

- Defined as:
  - < 2.5 health care providers /10,000 population (doctors, nurses & midwives)

- Many countries failed to meet:
  - 80% skilled attendance at delivery
  - measles coverage

- Estimated gap: 2.4 m

Countries with a critical shortage of health service providers (doctors, nurses and midwives) < 2.3 per 10,000 population



Source: WHR 2006

Shortages of HWs by World Region

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)

Variations in HW levels

- Stocks e.g. in OECD:
  - 1970s and 1980s: growth in physician and nurse density
  - Early 1990s: Cost-containment policies and slower growth
  - 2000s: shortages of doctors and nurses – efforts to increase national training
- Flows
  - Rural to urban
  - Public to private
  - Between countries:
    - Least developed to developing /developed country
    - Developing country to developed country
    - Developed to developed countries

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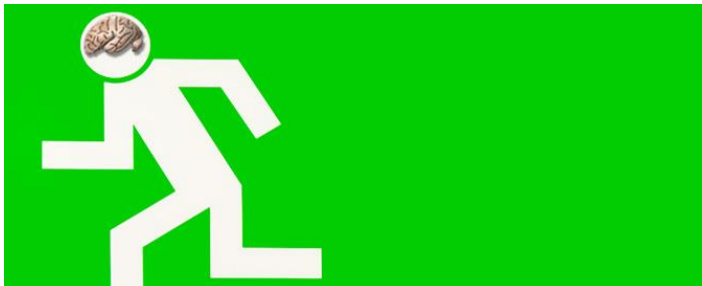
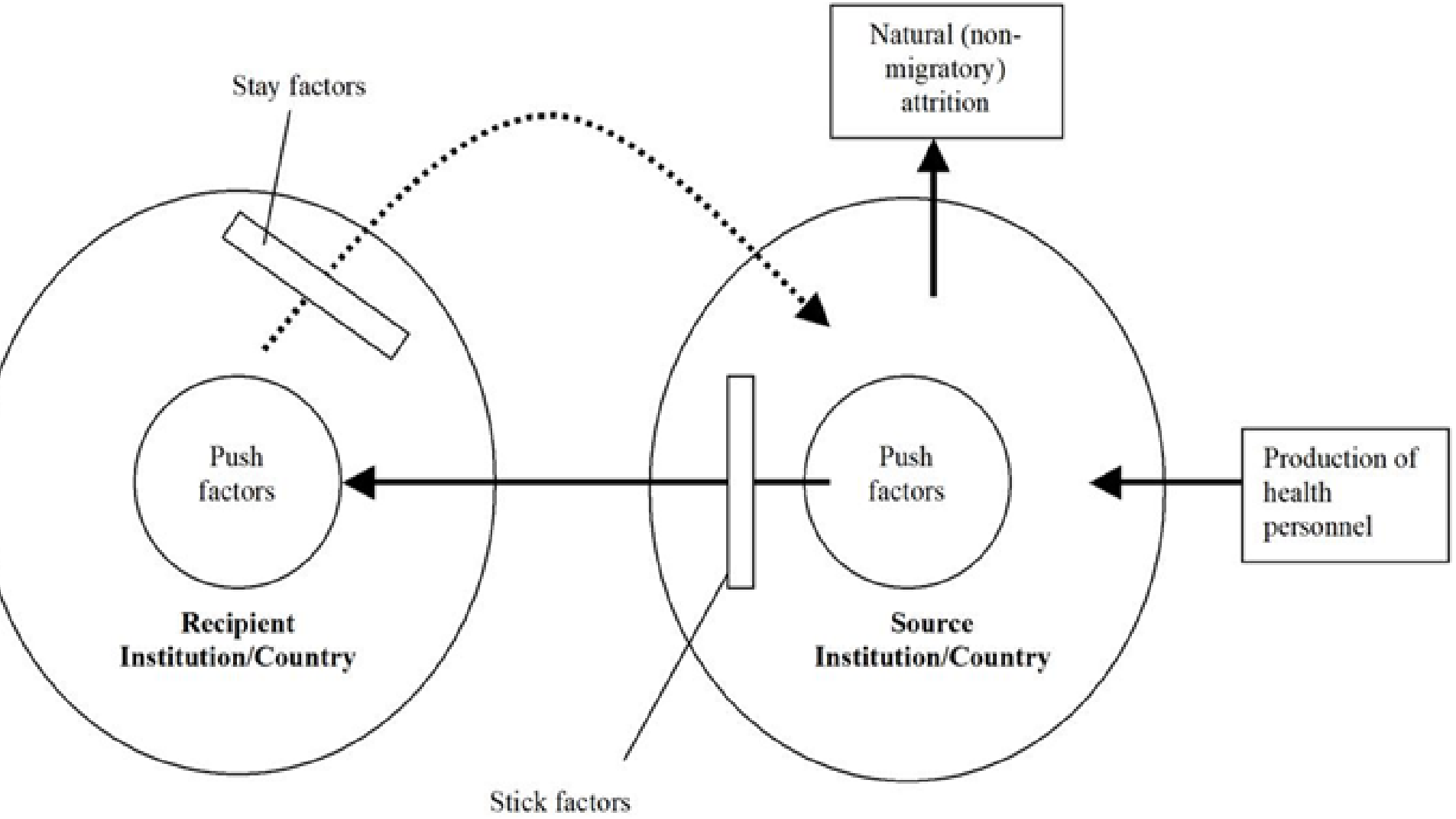


Determinants of HWM - Push-Pull Model



Adapted from Paradath et al. 2003. Also see WHR 2006

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

Henderson 2010

Push and Pull (Mc Donald and Crush 2002):

- Job Security
- Working Conditions
- Economic Considerations
- Political Considerations
- Physical Security
- Quality of Life
- Education
- Job Security
- Working Conditions
- Economic Considerations
- Political Considerations
- Physical Security
- Quality of Life
- Education

