Physician Migration: Ethical and Economic Issues and the Physician Healthcare Workforce

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a global commitment to public health

Roadmap

- Overview of physician migration issues and trends
- Economic perspectives
- Ethics perspectives
- Implications on physician workforce policy

Introduction

- Focus is on physician migration, but only one type of migration – “brain drain”

- “Brain drain”
  - Designates the international transfer of resources in the form of human capital
  - Mainly applies to the migration of relatively highly educated individuals from developing to developed countries
  - Physicians, engineers, scientists, and others

- Helps increase supply of skilled workforce in high income countries, but viewed as a serious constraint on the development of poor countries (and also some European countries!)

Background: health workforce as a global health concern

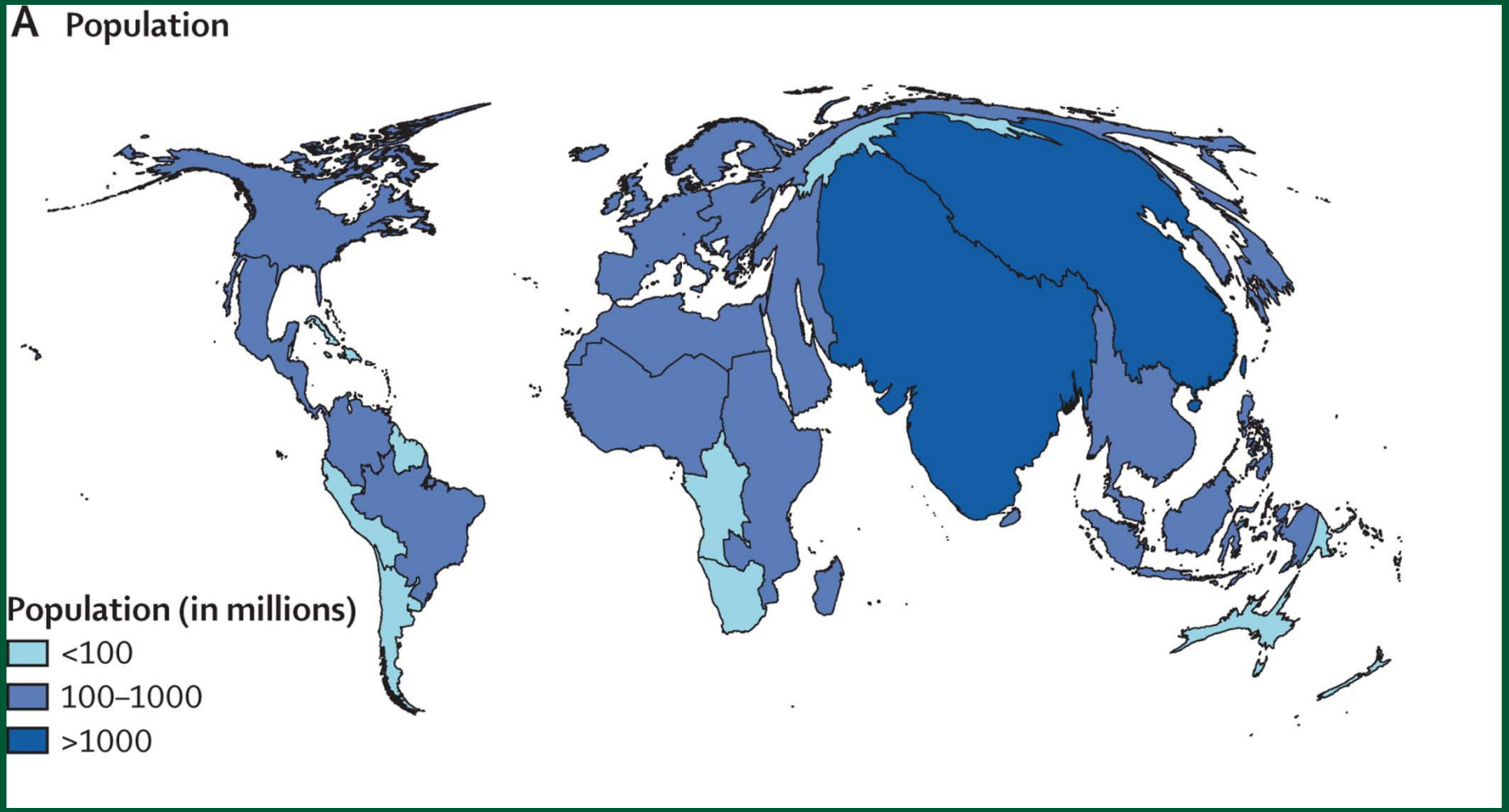
- An educated, effective workforce is an essential component of global health systems strengthening

