Globalization and the Health Equity Challenges of Health Worker Migration

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Not a new issue, but one that won’t go away

- 2006 WHO Report: global shortage 4.3 million
- 2013 WHO Report: global shortage 7.2 million, 83 countries facing serious shortages
- 2035 projection: global shortage 12.9 million
Not much has changed since 2006

Distribution of health workers by level of health expenditure and burden of disease

Canada: 192/10,000
Malawi: 2/10,000
WHO min: 22.8/10,000

World Health Organization
April 06

Not much has changed since 2006
Critical shortage of health service providers (doctors, nurses and midwives)
Globalization

processes by which nations, businesses and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion and travel
Globalization’s positive health claims

✓ More rapid diffusion of new health technologies
  • Child health revolution
✓ Declines in maternal mortality
✓ Improvements in life expectancy
✓ Increased gender rights
  • Female education as determinant of population health
✓ Increased sense of global obligation
  • Health (and development) aid and the MDGs
✓ Decreased extreme poverty
Numbers of people living below $1.25 a day

Do we have the right poverty goal?

• MDG: reduce by half the rate living in extreme poverty
• Extreme poverty goal met in south and east Asia a year before it was announced
  – Thank you China
• Post 2015 Sustainable Development Goal is to eliminate extreme poverty ($1.25/day PPP) by 2030
• UNCTAD: $5/day PPP should be considered the minimum to claim that people are no longer poor
$5/day poverty cut-off

• By 2030:
  – 4% would still be poor in Europe and Central Asia
  – 15% in Latin America and the Caribbean
  – 30% in East Asia and the Pacific
  – 50% in Middle East and North Africa
  – 90% in South Asia and sub-Saharan Africa

• Reducing inequalities matters

UNCTAD, *Growth And Poverty Eradication: Why Addressing Inequality Matters*, Nov 2013
GOAL 10

REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES

SUSTAINABLE DEVELOPMENT GOALS
More at sustainabledevelopment.un.org/sdgsproposal
Forbes 2014: Now only 67 people

The 85 richest people own the same wealth as the 3.5 billion poorest people.
Maybe a rising tide does lift all boats
But not all boats are born equal
The best outcome in terms of bringing about real change would be to see an end to neo-liberalism. So many of the problems that beset societies today and their populations’ health can be placed at its door...
Defining neoliberalism:

…a belief that free markets, sovereign individuals, free trade, strong property rights and minimal government interference is the best recipe for enhancing human well-being.

Friedrich Hayek

Economy is too complex for governments to regulate so let markets regulate themselves
‘the nastiest of men for the nastiest of motives will somehow work for the benefit of all’

Actual quote from Keynes’ collaborators:
Three Waves of Neoliberal Globalization

• 1.0 (roll-back)
  – Structural Adjustment Programs (1980s-1990s)
  – Liberalization, privatization, low taxation to attract FDI, public spending cut to service foreign debts

• 2.0 (roll-out)
  – Financialized economy (1990s-2000s)
  – Deregulation of banks, creation of financial crises, increased inequalities in wealth within countries

• 3.0 (austerity)
  – Post 2008 great financial crisis and great recession
  – Record unemployment, wage stagnation or decline, structural adjustment for (most) rich and poor countries alike
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Rise of derivatives (trillions of $)

Over 10 times the total value of the global economy

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Enter austerity, stage right, to reduce public debts mostly incurred by bailing out private bank debts.
Neoliberalism 3.0: Austerity Goes Global

- Reduce or eliminate public deficits, public debt
- Reduce social protection spending, public sector employment
- Increase VAT taxes
- Increase user pay in public programs (co-payments)
- Privatize state assets, increase public-private partnerships
- Eliminate fuel and food subsidies

How does neoliberal globalization relate to health worker migration?

• Health worker migration is about ‘push/pull’
• Income inequalities within and between countries drives the push/pull
• In many cases, this push/pull is a legacy of:
  – inequalities within and between countries
  – structural adjustment’s erosion of public health systems in the 1980s and 1990s
  – increased privatized trade in health services
Beginning of the end?

‘last bit, getting to zero, most difficult, most expensive’
Why were we so unprepared?

• Failure of health systems
• Failure of IMF policies
• Failure to stem health worker migration
Why were we so unprepared?