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
migration patterns

University of the Witwatersrand, South Africa

University of Cape Town, South Africa
University of Ibadan, Nigeria
University of Lagos, Nigeria
University of Nigeria, Nigeria
University of Ghana, Ghana
Addis Ababa University, Ethiopia
University of Benin, Nigeria
University of Ife, Nigeria
University of Pretoria, South Africa

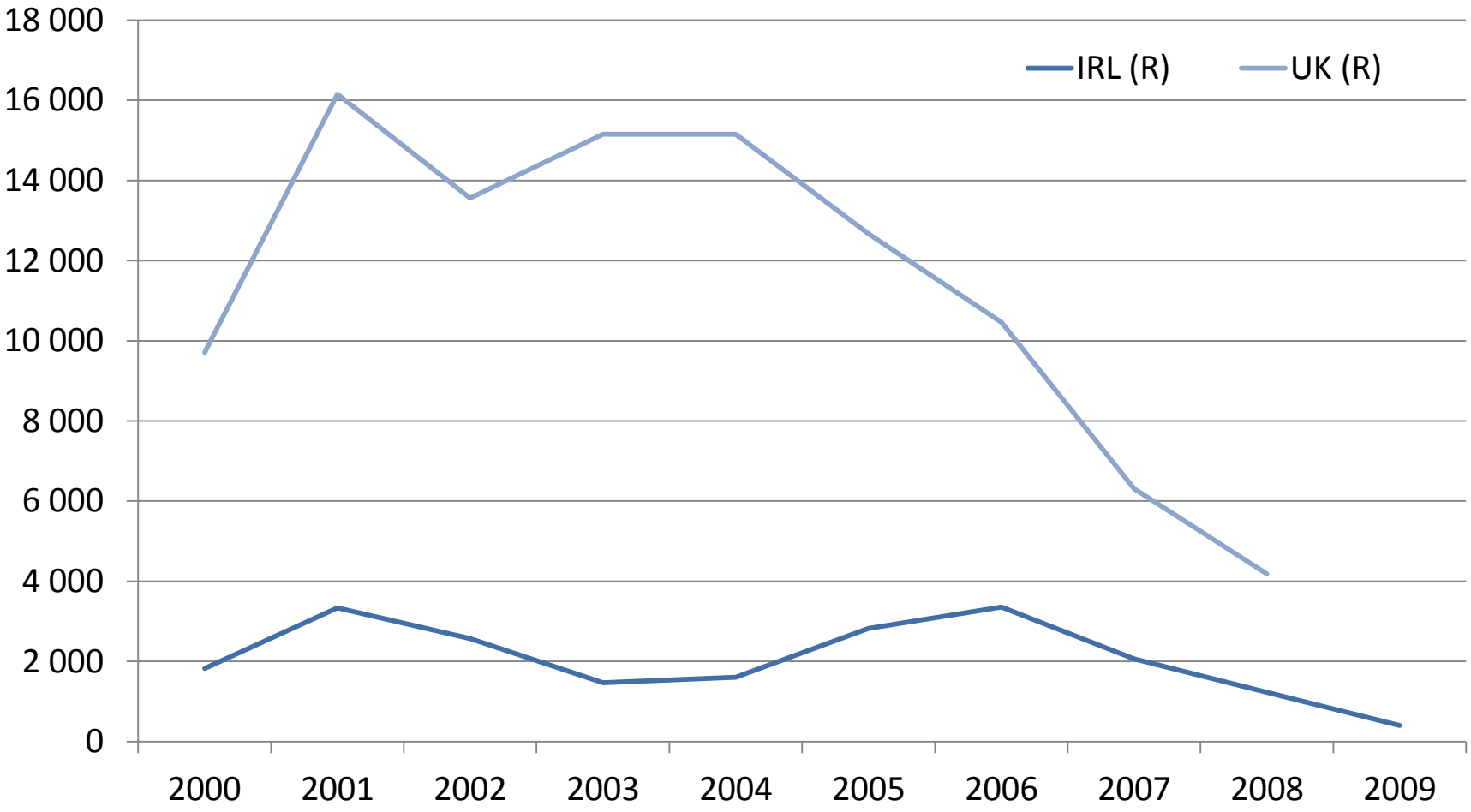
Nearly 80% SSA physicians practicing in the USA came from 10 medical schools

(Hagopian et al., 2005)