- "Global movements of people, pathogens technologies, financing, information, and knowledge underlie the international transfer of health risks and opportunities. We are increasingly interdependent in terms of key health resources, especially skilled health workers" Frenk, et al, 2010

Background: health workforce as a global health concern (2)

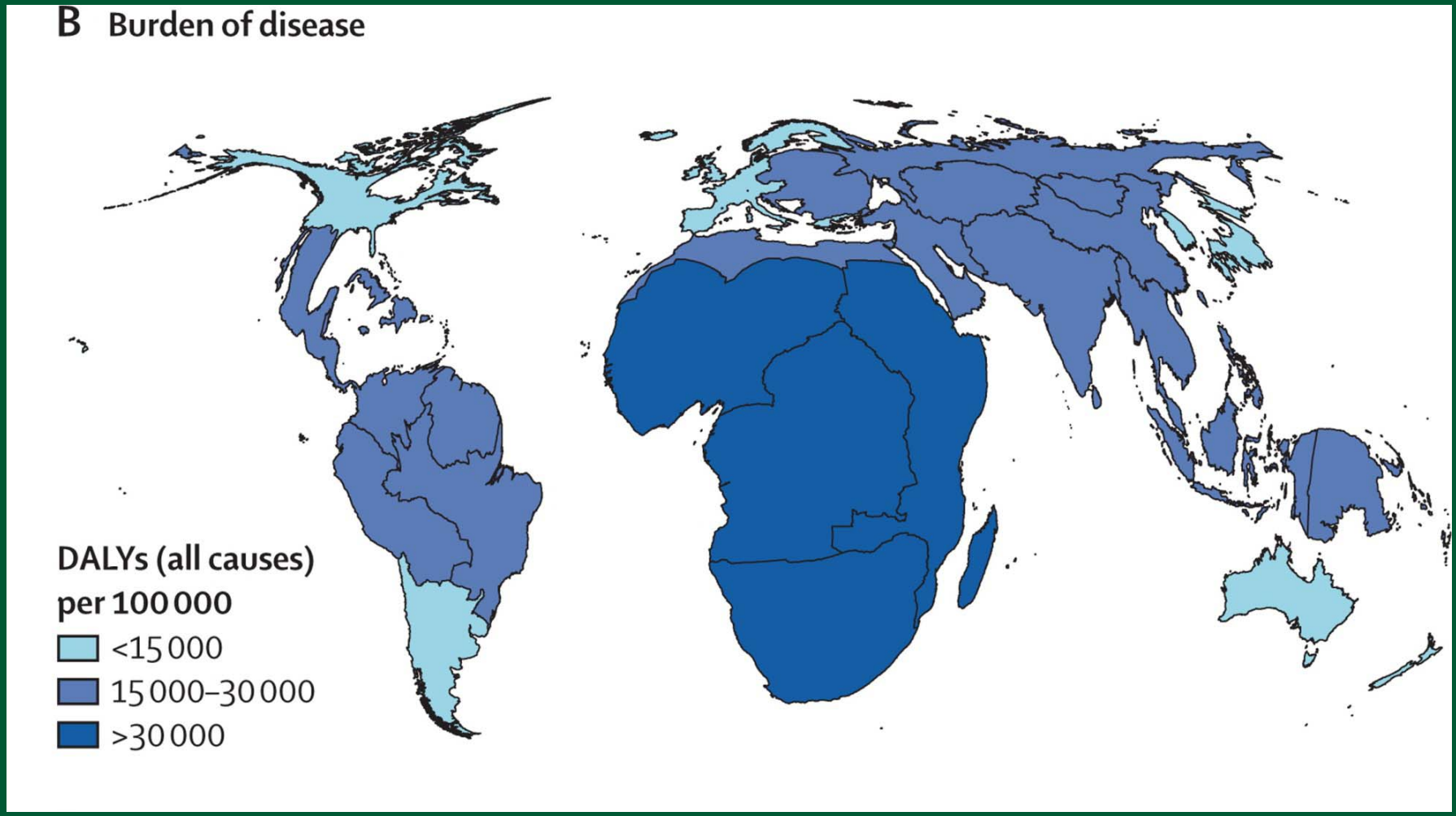
- Stark disparities exist in the burden of disease, the availability of medical education, and the availability of physicians and other health workers

