Building National, Self-Sufficient Health Systems – Facing the Challenge of the Global Health Workers' Shortage.

Surfacing some of the debates on the health workforce crisis.

By Edlira Xhafa

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"The importance of building national self-sufficiency to manage domestic issues of supply and demand, in rich and poor countries alike, is critical."
(The Global Nursing Shortage)

Abstract. Health workers shortage and migration comes up as a critical issue in almost all the debates around health. The paper does not dwell much on the separate issues of migration and health workforce shortage as the areas have been broadly researched and an extensive literature is available. It rather attempts to shed light on some critical issues, which have emerged from the discourse on global health workers shortage and migration. Compensation for the sending countries, portability of skills, task shifting and community health workers have come up in the global agenda. The paper tries to point to some of the controversies that these issues raise. In doing so, the paper questions first what lies beneath the health workers "shortage" in the developed world and its relation to migration. The discourse on migration is rather complex, but the paper tries to examine how a disarticulated approach to the question of migration in both the developed and developing countries has contributed to the exacerbation of the global crisis on health workers. As the crisis is attributed to a host of factors, which at first sight seem to be specific for developed and developing countries, more careful analyses would demonstrate a common background to the crisis. In fact the paper, attempts to relate these critical issues together, asserting that solutions to the crisis would need to address the common roots otherwise a focus on the symptoms would not be sustainable or would adversely influence the crisis.

Background facts on health workforce crisis

Health workers are the backbone of the health systems. Workers are the ultimate resource in health as it is people who deliver health. Amazingly, even though the workforce commands the largest share of the budget, it is the least strategically planned and managed resource of most health systems.

A Joint Learning Initiative (JLI, 2004)[1] report estimates a density of 2.5 workers per 1,000 as a threshold of worker density necessary to attain adequate coverage of some essential health interventions and core Millennium Development Goals (MDG)-related health services. This threshold, which is more of a guideline, is directly related to infant mortality, under-five mortality immunisation and maternal mortality. The same report asserts that higher worker density generates better health outcomes, and workers report lower burnout, better morale, and greater job satisfaction when the number and quality of staff are adequate.

The actual data demonstrate a high inequality in health systems worldwide. Average density is one worker per 1,000 population in sub-Saharan Africa, but more than 10 per 1,000 in Europe and North America.

Health workers are inequitably distributed throughout the world, with severe imbalances between developed and developing countries. This global workforce shortage is made even worse by imbalances within countries. In general, there is a lack of adequate staff in rural areas compared to cities. The health workforce crisis is recognized all over the world, with Sub-Saharan Africa facing the worse crisis. While it has 11 percent of the world's population and 24 percent of the global burden of disease, it has only three percent of the world's health workers.

The Americas	Sub-Saharan Africa
14% of the world's population	11% of the world's population
10% of the global burden of disease	25% of the global burden of disease
42% of the world's health workers	3% of the world's health workers
>50% of global health expenditure	<1% of global health expenditure

Source: WHO, 2006

According to a World Health Organization (WHO) report (2006), there are 59.8 million health workers worldwide, about two-thirds of them (39.5 million) provide health services; the other one-third (19.8 million) are management and support workers (WHO, 2006). The same report shows that the situation of health workforce shortage is more severe in 57 countries, most of them in Africa

[1] JLI was a network of a 100 health academics and leaders, who wrote for the first time, in 2004, a comprehensive report on global health workforce crisis. Much of the debates on the human resources for health HRH crisis refer to this report.

and Asia. WHO (2006) estimates that at least an extra 2.360.000 health service providers and 1.890.000 management support workers, or a total of 4.250.000 health workers, are needed to fill the gap.

Uncovering the roots of the health crisis

> The most important resource for any state is its people. The role of human resources is central to development, while the limited availability of human resources is a constraint… In the health arena the significance of human resources is doubled; skilled health personnel directly improve the quality of life for others, who are then able to contribute more to the wider society. Conversely, the lack of skilled health workers has harmful ramifications for the rest of society (PSI, 2005).

Examining the history of developed nations, the JLI (2004) report shows once more that the doubling of life expectancy among privileged populations in the last century was propelled in part by the transformation of the workforce into a cluster of science-based, formally organised, well trained and well compensated professions. The same report underscores how health workers have spearheaded systems, initiated change, and catalysed community-driven transformations in health. Moreover, unlike other inputs, a health workforce can not simply be bought on demand – it is an investment as it takes decades to build up a dedicated, professional and effective health workforce.