The case of the UK

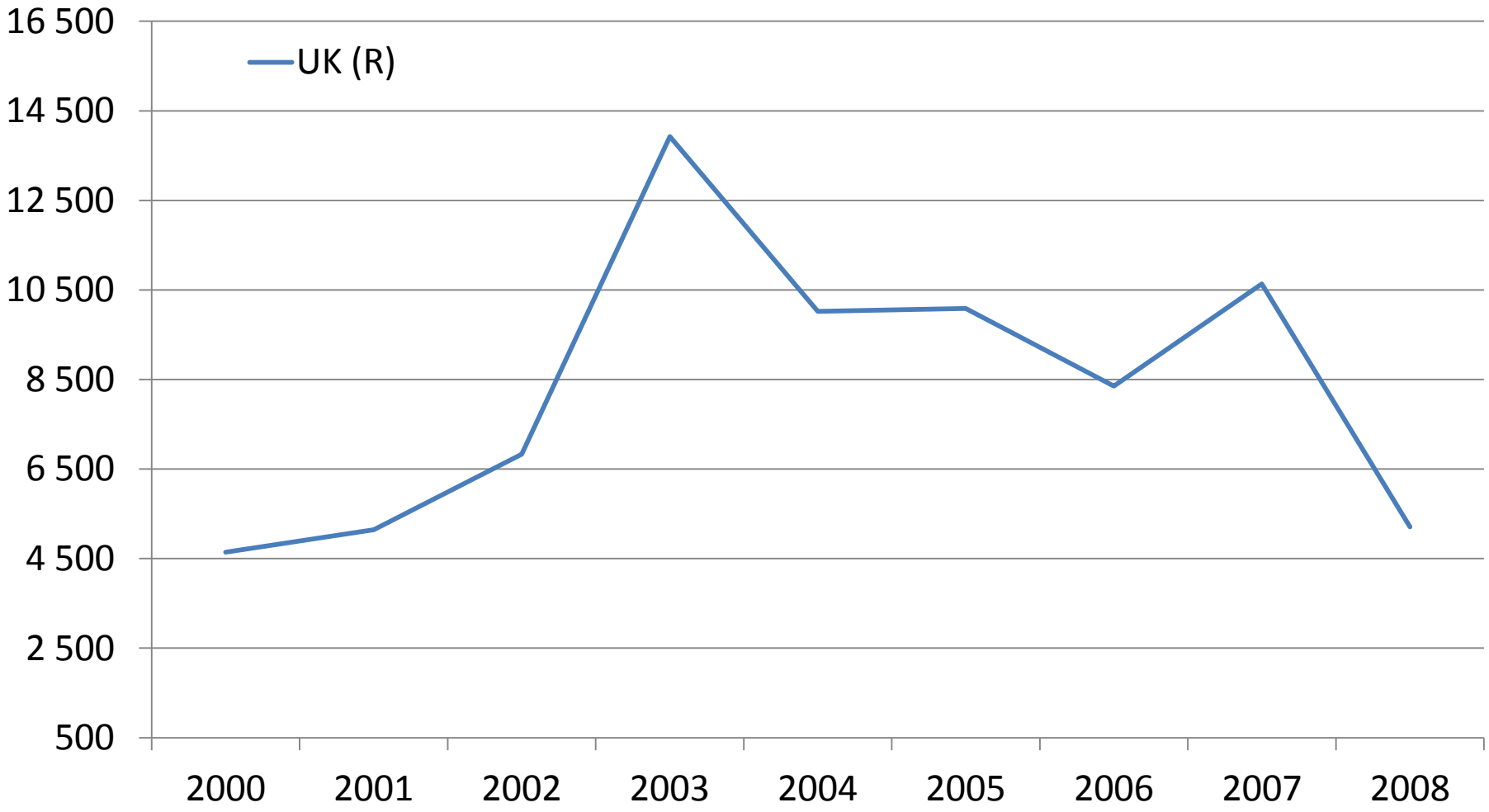
Active recruitment in early 2000

HWM to the UK - nurses



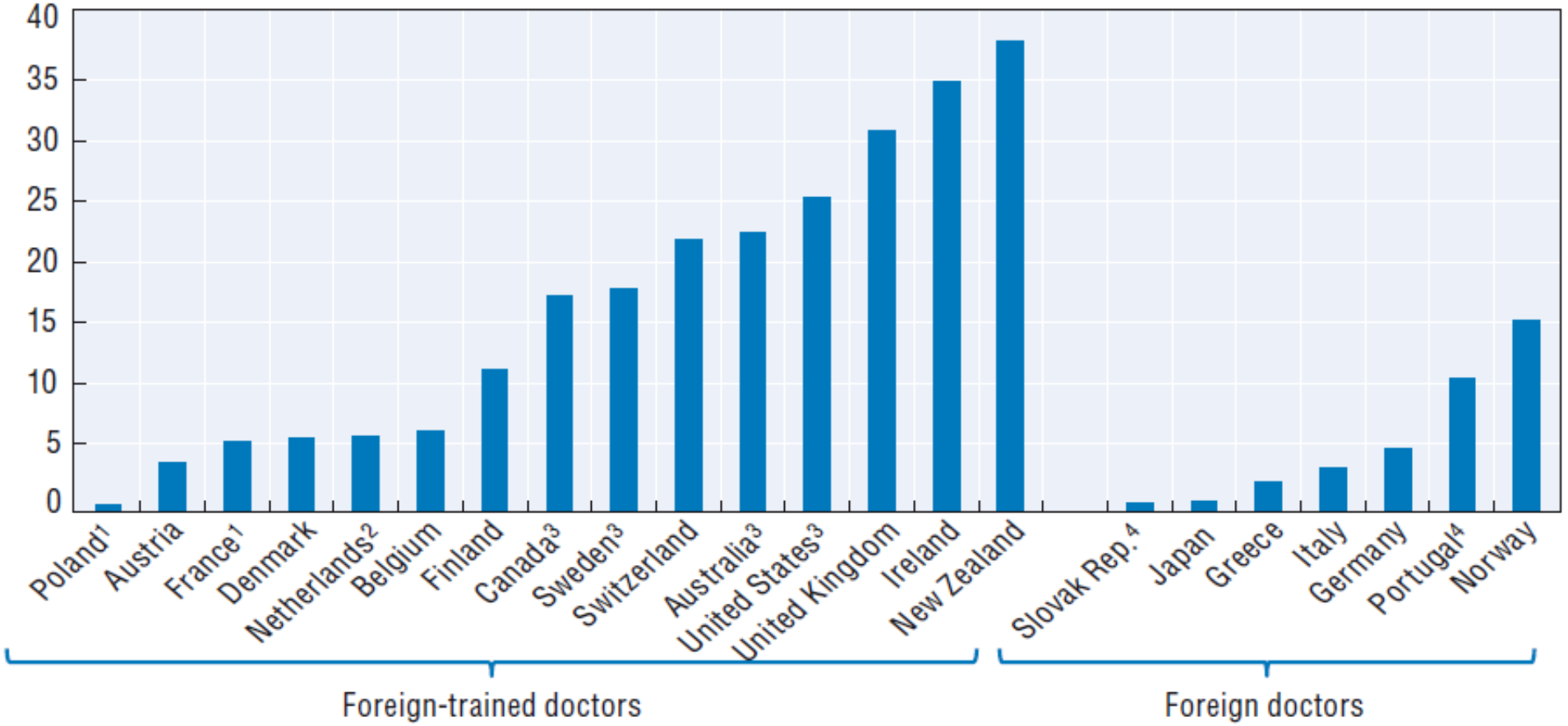
Migration flows of nurses to selected OECD countries, 2000-2009 :UK and Ireland
Available at: www.oecd.org/health/workforce