World map resized by population



J Frenk et al. The Lancet Volume 376, Issue 9756, 4-10 December 2010, Page 1935

World map resized by burden of disease



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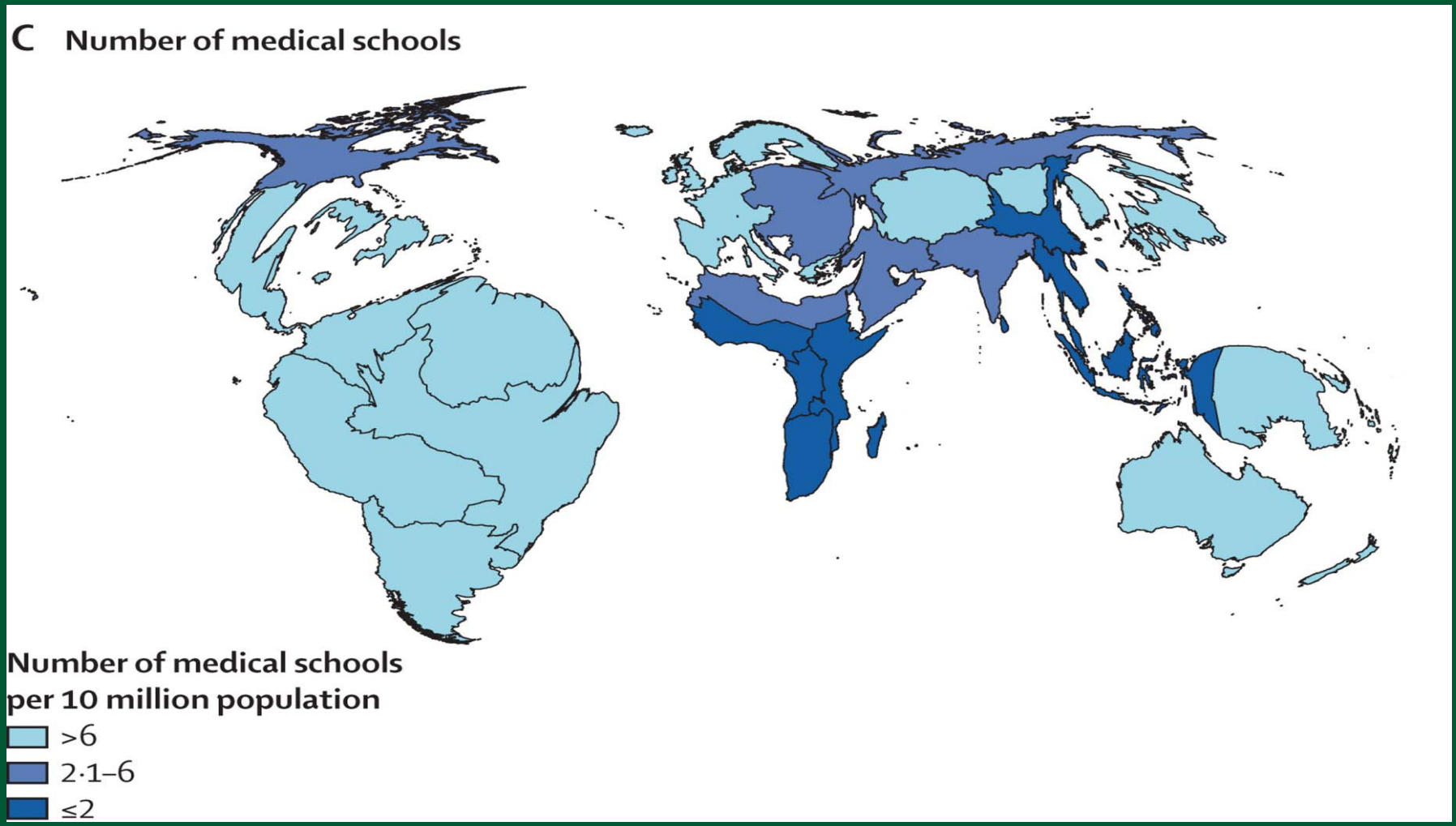
World map resized by density of medical schools