• *Failure of health systems*
• Failure of IMF policies
• Failure to stem health worker migration
Canada: $5800 per capita

Between 70% and 85% is out of pocket
(in Canada, 30% non-public, most privately insured)

Source: World Bank Data Set
Why were we so unprepared?

• Failure of health systems
• *Failure of IMF policies*
• Failure to stem health worker migration
IMF Conditionalities

• Some date back to 1990s
  – Fiscal restraints, wage ceiling, public sector layoffs, public sector spending cuts
• On average new IMF programs in SSA are not associated with declines in health spending
  – But governments overall spend less than they want or need
• Between 2010 and 2013 Ebola country health spending increased only marginally
  – Liberia: 1.6%
  – Guinea: 0.7%
  – Sierra Leone: 0.24%
IMF advice: low taxes to attract FDI

- Sierra Leone:
  - $44 million annually to corporate exemptions (primarily 2 UK mining companies)
  - $200 million annually to other Transnational Corporations (TNCs)
  - $25 million spent on health
  - $32 million spent on education
Why were we so unprepared?

• Failure of health systems
• Failure of IMF policies
• Failure to stem health worker migration
Ebola Countries

• Structural adjustment retrenchments led to reduced health staff
• Sierra Leone: 5 fold decline in CHWs per population
  – 1 in 5 doctors, 1 in 10 nurses work in UK, saving UK $35 million in training costs
  – Half of all doctors working in OECD countries
• Liberia:
  – Early 2000s at top of the list of countries with highest portion of trained health workers emigrating abroad
Figure 2: Health worker density versus child mortality rates

Source: Save the Children, 2011: 1
This book is a carefully documented condemnation of the illusion of Northern donor aid and free trade as Africa’s saviors. In the field of health, a profound critique of the G8 countries, and their African elite allies, is more urgent than ever. I anticipate that African civil society and their partners will take forward this analysis into successful advocacy and activism – as is already happening on AIDS medicines, reparations and the fight against privatization.*

Patrick Bond, Professor, University of the Witwatersrand (South Africa) Graduate School of Public and Development Management and Visiting Professor, Department of Political Science, York University (Toronto)

This book is a very welcome and important contribution to understanding the rapidly changing policy environment surrounding global health. The authors’ detailed analysis offers essential insights into the role of the G8 in global governance, showing that fewer of their health and development commitments are honoured than broken, and most fail to live up to the enormity of the problems facing poorer countries, particularly those in Africa.

A highly recommended read.*

Kelley Lee, Co-Director, Centre on Global Change and Health, London School of Hygiene & Tropical Medicine and Chair, World Health Organization Scientific Resource Group on Globalization, Trade and Health

This book is, to our knowledge, the first attempt to bring together an analysis of G8 policies, commitments and actions related to the South in the major domains known to influence health .... In addition to providing a rigorous and well-referenced evidence base for policy makers, researchers and activists, it is also an innovative presentation of what is effectively a textbook on policy for global health.*

from the Foreword by Christina Zarowsky, Leader, Governance Equity and Health Program Initiative, International Development Research Centre (Ottawa, Canada).

While there is a rapidly growing literature on globalization and its implications, this is the first book to attempt a comprehensive evaluation of its health effects. This book not only provides a detailed and systematic exposé of the contemptuous disregard of some G8 countries for health and other inequalities, as well as of the inadequate progress by the G8 towards meeting pledges that could ameliorate these inequalities, but also makes an important conceptual contribution in mapping out the pathways by which globalization may impact on health. In this way, it provides a useful foundation for researchers at country and regional level to explore the critical question of how global forces are affecting the health of their nations.*

Di McIntyre, Associate Professor, Health Economics Unit, University of Cape Town, South Africa
Mobility of health workers