The JLI report (2004) emphasizes some of the main concerns challenging the health workforce today all over the world:

- *A massive global shortage of workers*. An estimation of the shortage speaks for four million workers, yet the estimation is very approximate. Sub-Sahara African countries remain the region hit harder from the crisis and it is in this context that often the reference will be made to that region. The research considers the importance of making sure an urgent increase of one million workers in this region, to approach the MDGs achievement.
- *Skill imbalances, which create huge inefficiencies.* There is a skill mix which depends mainly on doctors and specialists; and the public health workers based on the needs of population are often let aside. It is obvious a need for a workforce which reflects the needs of the population and which uses better auxiliary staff and community workers.
- *Misdistribution which is worsened by unplanned migration.* Nearly all the countries have problems with a high concentration in urban areas, leaving the rural ones in very poor conditions of health service. The misdistribution has another aspect which is the movement from public to private sector, which from the other side is again more concentrated in the urban areas. Migration, especially unplanned migration, has caused severe crisis

especially in countries which are already facing desperate health service situation.

- *Negative work environment.* Nearly all the countries have problems with professions and work incentives, carrier opportunities, financial and non financial incentives, drugs and equipments and supplies.
- *Weak knowledge on workers impacts negatively on possibilities for greater effectiveness.* There is lack of information on workers, the data are fragmentary and there is limited research. These deficiencies heavily impact on planning, programs and policies.
- *Health workers leaving the health service.* Working in health services, which are constantly under the pressure for reforms and budget cuts, becomes increasingly difficult. Strong pressure, stress, lack of staffing and overload are becoming the main characteristics of work-place in the health services. (JLI, 2004)

Although the problems of human resources for health do vary, the JLI report (2004) asserts that all countries are faced with these challenges.

The paradox of the health workforce "shortage".

Health workers shortage and human resources for health crises is the highlight of almost all the events around health. In the perspective of economic logic, the high demand for health workers and the shortage of supply would translate in stronger bargaining position of health workers' trade union, resulting in better wages and working conditions.

But, this is not the reality as the paper attempts to show. In the times of high labour mobility and globalisation of health workforce, there is more space to rely on health workers elasticity, without needing to invest on people who deliver health.

Yet, some questions remain pending: Which is the cost of this solution? And is this solution sustainable?

What lies beneath the health workforce "shortage" in the developed world?

The health workforce crisis in the developed world is highlighted by a nurses' shortage. This shortage has caused alarm among a number of developed countries as the situation threatens to undermine doctors' ability to deliver high standards of clinical care on hospital wards and constrains delivery of health care in an increasingly aging population (McKee, 1998; Lovell, 2006). Save the Children (2006) reports that:

- By 2008, the UK will need 25.000 more doctors and at least 35.000 more nurses.
- By 2010, the USA will need to recruit an extra one million nurses.

Similarly, Nelson (2004) points to a critical situation where nearly every EU member nation and non-EU countries such as the USA, Canada and Australia, are reporting severe shortages of nurses. And the high rates of nursing vacancies in these countries show no sign of let up!

One of the most frequent reasons for the current shortage is the growing population of elderly in the North, who would require increasing level of health care. Ironically, the demographic data predicted long ago the aging trends of many developed countries. Policy makers decided to ignore these trends and instead proceeded with health workforce policies, which did not respond to the expected challenge. As the nursing workforce continues to age, and qualified nurses leave the profession faster than they can be replaced, the crisis grows. The lack of qualified nurse educators compounds the problem with the inability to quickly train new nurses (ICN/FNIF, 2006). The same is being confirmed by WHO (2006) which recognizes the workforce aging phenomena and stresses at the same time that "wealthy countries are not producing enough health workers locally". One reason cited is restricted access to training programs due to inadequate teaching staff and facilities. In the US for example, about 150,000 qualified applicants were turned down in 2005 at U.S. schools of nursing (both associate and baccalaureate degrees). Klein (2006) points to low pay for teachers of nursing as the main problem, combined with the fact that nurse-training programs are often money losers for community colleges and universities. WHO (2006) states that in fact the U.S is training 30 percent too few health physicians to cover its needs. Teaching in the nurses' school is not that attractive for qualified nurses as the wages are too low. In Britain, although there was an increase in the number of training places by the end of the 1990s, such increase only compensated for the significant cuts during the late 1980s and early '90s. (Finlayson et al, 2002). In 2003, 43 percent of British nurses were trained abroad, compared to 10 percent a decade earlier, whereas almost 25% of doctors in Canada, Australia and the US are foreign trained. (PSI, Migration Facts[2]).

Other reasons seem to be contributing substantially to the health workers shortage in the developed world. Nursing is a job, primarily preferred by women and is affected by gender-based bias in pay. As Lovell (2006) puts it, **"the emerging nurse shortage is caused by job satisfaction problems such as inadequate staffing, heavy work-loads, the increased use of overtime, a lack of**

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[2] See: http://www.world-psi.org/TemplateEn.cfm?Section=Women_Health_Workers&CONTENTID=8236&TEMPLATE=/ContentManagement/ContentDisplay.cfm

sufficient support staff, inadequacy of wages and by too few workers training as nurses".