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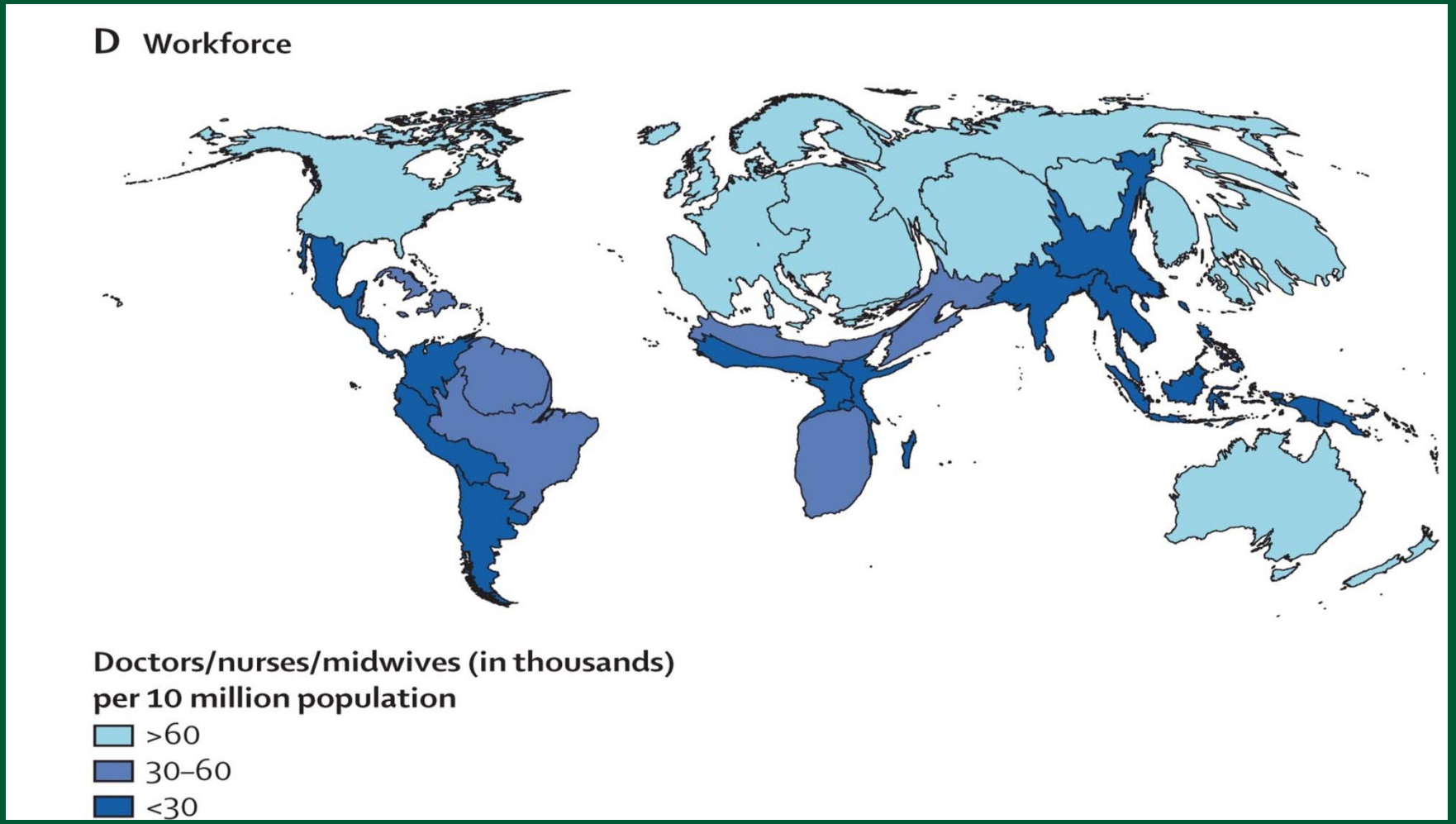
World map resized by density of health workforce