Source: Diallo (2004)
The ‘cascade’ or chain pattern

Cuba to South Africa to UK, Europe, USA

Kenya to Botswana and Zimbabwe to South Africa to UK

China to Pacific Islands to Australia, New Zealand

### Health workers to the OECD from developing countries

<table>
<thead>
<tr>
<th>OECD country</th>
<th>Doctors from abroad</th>
<th>Nurses from abroad</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of total</td>
</tr>
<tr>
<td>Australia</td>
<td>11,122</td>
<td>21</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td><strong>4</strong></td>
<td><strong>23</strong></td>
</tr>
<tr>
<td>Finland</td>
<td>1,003</td>
<td>9</td>
</tr>
<tr>
<td>France</td>
<td>11,269</td>
<td>6</td>
</tr>
<tr>
<td>Germany</td>
<td>17,318</td>
<td>6</td>
</tr>
<tr>
<td>Ireland</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Portugal</td>
<td>1,258</td>
<td>4</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>United States</td>
<td>3</td>
<td>27</td>
</tr>
</tbody>
</table>

Note: - = not applicable
Canada 2007: increase to 8% nurses
Since 1994, physician migration from South Africa Canada has saved between $350 - $700 million in training costs, while South Africa has lost between $50 - $70 million.
Discomfort over the ‘ethical’ recruitment of foreign-trained health professionals

“I shudder at the word ‘recruit internationally’…we’re only offering information”

“…there’s a concern about taking professionals from countries that are not well resourced…”

“…there’s a whole large segment of our health care sector…that thinks it’s very unethical…”

“we’ve always struggled with the ethics in taking people from a country that probably needs them more than we do…”
“Are we, you know, robbing one country to kinda save another? … in some countries there’s actually an abundance of nurses…Or there’s no funding.”

“So, you know, is there an ethical issue? If they’re unemployed…I don’t think there is…”
Source Country Perspectives on the Migration of Highly Trained Health Personnel: Causes, Consequences and Responses 2010 - 2015
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Research Questions

1. What is the present picture of recent historic trends in the migration of highly skilled health personnel from Jamaica, the Philippines, India, and South Africa?

2. What, according to various stakeholders ‘on the ground’ in these source countries, are the most critical consequences of the migration of highly skilled health workers?

3. What is the range of policy responses that have been considered, proposed and implemented to address the causes and critical consequences of health worker migration from these countries?
Methods

• Structured scoping reviews
• Key informant interviews (n=144)
  – Health workers, government ministries, recruitment agencies, university training institutions
• Surveys (n=4,400)
  – Beyond doctors and nurses to include pharmacists and dentists
• Secondary data and policy analyses
• Dissemination/validation events
  – Philippines, Jamaica
Health Worker Density/1000, Latest Year Available

- Canada (2010)
- India (2012)
- South Africa (2013)
- Jamaica (2008)

Source: WHO Global Health Observatory Data Repository

WHO recommended minimum density physicians and nurses/midwives
Push/pull factors

- No jobs, no promotion
- Poor pay, deteriorating facilities
- Inadequate supplies
- Stress, overwork
- Political/racial upheaval
- Gender discrimination
- Gender violence
- Personal insecurity (theft, violence)
- Poor accommodation, lack of transport
- Poor education for children
- Available jobs
- Reasonable remuneration
- Career challenges/opportunities
- Regular workload
- Better working conditions
- High income countries ‘safe, not corrupt’
- High income countries ‘tolerant’ with good quality of life
- Greater opportunities for children
Push/pull still alive and well: Jamaica

How likely is it that you will move to another country in the next 5 years?

N=361
Are health workers still leaving South Africa?

- Little change in health worker density in the past decade
- 30% physicians working in public sector serving 70% of population
- ~30% of South African trained physicians working in Anglo-American OECD countries
- Concern over nurses moving from public sector to global health initiatives

‘sowed considerably…’
‘gone down dramatically, we breathe a sigh of relief…’
‘three years ago a huge exodus of doctors, now more settled, but outflow is still there’
‘nurses no longer going to [UK], but [Gulf States] still recruiting’
Push/pull still alive and well: South Africa

Likely to move to another country within...

N= 1383
Push/pull still alive and well: The Philippines

Very or somewhat likely to emigrate

Interview N= 420

On-line N = 202
Push/pull still alive and well: The Philippines

Interview N = 420

On-line N = 202
The Philippines (cont.)