Nursing as a job is becoming more and more unattractive in the developed world. This is expressed in the high turnover of the nurses in the hospitals and in the high proportion of nurses choosing a job outside nursing. In the US, one in 20 licensed nurses (5%) has chosen a job outside nursing according to Lovell (2006). Some estimations show that the number of vacancies in the US is as high as 150.000; meanwhile, there are 136,000 nurses who are working outside their profession and 120,000 under the age of sixty who have left the labour market entirely (GTAG, 2007). Ironically, instead of investing more in training facilities and possibilities, the political decisions go another way.

> "In 2006, the US senate voted to increase substantially the number of foreign nurses allowed to come to the US after the American Hospital Association claimed that there was a national shortfall of 118.000 nurses. Meanwhile, in 2005, US nursing schools had to reject almost 150.000 qualified applicants for lack of space." (Faux, 2007)

The same trend is observed in the UK. According to Finlayson et al (2002), "the NHS is struggling to recruit and retain nursing and midwifery staff in a time of high turnover rates and low morale". In Canada, Nelson (2004) quotes the president of CAN (Canadian Nurses Association) Robert Calnan saying, that despite shortages, large numbers of Canadian nurses cannot find full-time employment in Canada. The Canadian Institute for Health Information (2006) reports that in Canada only 53 percent of nurses work full-time. Calnan continues by claiming that "if we're going to keep our nurses, employers must create more full-time positions, improve working conditions, and support the ongoing educational needs of the nursing staff."

Indeed, the foregoing trends were already confirmed in the JLI (2004) report:

> "It is tragic that, in the midst of a serious and growing nursing shortage, we have nurses who are educated and want to work, but who remain unemployed as a result of spending limits. It is clear that without lifting public expenditures ceilings, expansion of the workforce and improvements in salaries and financing incentives will be impossible."

On the same vein, PSI (2004:12) laments the misallocation of resources within health systems where money is being spent on the purchase of high-tech medical equipment, rather than on human resources. The research points out that "in such cases, priority is not given to increasing the wages of health workers in order to retain existing staff or to motivate those not currently working in the field to return to work in the health sector" (PSI, 2004:12).

Clearly, the health workers in the developed world are not lacking. They are not just willing to work in health systems which are increasingly under reforms, following cuts in the governments' expenditures resulting in stressful, pressured, understaffed and under-resourced workplaces. Today, even newly trained graduates are leaving the professions after only a few years (PSI, 2004) like in the case of one Ontario government (one of the states in Canada) where 20% of young nurses are leaving the profession (Canadian Federation of Nurses Union, 2006). In Britain, four main reasons have been pointed out as the root of the high turnover: pay and the cost of living, the changing nature of the job, perceptions of being "valued," and other employment opportunities (Finlayson et al, 2002).

The dynamics of the foregoing situation constitute in fact a perfect climate for the business of recruiting companies if met by a willing workforce to migrate from elsewhere. The EU Commission acknowledges the same when it states that, "inadequate long-term human resources planning and domestic production of health workers, coupled with aging population in developed world, will continue to fuel recruitment from resource-poor countries" (EU Commission, 2005).

But who would want to take the place of the frustrated health workers in the developed world?

An article from the Le Monde Diplomatique (2006) refers to African health workers as the easy preys for the northern economies. A Physicians for Human Rights report (2005) notes that:

> "Health facilities and agencies in wealthy countries – including the G8 countries of more predominantly, the UK, US, and Canada recruit health professionals from Africa (and other developing countries) to meet their own health care needs. Many wealthy countries are themselves experiencing shortages of nurses and doctors, with the nursing shortage becoming particularly significant. Higher income countries are increasingly turning to lower-income countries to bridge the gap, such that countries including Malawi, Nigeria, Ghana and South Africa are essentially training their nurses – and paying for that training – for work in wealthy countries. "

The continual drain of human resources from Africa, combined with decades of harsh economic policies, has led to chronically under-funded health systems. Le Monde Diplomatique (2006) point to the meagre salaries of the health staff, giving the example of the purchasing power of the wage of a Nigerian doctor, which is 25 percent lower than that of a doctor even in Eastern Europe. "They work in insecure areas and have heavy workloads, but lack the most basic

resources, including insufficient drugs and medical equipment. In short, they have little chance of career advancement" (Le Monde Diplomatique, 2006).

Indeed, globalisation has resulted in an increase in movement of internationally competitive professionals, among whom nurses and doctors rank high, and perhaps second only to information technology engineers (Narasimhan, et al. 2004). Ndioro Ndiaye, Honourable Minister and Deputy Director of the International Organization for Migration, points to the fact that, every year, 20,000 skilled health workers leave the African continent, resulting to a total annual loss of $500m superior to the international development aid (Save the Children, 2006). Accordingly, to train a doctor, a government has to spend $60,000 and $15,000 for a nurse.