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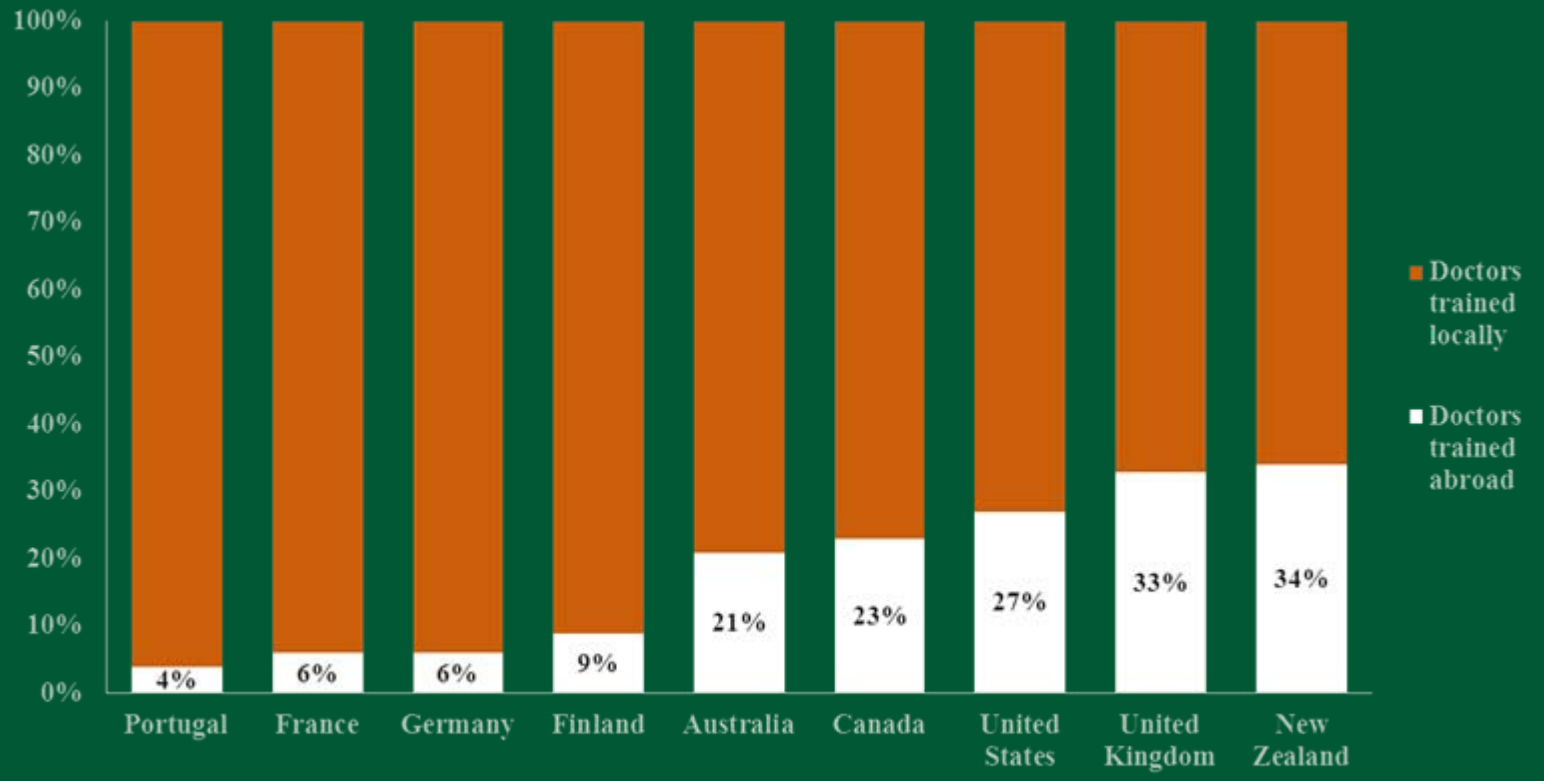
How big is the brain drain?