HWM to the UK - Drs

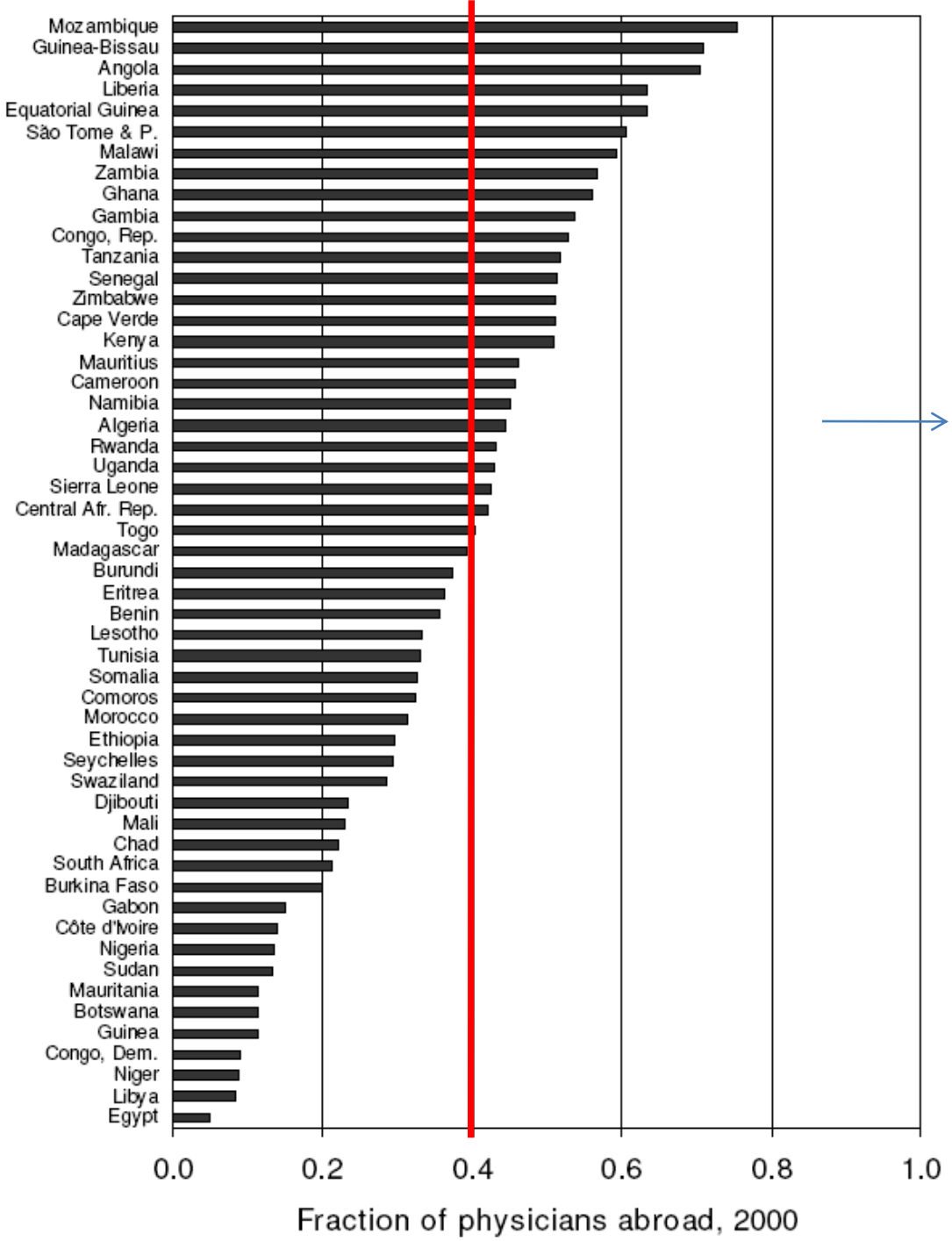


Migration flows of doctors to selected OECD countries, 2000-2008

Reliance on Migrant Doctors in OECD



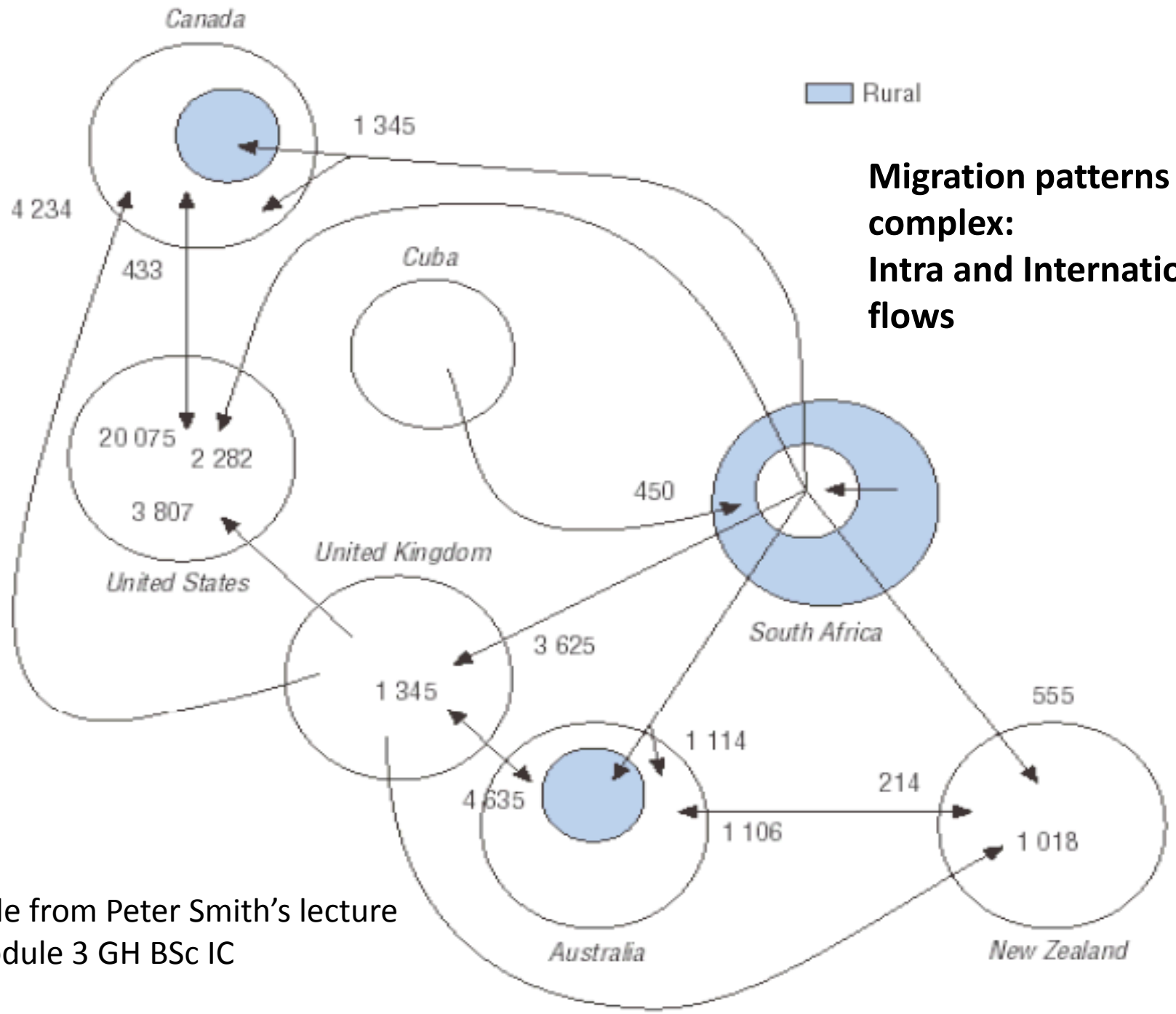
Share of foreign-trained or foreign doctors in selected OECD countries in 2008 (or latest year available) Percentage. 1. 2005. 2. 2006. 3. 2007. 4. 2004. Source: www.oecd.org/health/workforce.



The missing Émigré Health Professionals In Sub-Saharan Africa

Results: in nearly half of all African countries, > 40% doctors born there now live outside their countries' borders. Similar results for nurses.

Clemens and Pettersson (2008)



Migration patterns are complex:
Intra and International flows

Slide from Peter Smith's lecture
Module 3 GH BSc IC

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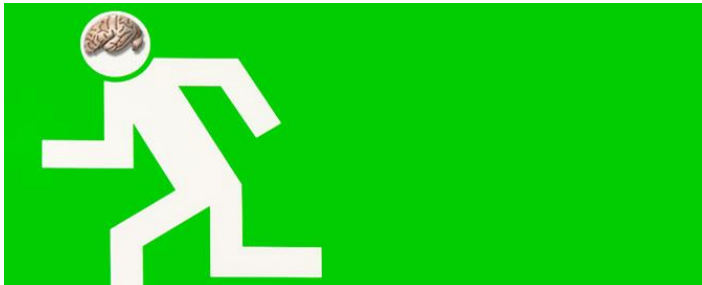


Effects of HWM

Costs

- Worsening of health outcomes?
- ‘Beheading’ of the health system
- Extra pressure on others in the health system
- Creates further pressure for migration

Benefits

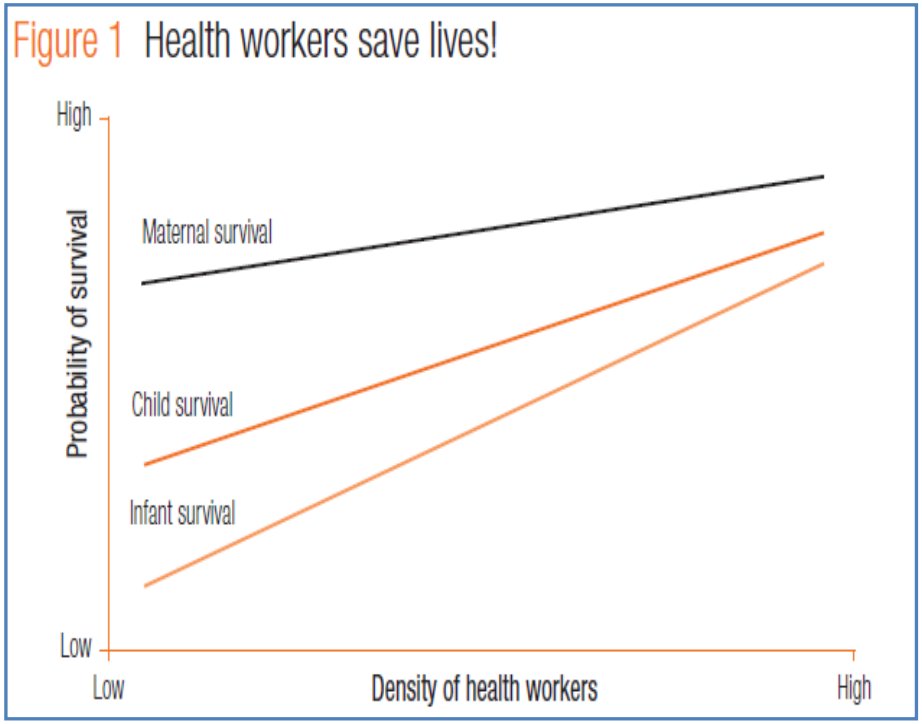
- Remittances
- Circular migration may mean new skills are introduced into the system
- Puts pressure on government to respond to wage/health system reform demands
- Puts pressure on government to do more efficient substitution of skills