In their attempt to address the serious situation of HIV/AIDS in the developing world, the WHO and Joint United Nations Programme on HIV/ Aids launched in 2003 the 3 by 5 initiative. However, the initiative fell short of its objective "to have three million people in low and middle-income states onto anti-retroviral drugs by the end of 2005" because although the money and the drugs were available, the delivery systems [health workers] were inadequate (PSI Focus, N.1, 2006). Senior officials in Ethiopia, Nigeria, and Uganda have all cited lack of health personnel as the main constraint to mobilising responses to health challenges. The commitment of Botswana, a comparatively rich African country, to provide free antiretroviral therapy to all eligible citizens is being hindered, not by lack of money but by lack of health personnel (Narasimhan, et al. 2004).

Health workers migrate in a desperate attempt to escape poverty and help their families back home. The factors that influence decisions to migrate are well known: low pay, irregular pay, poor working conditions, work overload, limited promotion and training opportunities to name a few. A Polish nurse has this to say:

> Nurses don't leave Poland because they want to…, but because they are forced to leave. If we had at least a minimum living situation secured, and we are not talking here about comfort, or about luxuries, but at least minimum standards, then nobody would consider going abroad and severing herself from her family. Maybe a small group of people would emigrate under these conditions, those pushed by the spirit of adventure, and that's it (PSI, 2004).

Clearly, migration is by no way just an individual decision as the neoclassical economic theories of wage differentials or rational choice try to explain it. The political developments of the last three decades have shaped a structural framework that has accelerated significantly the process of migration. The International Organisation for Migration (IOM), the WHO and the Organisation

for Economic Cooperation and Development (OECD) have largely relied on a "push-pull" factor analysis on the migration issue, ignoring to a large extent the broader structural framework on which migration occurs (PSI, 2004). Indeed, the importance of complementing a "push-pull" analysis with a structural framework analysis becomes essential.

> "On first impression … (migrants) would seem to move by their own free will. But many migrants would rather not have to move to seek work or money. They are compelled by varied combinations of individual and structural factors. The primary structural factor is disparities in income and opportunity between different countries…. Thus, behind this "freedom of movement" lie compelling structural factors based on global inequalities. Much of the blame must be put on the promotion of market economics and especially the imposition of Structural Adjustment Programmes." (PSI, 2004)

The consequences of health workers migration have been severe for many countries around the world. "While nursing migration often occurs between nations of similar economic status, nurses are also being widely 'poached' from poor lands to rich ones. Unfortunately, the nations that can least afford to lose their health-care workers, and who cannot compete in the global trade, can only watch as their trained nurses are siphoned off (Nelson, 2004). The nurse poaching has transformed the realities of many countries as the Global Health Watch (2005-2006) shows:

> "For example, the number of non-European Union nurses registering with the Irish Nursing Board rose from less than 200 a year to more than 1.800 between 1990 and 2001. In the UK, the proportion of overseas-trained nurses admitted to the professional register each year rose from just over 10% in 1990 to more than half in 2001. The countries that experience high levels of out-migration are often those that can least afford to lose skilled personnel, such as Zambia where an estimated 550 of the 600 doctors trained since independence have gone abroad. The migration of teachers and academics from poor countries has also damaged countries' capacity to train new health workers" (Global Health Watch, 2005-2006).

The picture of health workforce composition has changed increasingly. As Nelson (2004) notes, Ireland, once overflowing with excess home-grown nurses, is now recruiting from the Philippines. Canada is recruiting British nurses. The UK, which lost over 8,000 nurses last year to overseas employment—the highest number in 10 years—then draws nurses from countries such as India, South Africa, and Jamaica. South Africa, in turn, looks to nations such as Ghana for replacements, and Jamaica is recruiting from Nigeria.

> “Ghana lost over 500 nurses to overseas employment in 2000, three times the number from 1999, and more than doubled the number of nursing graduates Ghana produced that year. Nurses in Ghana earn on average US$75 a month. This amount is not enough to compete with overseas jobs, nor sufficient to attract foreign nurses to their country. Even the Philippines, long considered to be a bottomless source of highly qualified nurses, is beginning to feel the strain of over-intensive recruitment. According to figures from the Philippine Overseas Employment Administration, nearly 34 000 nurses went abroad between 1995 and 2000. But in 2001 alone, the figure was 13 536, or 40% of the total 1995–2000 deployment. “Very soon, the Philippines will be bled dry of nurses”, notes Jaime Z Galvez-Tan, vice chancellor of the University of the Philippines, in a paper about the nursing crisis in the Philippines. “Sadly, this is no longer a ‘brain drain’ but, more appropriately, ‘brain haemorrhage’.” (Nelson, 2004)