- About one quarter of physicians in US, Canada, and Western Europe are trained overseas

- “Push” and “pull” factors at work to drive physician migration

Physicians trained abroad working in OECD countries



Source: World Health Organization (2006).
Note: Only a portion of foreign-trained doctors come from undeserved low-income countries.

Physician migration trends

- Long-term trends over the past 25 years show the number and percentage of IMGs have increased significantly in most OECD countries

- With increasing burden of chronic shortages of physicians and nurses, importation is likely to increase

  "Push" and "pull" factors (drivers) will continue to be forces conducive to physician migration

Some source countries have explicit strategies to promote emigration

- India and the Philippines have deliberate strategies to promote migration of nurses
- Examples of countries promoting physician emigration – China, Cuba, India and the Philippines
- OECD countries also have special immigration practices to facilitate the migration of highly skilled health professionals

From brain drain to brain gain?

- “It is a good thing for rich countries to integrate a skilled and talented workforce, and the move is also worth while from the perspective of the individual migrant. However the return to human capital is likely to exceed its private return given the many externalities involved.”

  Docquier and Rapoport (2006)

- Externality argument in early brain drain economic literature: brain drain entails significant losses for those left behind and contributes to increased inequality

From brain drain to brain gain?

- Reversal of argument: prospect of migration may increase incentives to study
- Under certain circumstances in a series of recent theoretical papers, this can be turned into a gain for the source country
  - Some empirical evidence: Beine et al. (2006) found a positive and significant effect of migration prospects on human capital formation in a cross-section of 127 developing countries
- What matters is how many remain at home

Impacts of physician migration

Destination country

- Decreased shortages of physicians, particularly in rural areas (+)
- High qualified workforce (+)

Source country

- Increased shortages of physicians, more limited availability of health care services (-)
- Remittances, decline in poverty (+)
- If physician returns, significant skills and experience back to country (+) – not common
- “Perverse subsidy” to wealthy country (+ and/or -)

Evidence of impacts on source countries

- Need for physicians in developing countries outstrip numbers of immigrant physicians in OECD countries, implying that international migration is not the biggest cause of physician shortages
  - All African-born doctors and nurses working in OECD represent no more than 12% of the total estimated shortage for the region

Evidence of impacts on source countries (2)

- Some countries have particularly high emigration rates. Some of these have very low density of physicians, indicating a worrisome situation

- But for India or China, physician emigration does not seem to have affected domestic density (aggregate)

Summary thus far

- Brain drain neither the main cause nor would its reduction be the main solution to the world wide health human resources crisis
- Nevertheless, international migration is likely to exacerbate situation in some countries – but more of a symptom of domestic conditions
- Brain drain has some feedback effects, and there is an argument that emigration possibilities increase the incentives for medical training