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)

Effects of HWM on health outcomes

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, 2004

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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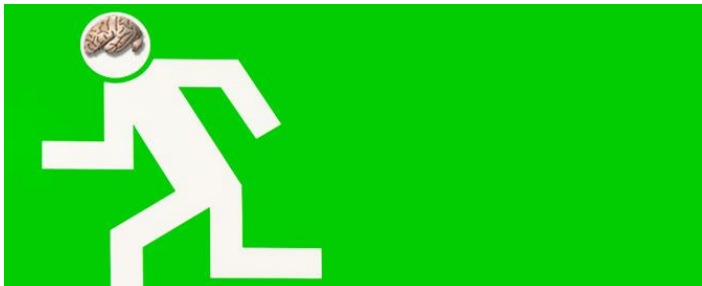


Rights-based approach to HWM

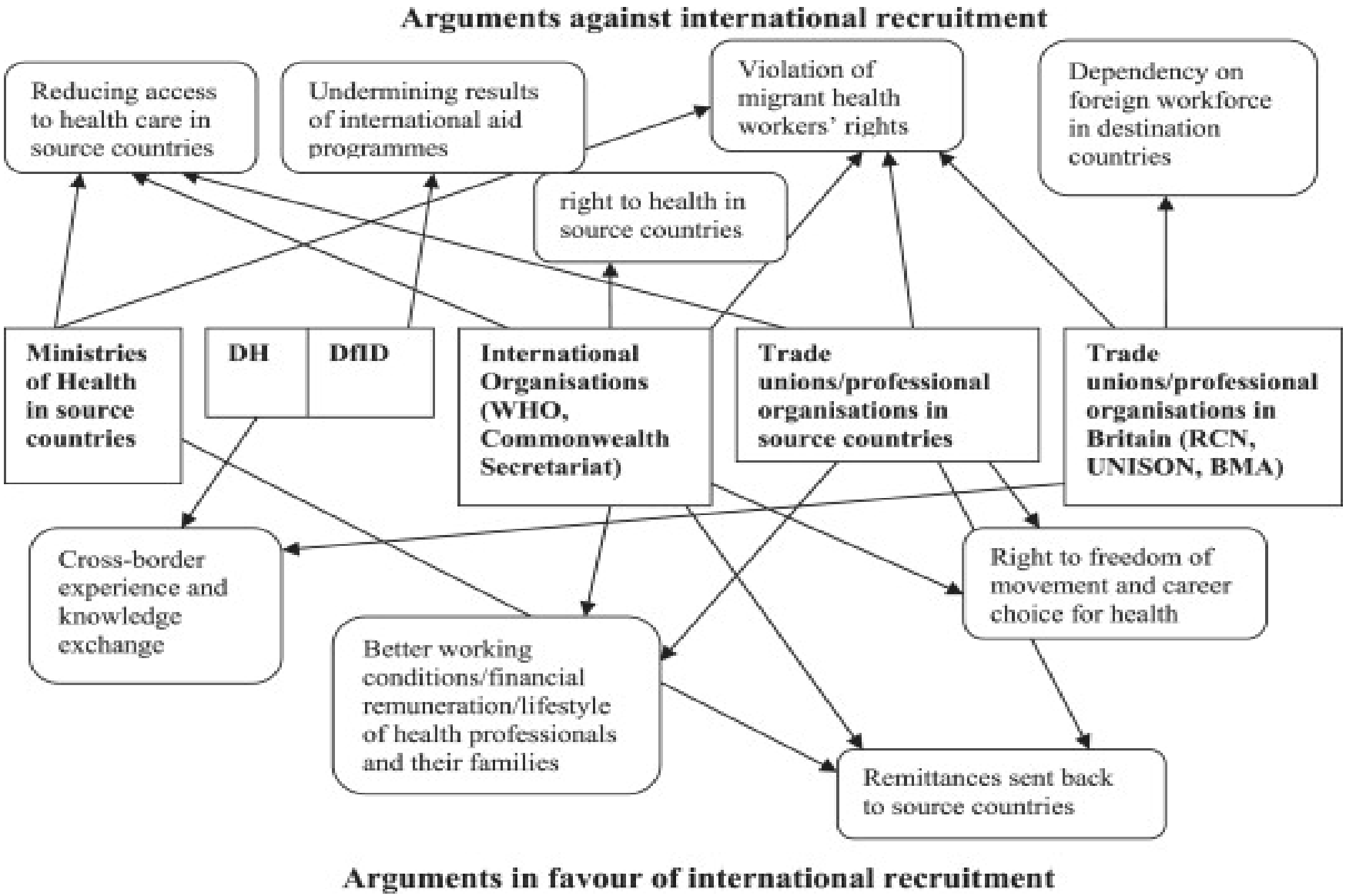
3 rights under international and regional human rights law:

- 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: Main Actors



Global Development Assistance for Health
Health sector support
(Institute for Health Metrics Evaluation 2009)

Some policy solutions to prevent or mitigate HWM

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!