Sometimes, countries (governments) themselves decide to pursue a nurses’ export policy as a solution to the failure of creating employment, but also considering the remittances as “a major financial muscle … [as the chance the next half of the century] to conquer world poverty if migration is open and managed adequately” (PSI, 2004). Some countries like India, the Philippines, Cuba, and increasingly Indonesia and China have decided to increase the health workers training and prepare them for **export**. A Report from the European Commission (EC, 2005), states that this policy is pursued in spite of domestic shortages and inadequate access to services for the poor. A case in point is the Philippines which is operating a managed migration policy and is the largest source of registered nurses working overseas. Entire units of nurses have left hospitals causing severe understaffing and now doctors are increasingly retraining as nurses in order to migrate to higher paying jobs, particularly in US (EC, 2005). At this point, the demand for health workers, primarily nurses and the “willingness” to migrate at the cost of even being trained as nurses in preparation to migrate is hardly believed to be a personal decision.

Clearly, countries decide to “forget” the historical lesson on the importance of building national self-sufficiency to manage domestic issues of supply and demand, in rich and poor countries alike. This is underscored in the JLI (2004) report: *Investment was replaced by neglect;* almost three decades of health sector ‘miss-reforms’ under the neo-liberal agenda treated health workers as a cost burden, not as an asset. This sorry reality made Chen (2004) ironically remark that, “Amazingly, buildings are considered capital assets, while human capital is considered a recurring burden”.

Indeed as the paper attempted to demonstrate, health workforce is exposed to the same neglect worldwide. Under the gospel of “private sector – the cure for all”, the governments undertook “health sector reforms which followed an

‘American model’ of industrial restructuring in which the cheapening and reduction of the workforce was designed to reduce the costs and increase efficiency” (PSI, 2004). The reforms were based on the assumption of the “infinite elasticity”, where the health workers (women and migrant workers) would be forced to work, either because of professional dedication or out of increasingly unsecured labour market (PSI, 2004). Corollary, the developed world ignored to address the needs of health workers at national level and opted for global market solutions. They decided to bridge the gap of health workers shortage through overseas recruitment, instead of investing in their own health systems. In a global market where the players have different powers, the results of this political movement could be easily anticipated. As “recruitment from abroad seems to be cost-effective and a simple solution to a shortage of health workers”, in “seeking personnel from Africa, rich countries save on the cost of training, which is about 10 times higher at home than in Africa” (Le Monde Diplomatique, 2006). In the meanwhile the poor countries are experiencing a severe shortage of health workers and worsening of their health systems.

Would a compensation scheme resolve the human resources for health crisis?

Brain drain may be one of the most used terms associated to migration. Stiglitz (2006:51) quotes what Mahathir bin Mohamed, former Malaysian Prime Minister, said about migration of highly-skilled workers: it is like "stealing the developing countries' intellectual property". While intellectual property protections assure drug companies of high prices and high profits, developed countries that "export" highly-skilled workers received nothing in compensation (Stiglitz, 2006: 51). Since 1999, Ghana has lost $67m in health system investment because health workers emigrate once they have completed their training (Le Monde Diplomatique, 2006). Needless to say, it is much more difficult to calculate the lives that would have been saved or the missed opportunities for better health for Ghanaian citizens. As there is an increasing recognition of the perverse subsidy that poor countries are making to the health systems of rich countries, the sending countries are demanding compensation. But the debate is more complex.

The World Health Assembly (May 2006) surfaced once more the tensions on the issue of human resources for health crisis and migration. Khor (2006) describes a tension emerging among the Assembly members. The rich countries’ intention to help to fund medical education of developing countries to train more doctors and nurses to provide health care at home country and for other countries was received with disappointment from many in the Assembly. The proposal was considered “an inadequate solution” and instead the developing countries proposed more direct interventions as “disallowing out-migration of health

personnel, or asking for compensation to the 'source countries' that have trained the personnel at high cost". According to Khor (2006), these interventions proposed by developing countries are too "sensitive" for the developed world. As a result, the World Health Assembly adopted a mild resolution on 'scaling up of health workforce production', urging governments "to consider having mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel, through migration" (Khor 2006).