- About half of all nurses surveyed reported intent to migrate in next year
- Future intent even higher
- Many do not work as nurses in countries to which they emigrate but as personal care providers (failure in high-income countries to provide effective elder care)
- Nurse/patient ratio government hospitals 1:50 (1994) and 1:100 (2004), basic health indicators slowing or worsening since 2002

_Four out of five new nurses in hospitals came from abroad in 2013-14, most from Spain, Portugal and the Philippines_
Push/pull still alive and well:
India (Punjab)

N= 399
Push/pull still alive and well: India (Punjab)

Fig 8. Migration Abroad and Time

Fig 9. How likely the Health Professional will Migrate in next Five years

N = 399
Push/pull still alive and well: India (Kerala)

‘Doctors or nurses in government rarely prefer to move out…more secure here than abroad’

‘private sector nursing salaries are very low and service conditions are poor. Government jobs are not available. Therefore nurses migrate…’

‘We want people to migrate, but we don’t have a conscious policy. …people will migrate and this is better for the state if they migrate with a better bargaining position…’

N= 1337
India

- Still considered an HRH ‘crisis country’ by WHO
  - Although perception that outmigration is less now than it was even 5 years ago
- Highly privatized health system
  - Only 6% public, in top 20 countries in portion of GDP ‘out of pocket’
  - 2015 health plan continues privatization expansion
- Expanding physician and nurse training aimed at exporting health workers
Top Reasons for Migrating

Workplace:
• Poor income
• Poor work infrastructure
• No advancement opportunity

Living:
• High living costs
• Poor public infrastructure
• Poor quality consumer goods

Workplace:
• Lack of respect from government
• Poor infrastructure
• Personal security at work

Living:
• Level of corruption
• Lack of personal/family safety
• Poor future, children
Top Reasons for Migrating

Workplace:
- Poor income
- Poor working conditions
- Poor education opportunities

Living:
- High living costs
- Pay back training costs/loans
- Personal and family safety

Workplace:
- Ease of finding health job overseas
- Low job satisfaction
- Poor advancement opportunities

Living:
- Lack of employment
- High living costs
- Poor living conditions
Return Migration

‘Some do [return] but it is the minority’
‘I don’t know of many who actually come back.’

• 11% of respondents had worked abroad
• Many had problems returning (lower salaries, loss of status)
• Most do not think their return permanent

‘They are using the option of going [abroad] for a few years to earn some money... then coming back [with] a nest in which to work.’

• Most do not think their return permanent
Return Migration

‘Unmarried [nurses] go abroad, marry, don’t return’

• Very little evidence of return migration
• Nurses twice as likely as other SHWs to return; challenge is reintegration
• Age limits on return: <30 (nurses), <50 (doctors)
• Most return to private sector where conditions are worse
• Return migration not even encouraged

‘Those who are in the UK, USA and western countries, they won’t come back…dislike working conditions in India’

‘The present administration has made its position when the President said that he wanted our migrant workers to come home’

‘Well, if you look at the typical advertisements for migration, it’s actually being promoted [and] by the national health department’

• Promoting medical tourism to promote return migration, no evidence of effectiveness
• Financial incentives to returnees, but émigré health workers not returning to health care work
Remittances

- >$2 billion annually all émigrés
- 80% of survey respondents said they would send some money home, but did not indicate how much
- Second highest ($1 billion) after Kenya
- SA physicians in Canada: only 19% remit regularly, > 30% never remit
- Likelihood to remit by profession and % of earnings
Remittances

• Largest recipient of net remittances (>$70 billion annually all émigrés)

‘Two-thirds of the recently passed nurses (women) prefer to migrate and having common characteristics like they all belong to middle class families’ (Punjab).

• 3rd highest in the world (>$23 billion)

• Online respondents even more likely to indicate intent to remit

• Doctors likely to remit highest median portion of their income
Remittances

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Health System Impacts

“We have lost a whole generation of nurses. Our records show that every health facility lose their qualified staff on a continuous basis.’

• >80% respondents note problematic impacts due to migration
• Decreased care/prevention for HIV
• Decreased immunization rates
• Recruitment of Cuban, Nigerian, Indian and Burmese to fill the gaps

‘I’m an intensive care nurse myself, and I’ve had to work a 48-hour shift before, because of [shortages]’

‘So we often close our casualties, have ambulances by-pass, because we don’t have staff…’

• Unfilled physician and nursing posts rising, and now ~50%
• Most specialists work in private sector or migrate
• GHIs (notably PEPFAR) taking health workers out of health system
Health System Impacts