Policy considerations

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

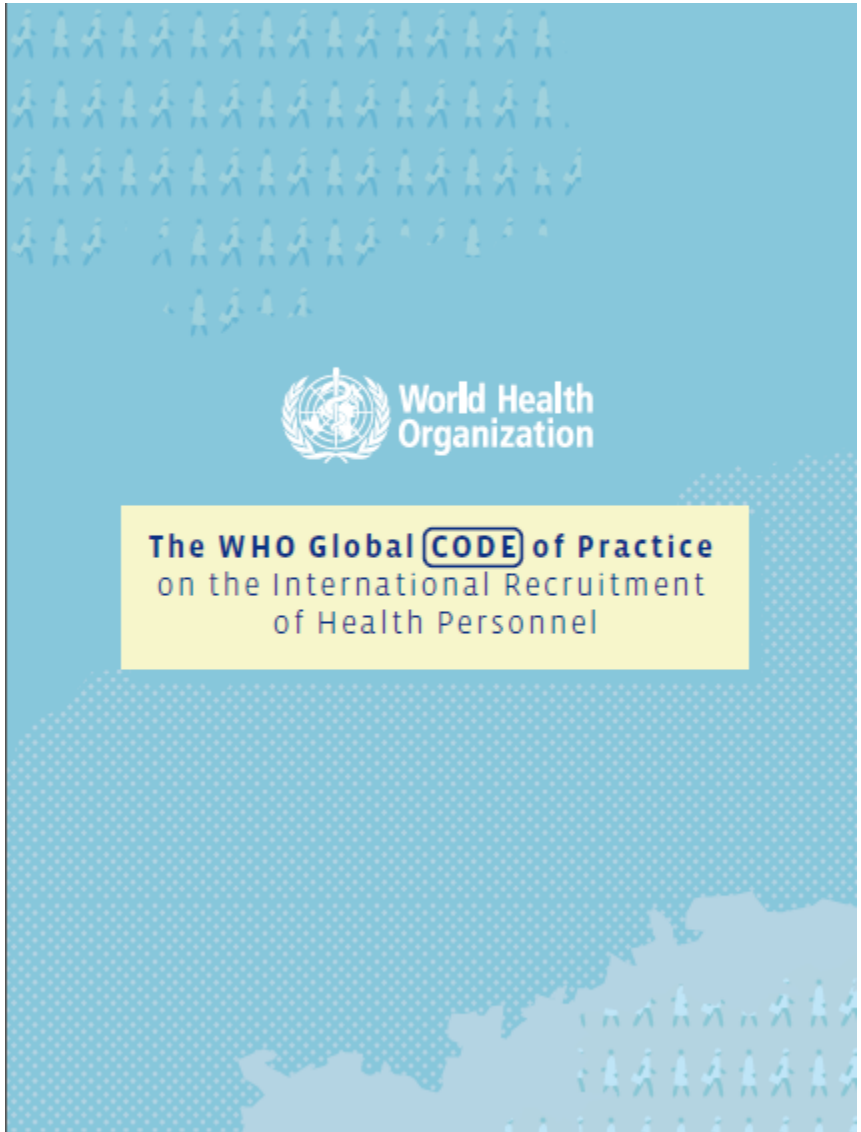
Context of HWM Policy

- Tensions :
  - Right of the HW to migrate
  - Right of the population to health
- Slow progress: none of the 57 countries in HRH crisis have risen out of it since WHR 2006

Policy Initiatives and agreements to Manage HWM

Type of Agreement	Example
General Agreement on Trade in Services	
Bilateral Agreements	UK - South Africa memorandum of understanding
Regional Agreements	Commonwealth Code of Practice for the International Recruitment of Health Workers, 2003
National Agreements	United Kingdom National Health Service Code of Practice for the International Recruitment of Healthcare Professionals, 2001

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



The UK response to HWM

- **1999** – England DoH Guidelines to limit recruitment from South Africa and West Indies
- **2001** –Code of Practice for NHS employers –not to 'actively recruit' from LICs unless bilateral agreement
- **2004** – Code strengthened