The debate on compensation raises some important issues. The receiving countries seem to be still unwilling to invest on their own health workforce, the education of health professionals included. Indeed, "health sector reforms following cuts in government expenditures, in countries in both North and South, have relied on health sector workers to work longer hours with less pay" (PSI, 2004). The debate on the World Health Assembly of 2006 echoes this consistent political choice of tight governmental budgets for the health workers. This implies that poor countries will need to come together strongly to push for a compensation bill. Immediately some questions are raised. Will a possible compensation bear the cost of training of health workers and other occurring costs of out-migration just to make both parties feel more 'comfortable'? Or will it be accompanied with measures to disallow out-migration of health workers aiming at building self-sufficient health systems? Put differently, would it be a compensation for the costs occurring to prepare for migration or would it be a fair compensation calculating the cost of the perverse subsidy that sending countries have been providing for decades? If compensation is agreed, where and how will the sending countries invest?

If the compensation goes to strengthen human resources for health, as investment to people who deliver health, most probably the flow of health workers migrating to other countries will slow down. This is in fact the target objective of any policy intervention to solve human resources for health crisis. The WHO has estimated that African health services will need to train and retain urgently an extra one million health workers by 2010 if they are to meet the MDGs. To achieve that objective according to the Commission for Africa, between $1bn and $6bn will be necessary from 2006 and as much as $7bn from 2010, to make up for the lack of African health professionals (Le Monde Diplomatique, 2006). Four million workers are to be trained in the 57 countries facing the most severe crisis of health workforce till 2025 if the gap is to be closed. That would mean that health budgets will need to increase at least US$ 10 per person per year by the year 2025 (WHO, 2006). As it will take 6-8 years to train the additional health workers and to see the first results, urgent short-term measures are necessary, notably increasing salaries and introducing financial incentives for services in the remote areas.

Will compensation be enough to address the HRH crisis?

The financial resources are crucial to tackling the HRH crisis and poverty is the underlying factor. The Malawi's Minister of Health, Dr. Ntaba, said: "I would like to bring to the attention of the international donors that it is impossible to deliver quality care with $12 per person per year" (Le Monde Diplomatique, 2006). A compensation for "making use" (to put it mildly) of poor countries intellectual property to the detriment of the health of their citizens, will shift the whole discussion on aid, donation or assistance into a discussion of making justice to the poor world.

At the same time, the compensation can be understood as sincere only if based on a global agreement and commitment for an urgent need to invest in national health systems, in the developed and developing world alike. Any deviation from the recognition that health workers are the most important resource of health systems and that each country should take its responsibility to ensure sustainable health systems without harming health systems of other countries would lead to higher inequalities in health. At this point the role of the trade unions is essential both to pressure the governments of the rich countries to consider fair compensation and to advocate that such compensation be channelled into investment to strengthen health workforce and national health systems.

Contextualizing portability of skills and task shifting within the health workforce crisis.

In the light of the arguments put forth in this paper, the introduction of portability of skills in the health sector questions further the debate on compensation. If put in the context of the reality of health crisis, the portability of skills seems to be at best just a cosmetic remedy, which will have adverse impact on the shortage of health workers. Firstly, the portability of skills discourse though appearing to have elements of protecting migrant workers may be viewed as a strategy aiming to liberalize migration for a specific category of workers that developed countries need (due to their neglect in improving their own health systems and upgrading the conditions of their own health workforce) thus further adding to unfairness and exclusiveness. Secondly, the portability of skills approach acts as a regulatory control, filtering the movement of workers. Despite the rhetoric for the free movement of people, it is only the skilled workers who are allowed to move across borders to the countries that have the highest market value. The unskilled workers who among others are faced with a degrading health system are excluded.

The discourse on portability of skills masks the debate on the root causes of the health workers shortage, constituting in fact as another barrier to address the crisis in health systems. In general, nursing associations in developed nations do not support widespread recruitment of foreign nurses, as the report from Nelson (2004) asserts. "Bringing in nurses from overseas does not address the causes of our nursing shortage", says Cheryl Peterson, a senior policy fellow at the American Nurses Association (Nelson, 2004). A Polish nurse, quoted from a PSI research (2004), laments the fact that the government prefers to hire migrant workers (on irregular contracts) rather than raising wage levels in order to attract Polish workers in the local labour market.

American nurses have raised concern that if a flood of overseas replacements pours in, particularly those from the Philippines, wages will go down and the work environment will remain unchanged. The concern is quite justifiable according to Nelson (2004). Nurses in the Philippines earn about $150 a month in the cities, maybe $75 in rural areas, explains Philip Slaton of The Icon Group (Silverdale, WA, USA), a firm that recruits Filipino nurses. According to Slaton, the nurses' big dream is to come to the US to earn decent money to send to their families back in the Philippines. Compared to the Philippines, where they may have 30 or more patients per nurse, says Slaton, US working conditions look great to them. Therefore, they are less likely to complain about the problems which are driving American nurses away (Nelson, 2004). The Le Monde Diplomatique (2006) article raises the same issues in pointing out the advantage of employing migrant workers: "African health workers are more flexible – prepared to work for less money and more willing to work night shifts and overtime".