- Punjab:
  ‘Nurses, certainly a loss but not many go’
  - Benefits of remittances seen as compensating for losses
  ‘doctors are terribly overworked, we need more infrastructure, then more doctors’
  - Shortages at all levels of care

- Kerala
  ‘all the really good people are serving for other countries’
  - Main shortage is mismatch, rural to urban; main migration is from private, not public

- Survey responses:
  - Worker shortages
  - Reduced services
  - Increased medical errors
  - Poorer care quality
  - Long wait times
  - Patients having problems with access
  ‘a lot of our health workers, when they migrate, most of them are the cream of the crop’
  ‘(Families are) disintegrating—migrants’ families are becoming non-functional’
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Mitigation Policies

• Bonding or return of service
• Increased wages and training enrolment
• Opportunity to divide practice time, USA/Jamaica (‘circular’ migration)
• Non-financial incentives *but* government spending in health is declining *and none* of these options have been evaluated

• Source and destination country
• ~ 25% of physicians foreign-trained, bilateral agreements with Tunisia, Iran and Cuba
• New training facilities, bonding or return of (rural) service for free education
• Training new cadres (clinical associates), task-shifting
• OSD – occupation specific dispensation

‘*With the introduction of OSD, we found some people coming back especially the nurses*’
Mitigation Policies

- ‘India policy not to stop migration for financial (remittance/foreign exchange) reasons’
- ‘allows active recruitment’
- Increase health worker production (including mid-level cadres)
- Provide more infrastructure (Punjab)
- Public salaries improving for nurses ‘migration only if you can’t get job in government sector’
- Reputational and non-financial incentives

‘The Philippines has the best system for migration. (The country has) these machineries or systems created to facilitate migration. POEA, DOLE, OWWA, part of the machinery for labor export.’

- No policies to prevent migration, some to assist retention
- Scholarships with return of service
- Most respondents agree with return of service/community work requirement (& in rural area if scholarship trained)

‘For me, in order to stem the migration of any profession we have to make the Philippines a viable place to practice.’
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Policy Responses to Global HHR Flows: Mitigating Push/Pull

Return migration (minimal impact/high cost)
Restrict emigration/bonding (minimal impact) or immigration (moderate impact but unpopular and violates human rights treaties)
Bi- or multilateral agreements (moderate impact but limited in scope)
Improved domestic HHR self-sufficiency (widely endorsed but not followed)
Policy Responses to Global HHR Flows: Mitigating Push/Pull

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Restitution (equitable but not popular with countries accepting HHR émigrés)
Four Arguments for Restitution

- **Normative:** Agreement on MDGs, three directly health related, all indirectly health related, commitment that no country should fail to meet them due to lack of financial resources; and now the SDGs
- **Legal:** Human rights treaties (ICESCR) actually obligate wealthier nations to do this
- **Political:** federated states, European Union – transfers from wealthier/more populous to poorer/less populous for purposes of improving equity in peoples’ access to essential services/resources (‘capabilities’)
- **Ethical:** Thomas Pogge’s argument of ‘relational justice’ – evidence that global institutional arrangements are disproportionately benefiting some and contributing to poverty of others; those benefiting from/upholding these institutions are duty bound to rectify their inequities
GOAL 10

REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES

SUSTAINABLE DEVELOPMENT GOALS
More at sustainabledevelopment.un.org/sdgsproposal
• Reduce maternal mortality
• End preventable newborn and <5 mortality
• End AIDS, TB, malaria and neglected tropical diseases
• Reduce preventable NCD mortality
• Ensure universal health coverage (UHC)
• *Increase health financing and recruitment/retention of health workers in LMICs*
Policy Responses to Global HHR Flows: Mitigating Push/Pull

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Bi- or multilateral agreements (moderate impact but limited in scope)
Improved domestic HHR self-sufficiency (widely endorsed but not followed)
Restitution (equitable but not popular with countries accepting HHR émigrés)
Bilateral tax transfers from émigrés to home country (potentially most equitable and easiest to administer)
Taxes are the price we pay for a civilized world
Source: WDI, data for 2012
Health spending per capita US$

Sources:
A TAX OF 1.5% ON BILLIONAIRES SINCE THE FINANCIAL CRISIS COULD HAVE SAVED 23 MILLION LIVES

1.5% TAX 23m LIVES

OXFAM: Even it Up, 2014
Improve/develop global systems of taxation (FTT):

• .05% on all global currency trades $8.63 trillion a year

• 63 countries have signalled support for an FTT

• 11 of 27 Eurozone countries: $40 - 47 billion annually (2016) (maybe… if they can stop squabbling on the details)
So What Might We Conclude?