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

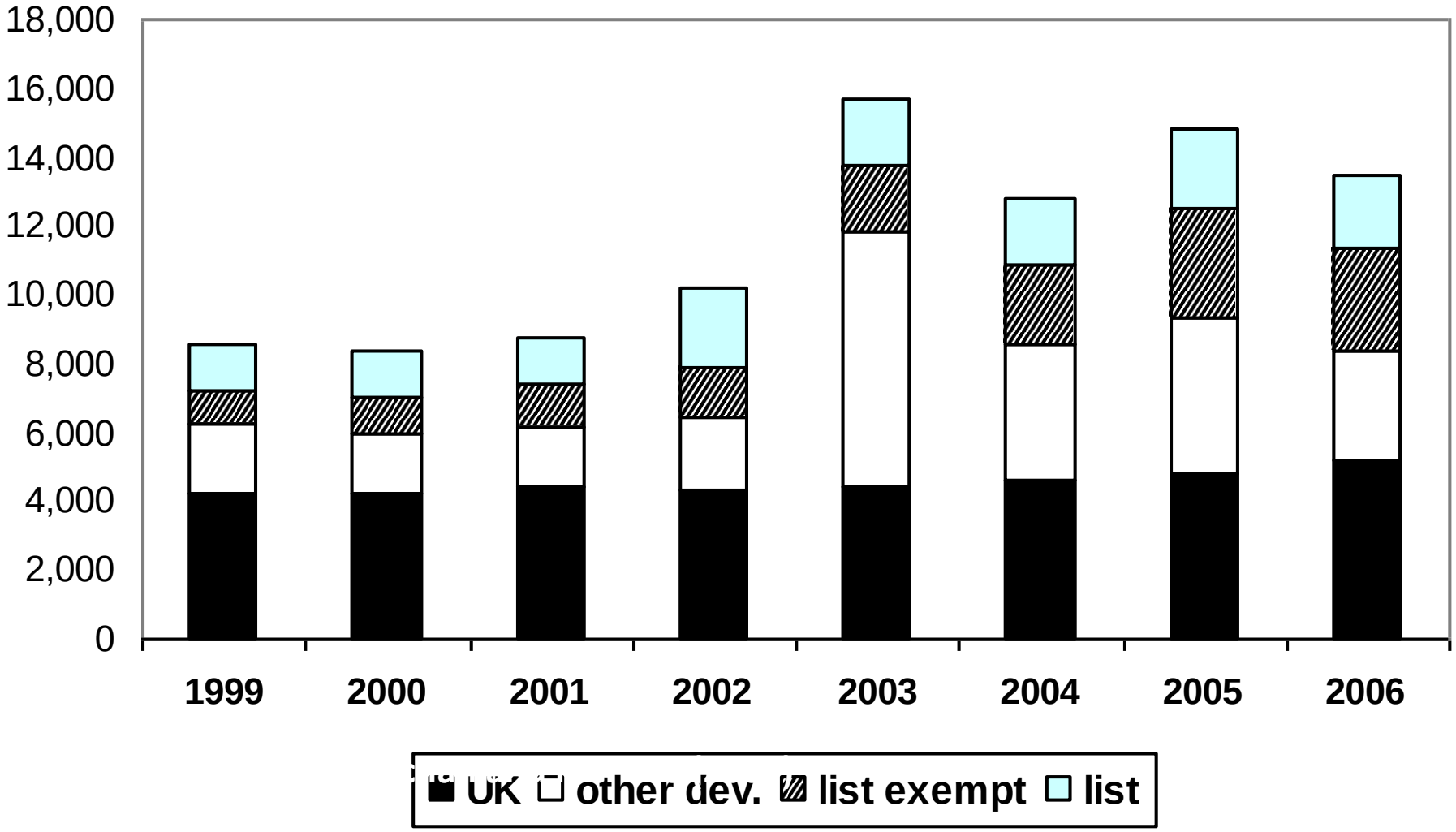
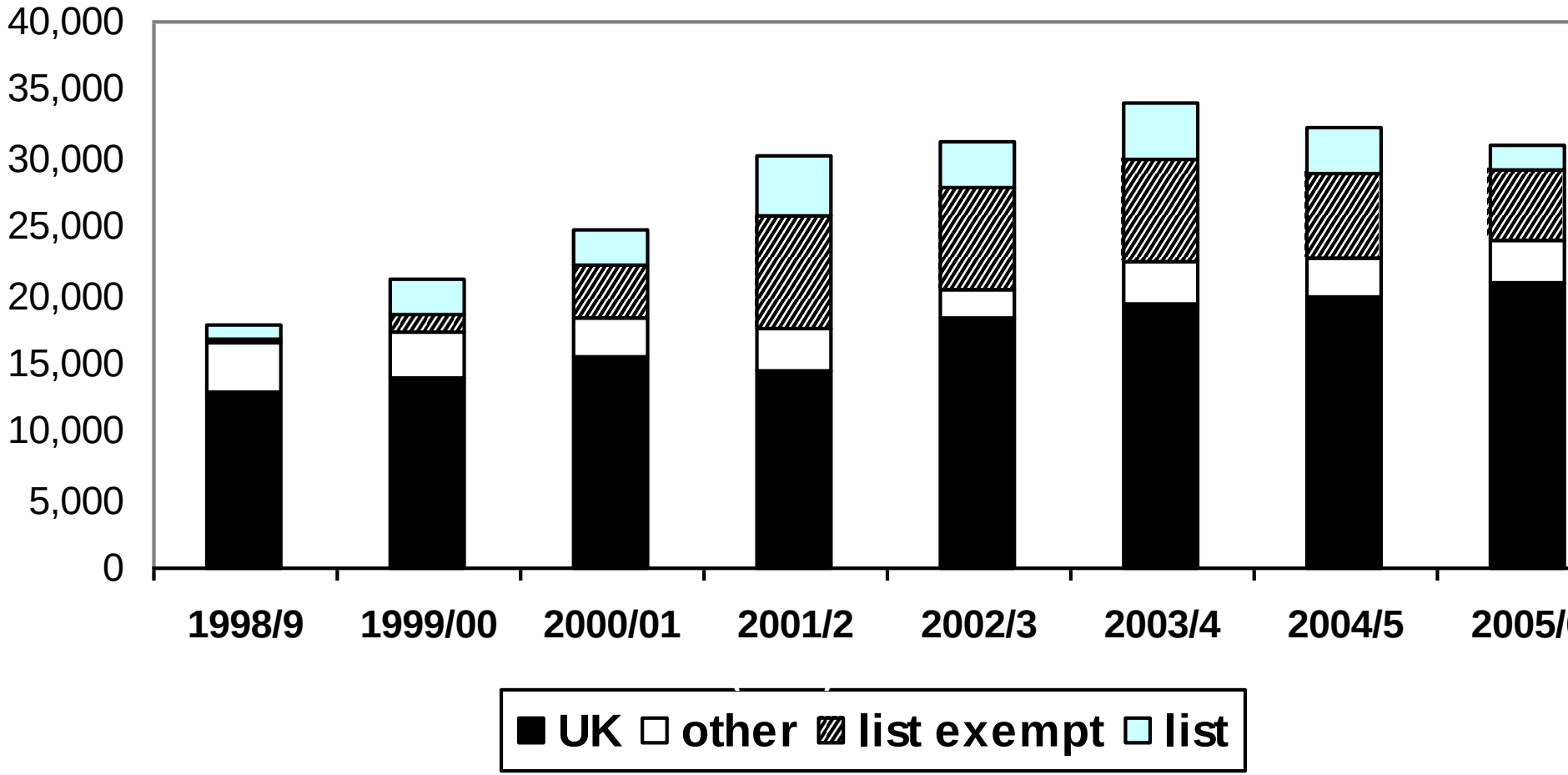


Fig 2 :Nurses: New Registrants- from UK, other developed countries, l exempt countries and list countries, 1998-2006



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

The case of 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?

Mensah et al 2006

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. However, is this feasible?

(McIntosh et al, 2005)

Reflections

What is the appropriate response to HWM?

...long term?

...medium term?

…short term?

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