ETHICS AND PHYSICIAN MIGRATION

Global Considerations

How we view ethical dilemmas

- A broadened sense of awareness of global ramifications of ethical decision making
- Traditionally the breadth of one's analysis extended only to one's own borders

Ethical value – utility & justice

- The obligation to balance ethical principles in achieving the greatest good for the greatest number in resolving an ethical dilemma

- The obligation to act in a fair and impartial manner in making decisions in such areas as the allocation of limited resources and/or services; benefits or burdens; risks or costs

The world health organization code of conduct

- Adopted on May 21, 2010 by the World Health Assembly of the World Health Organization.
- Only the second such code adopted in the organization's history.
- Its objective is to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems.

Global workforce crisis

- The WHO asserts that “increasingly inequitable access to health care can result from these movements [of migrating health personnel from developing to developed countries]. The WHO Report 2006 highlighted a global shortage of almost 4.3 million health personnel and identified 57 countries, most of them in Africa and Asia, facing a severe shortage of health personnel. Increased migration adds to these shortages.” WHO, 2010

A balancing of rights

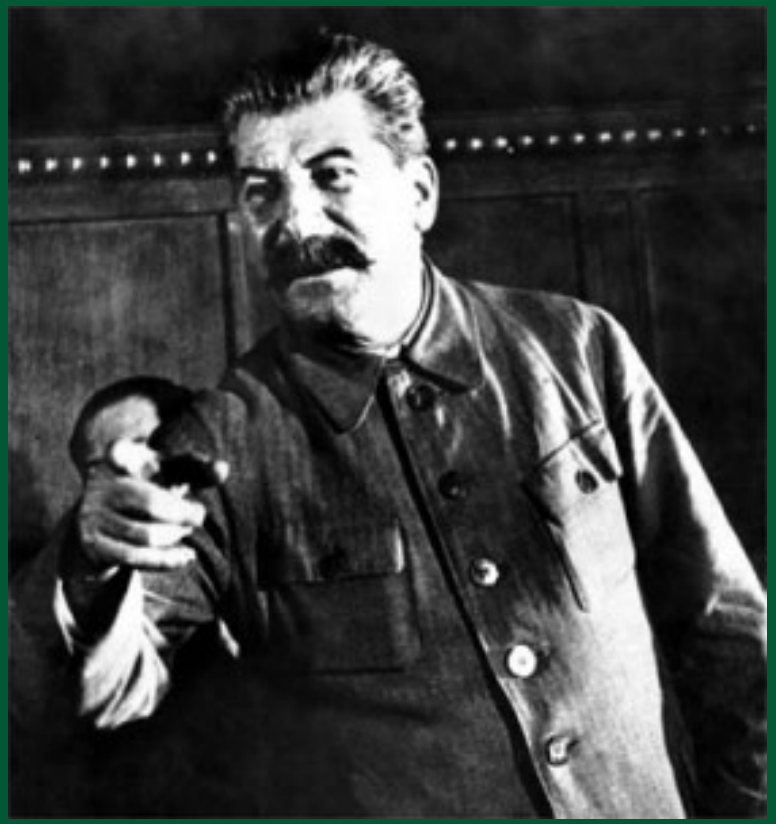
- The exporting nation
- The receiving nation
- The individual health professional
- The global community in recognition of disease as a global burden/threat

Specific problems of remote/rural areas

- One of the most complex challenges for policy-makers is to ensure that people living in rural and remote locations have access to trained health workers. Although approximately half the global population currently lives in rural areas, these areas are served by only 38% of the total nursing workforce and by less than one quarter of the total physician workforce (WHO, 2006)

Access to primary care is a global problem

- "If a supposed 'problem' has not been significantly ameliorated in any of 20 or more countries, maybe American failures are not due to American institutions. Maybe the problem is really, really hard. As my mentor, Aaron Wildavsky, commented to me, 'even Stalin and Beria couldn't get doctors to move to the countryside.'"
- Joe White, Professor, Case-Western Reserve