• Health worker shortages persist
• Several countries remain in health worker crisis
• Despite some improvements in some countries (e.g. South Africa) the intent to migrate remains strong
• Push factors predominate, and extend to national political factors and not simply health care facility or professional work-related factors
So What Might We Conclude?

- Some evidence of return migration often due to nature of contract work abroad
- Return migration unlikely to be permanent and intent of governments to promote (notably the Philippines) questioned by many
- Remittances important but more personal or indirectly economically enhancing than contributing to health worker shortages, employment opportunities or improved health care access
So What Might We Conclude?

- Most study countries report negative impacts on health system of migration (even when migration not the major reason for health system problems)
- Bonding, return of service, short-term circular migration, improved wages and non-financial incentives, task-shifting, training new cadres and improving national living conditions all possible helpful mitigating policies
- Some reference still to restitution
Health worker migration: A force for global health gain or loss?

- It is imperative that international agencies implement pilot programs for **reducing the emigration of physicians from Sub-Saharan Africa** (Bhargava & Docquier, 2008)
- Africa’s generally low staffing levels and poor public health conditions are **the result of factors entirely unrelated to international movements of health professionals** (Clemens, 2006)
Brief return to the globalization context

• Inequalities rising in most countries
• Unemployment still extremely high
• Wages stagnant or falling in many countries (relative to inflation)
• Taxation falling (or not rising) in most countries
• Private investors keen to grab more of the government slice of services (knowing governments *must* provide to remain in power) (and using trade and investment treaties to do so)
• Share of global wealth going to labour way down since the rise of neoliberalism
• Share of global wealth to the 1% (or 0.1%) way up since the rise of neoliberalism
• *Should we be surprised there is still HRH migration?*
Private sector contributions and their effect on physician emigration in the developing world
Lawrence C Loh, Cesar Ugarte-Gil & Kwame Darko

- Looked at 3 countries and found an inverse relationship between private health care expenditure and physician emigration (% of total physician population)
- Speculate that private systems are financially more attractive to physicians (earn more)
- Private systems (especially in less regulated India) increase ability of poorly trained physicians to practice and earn a living
- Cautioned that impact on equity in access to health care (universal health coverage) an issue
- And very limited sample!
Lesotho’s IFC Public-Private Partnership

Source: A DANGEROUS DIVERSION Will the IFC’s flagship health PPP bankrupt Lesotho’s Ministry of Health? Oxfam 2014
Trading health for oil? Uganda should not export its health workers

<table>
<thead>
<tr>
<th></th>
<th>Physicians (per 1000 people)*</th>
<th>Nurses and midwives (per 1000 people)*</th>
<th>Under-five mortality rate (per 1000 people)†</th>
<th>Maternal mortality rate (per 100 000 people)†</th>
<th>Skilled birth attendance (%)†</th>
<th>Health spending per capita ($)†</th>
<th>GDP per capita ($)†</th>
<th>Taxes (proportion of GDP)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinidad and Tobago</td>
<td>1.175</td>
<td>3.562</td>
<td>21.3</td>
<td>84</td>
<td>97.8%</td>
<td>972</td>
<td>18 373</td>
<td>28%</td>
</tr>
<tr>
<td>Uganda</td>
<td>0.117</td>
<td>1.306</td>
<td>66.1</td>
<td>360</td>
<td>41.9%</td>
<td>44</td>
<td>572</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Data are from Global Health Observatory. †Data are from World Bank Data set (for latest comparable years available).

Table: Comparison of health systems

T&T: In return for oil expertise, requests 263 health workers from Uganda to fill gaps in its own workforce (55% physician, 65% nurse expatriation rates) (no ‘critical’ shortage)

WHO Code: ‘discourage active recruitment from developing countries facing critical shortages’ (Uganda ‘critical’ shortage)

T&T: Growing medical tourism, projected 6,500 international (primarily American) patients by late 2015, in private facilities, in areas requested of Ugandan health specialists…connection?
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