But this is not all. If the reality of overseas work does not meet migrant workers' expectations, which is often the case as the survey of PSI (2004) has demonstrated, they are still powerless to do anything against it or leave that work as many national nurses would do. For one, American hospitals are paying a great deal of money to bring Filipino nurses over. And since they are bound by a 3- year contract, the hospital can sue them if they break that contract. The hospital can even try to get them deported, citing that they did not fulfil their obligation for immigration (Nelson, 2004).

The International Council of Nurses (ICN), according to Nelson (2004), condemns the practice of recruiting nurses from countries where governments and other relevant authorities **have failed to address deficiencies known to cause nurses to leave the profession and which discourages them from returning**. If migration continues in this setup without addressing the deficiencies of the health systems, it will do very little to a long-term solution of

health workers shortage, if not affect it adversely. Indeed, "migration is both a cause and consequence of shortages" (PSI, 2004).

The nurses in the developed world do realise though that the options for countering economic migration are few and far between, as the individual nurses have a right to migrate (Nelson, 2004). However, they also urge that the recruiters must acknowledge the potential negative impact that migration may have on the **quality of health** care (Nelson, 2004). Here it is clear that a health workforce shortage, suffering from low morale, directly influences the health status of people.

As nurses in the receiving countries have asserted, migration is not a solution. Moreover, it is dubious, up to what extent would migrant health workers deliver quality health care in other countries if they continue to struggle between their responsibility for people left home and the harsh reality of being a migrant worker? A Kenyan nurse recounts how a fellow health worker working overseas struggles to survive:

> "One friend who was [abroad] came back in December. She said the work is there, the money is there – but you have to work. You have to work. If you are just working for one employer the money will not be enough to pay you rent, your meals and accommodation and so forth. The salary from one job is not enough for your maintenance. So, she was saying what they do is, they register with other agencies – so that if you finish here and you have time, you can go and work there. So [you] end up doing a lot of jobs. In private homes, nursing homes, they do not pay well but you see because they [the nurses] are looking for some money, sometimes they have no option…. They have very little time for themselves, because they have to make money to be able to live, to survive." (PSI, 2004)

Indeed as many researches have shown, "nurse burnout, attributed to high workloads and stressful work environments, reduces patient satisfaction with care" (Lovell, 2006), or in tandem with other factors, is a death sentence for many people in the poor countries.

It is understandable from here that the poor countries are experiencing a much more bleak reality. As the richer countries, can mitigate (for some more time) the crisis of health workers' shortage, poor countries, lacking the market power, are faced with a seriously critical situation. Indeed, as richer countries are poaching health workers from each-other, one may ask: Where does Ghana go for replacements, or Tanzania, or Malawi? (Nelson, 2004)

Task shifting, voluntary and community work is the emerging discussion as a solution for the countries which can not poach (or not poach enough) ready-made health workers from elsewhere. This approach is coming out of the attempts to tackle the HIV/AIDS and other pandemics. Although, assessing the impact of this approach necessitates much more cautions analyses, some critical issues are already obvious.

Some of the concerns with regard to task shifting have been already expressed by the trade unions in Southern Africa[3] as: the issue of adequate compensation for increase in responsibilities, the extent to which the task shifting compromises the quality of health care, the levels of workload for nurses and nurse aides. And an important question arises regarding the sustainability of this solution. It is still unclear for how long is the task shifting going to stay in place and what is the strategy to address the human resources crisis in the long run.

On the same vain voluntary and community work is as well worrying. This segment of workers is being left outside of the regular health workforce, exposing them to a real risk of becoming informal workers. They are paid a very low stipend and they are given very little training to provide health care. It is important to realise that the communities can not bear the burden of failing state's policies forever. Their resilience, which is at its extreme limits, is not an excuse for governments not to fulfil their duty of guarantying quality health care for people.

Clearly, although it seems that the poor countries may appear somehow able to cope with the health crisis with less budgetary burden, the price for this solution is even more expensive in the long run. Task shifting and community health workers seem to be another short-sighted attempt, to address the disease crisis in the short-term, with less concern to build a national health workforce policy for the future.

Conclusions

At the first sight it seems that the issues discussed in this paper, emerging out of the global health workers shortage are not directly related. Yet, in an interdependent and globalised world it is hardly convincible that the global players are moving spontaneously. Hence there are good reasons to think of a relation in between the difficult debate on compensation for the sending countries and the discourse on the portability of skills. Indeed, if the compensation debate is seen from the prism of portability of skills, it does rather

[3] Report from the planning workshop and project proposal on « The Public Health Sector and HIV/AIDS in Southern Africa ». 2006.

qualify as a form of outsourcing the education and training of health workers, this being the clear trend of the last decades. This move will make sure that health workers from the developing world will continue to fuel further the global market to respond to the needs of the developed world. In the meanwhile, poor countries are left with strategies as task shifting and community and voluntary work to face the severe health crisis.

This paper tried to unearth some of the main controversies related to the discourses around health workers shortage, pointing to the danger of the worsening of health care quality in both the developed and developing world. This is a very high price to be paid for this generation and not only.

All countries and their people need urgently proud and trained health workforce to deliver quality health care. Some countries especially in Africa desperately need health workers to keep people alive. Unsustainable solutions which do not address the real roots and at best only provide cosmetic adjustments to the health workforce shortage would only contribute to more health inequality in the world. The portability of skills strategy sounds appealing, but it should be contextualized on free choice or decision to migrate, and not as the only way to survive or escape a life without dignity.

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The perverse subsidy of poor countries to health systems of rich countries – case study[4]

The Ghana example has been widely researched and does represent in many aspects the dynamics of a perverse subsidy of developing poor countries to rich countries. There has been always a flow of migration of Ghanaian health workforce in UK, but the last years have seen a fast increase on the detriment of Ghanaian health systems.

The report from the EU Commission (2005) presents estimations of the savings in training in UK from recruitment of the 293 Ghanaian doctors and 1.021 Ghanaian nurses registered as practicing in the UK in 2003/2004 at £65 million for doctor training and £35 million for nurse training. Ghana's loss includes both the training cost and the opportunity cost of the understaffed health facilities.[5]

Britain	Ghana
Saved $117 million in training costs by recruiting Ghanaian doctors since 1998.	Ghana has lost $63 million of its training investment in health professionals.
1 child in every 150 dies before age 5.	1 child in every 10 dies before age 5.
Average per capital spending on health is $1668.	Average per capital spending on health is $11.

Source: New Internationalist (2005)

It asserts that the employment in wealthy countries of health professionals trained in staff-short low-income countries contributes to rising international inequity in health care. That effect should be central to the design of policy responses to health professional migration: the inequity ought to be tackled systematically and in a co-ordinated way. The objective of policy towards migration should be, not limitation of mobility, but equity in health care as soon as possible.

The migration of health service professionals is an aspect of rapid international integration and commercialisation of health service labour markets, in the context of high levels of international inequality. These processes are cumulative, self-reinforcing, and hard to reverse; policy must work with, not against their grain.

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[4] This case study is based on an in depth research on the case of Ghana and UK: "The 'Skills Drain' of Health Professionals from the Developing World: a Framework for Policy Formulation", 2005.. It is commissioned by Medact. For more information see: http://www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf; accessed 20 May, 2004.

[5] EU Commission of the European Communities. "EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries". 2005.

Coercive measures to prevent departure, taken in low income countries that are losing staff, work poorly; worse, they can intensify pressures to leave. Conversely, incentives to stay that redress the key violations of decent working and living conditions, and that value skills and commitment, do work, and lessen rather than worsen inequalities; the implication is that health service financing and governance needs to improve in countries that are losing staff.

The UK Department of Health's 'ethical recruitment' Code reflects a welcome recognition of the detrimental impact of international recruitment on the health systems of some developing countries. It is however generally ineffective; it may impose increased migration costs on staff from those countries; furthermore it is implicitly discriminatory along the lines of race', affecting as it does mainly African and Caribbean, hence predominantly black, staff. The Code is thus neither an ethically satisfactory nor an effective response to the detrimental impact of staff loss on low income, staff-short health systems; a better recruitment policy response would improve migration experiences and strengthen likelihood of return.

The benefits of migration to migrants' home countries are substantial, but do not compensate for the health service impacts; furthermore the problems suffered by migrants and by divided families can be substantial.

The net effect of some types of health professional migration such as that from Ghana is a perverse subsidy: a net flow of benefits from poor to rich country health services. That perverse subsidy is indefensible, contributing as it does to worsening the huge inequality in health services between the UK and developing countries, including Ghana. UK health service users benefit from the services of people who would otherwise be caring for African health needs, hence compensation should be paid to remove this perverse subsidy from poor to rich.

It is possible to design compensation in such a way that it overcomes most of the main objections usually presented, of which by far the most important is that it constitutes a tax on migration that undermines the right to migrate.

This would be best done within a political framework that accepted that health professional migration blurs the boundaries between countries' of origin and destination countries' health services. In the case of the UK and Ghana these boundaries are already permeable. The best way forward is therefore to build on current links between institutions, professional associations, trades unions and individuals so that, for example, Ghanaian and UK professionals increasingly accept that they are colleagues in a joint

enterprise of health service development that can only be done ethically if it explicitly addresses, over time, inequalities of services and conditions.

The Ghana case highlights the core argument of this paper: ***The objective of migration policy is not limitation of mobility but equity of health care as soon as possible.***