Nature of the code's authority

- It is a recommended standard of behavior for nations and other actors.
- They are commonly adopted as formal resolutions of intergovernmental organizations, and most are non-binding.
- They create norms, or expectations, for future behavior.
- In short, they are VOLUNTARY in nature
- WHO Code, 2010

A case example: Ethiopia's response

- Current ratio of physicians to population is one to 37,000; the WHO target is one to 10000 people
- Ethiopia has adopted a "flooding strategy"
- Since 2004, 9 public, 1 army, and 2 private medical schools have opened
- Focused on producing general practitioners
- Limitation on growth is availability of faculty, many of whom are imported from India, Sudan, and Nigeria as a temporary measure
- Bonus compensation paid to physicians willing to practice in rural and underserved Ethiopia
- Source– Abraham Haileamlak, MD, Dean, Jimma University

E+E=P

- Economics plus Ethics equals policy
- The case examples of the UK and the US; A study in contrasts

The UK – Deliberate Policy

- In 2001 the Department of Health , England adopted a code of practice for international recruitment of health professionals.

- The Code required NHS employers not to actively recruit from low income countries, unless there was government-to-government agreement (as in the case of China, India, and the Philippines in 2007 amendments)

Results of the UK code

- Buchan and colleagues found a considerable reduction in inflow of health professionals; from peak years up to 2002 for nurses and 2004 for physicians--multiple reasons for the decline are cited, including decline in UK demand
- In the specific instance of Ghana and Kenya; active recruitment from the UK was significantly reduced– but it is not clear whether this resulted from the Code or reduced demand --Buchan, et al; Human Resources for Health; April 9, 2009

Challenges to medical professionals

- Gaps and inequities in health within and between countries
- New infectious, environmental, and behavioral threats superimposed on rapid demographic and epidemiological transitions
- Significant increase in chronic conditions
- Patients more proactive in health seeking ways
- Frenk, 2010

Dynamic professional boundaries

- The “Division of Labor” varies country to country
- Continuous struggles across professional boundaries (witness MDs vs. Osteopaths vs. Chiropractors in U.S.)
- Barriers created by formal licensure; credentialing of providers
- Role of informal providers outside health occupational structure

Little standardization across nations

- An MD in China may receive professional practice degrees with 3, 5, 7, or 8 years of post-secondary education
- Nearly 1 million village doctors have only vocational training (apprenticeship) in China; India has about 1 million uncredentialed rural practitioners
- A U.S. RN may be licensed with 2, 3, or 4 years of post-secondary study

Little relationship between medical graduates/supply

- Also found in case of nursing
- WHY?
- Unemployment of graduates
- Non-degree holders performing this work
- International migration (India to US for physicians; nurses from Philippines and Caribbean nations to wealthier countries)
- Cuba's explicit policy of training medical personnel to share with other countries
- Frenk, 2010

Globalization of professional education

- One global pool of health professional talent
- Global labor markets result in professionals on the move crossing national borders and creating global communities of expertise
- World Health Organization has approved a “Code of Conduct” for international migration of professionals (www.who.int/hrh/migration/code/practice/en)

Role of wealthy countries

- With increasing burden of chronic shortages of physicians and nurses, importation is likely to increase
- About one quarter of physicians in US, Canada, and Western Europe are trained overseas
- US citizens receiving training abroad are subsidized by US loans at $315 million per year

The US – fluctuation policy at best, no policy at worst

- The US has largely relied on market mechanisms in workforce policy
- 1994-95 Health services researchers predict acute surplus of physicians as a result of managed care
- 1997--- Balanced budget amendments freeze Medicare financed residency position at current level of US medical school graduates plus 10 per cent
- 1999– Wall Street Journal reports on unemployed graduates of University of Washington Anesthesia residency
- 2002– Physician shortage predicted; AAMC encourages 30% expansion of medical school classes and the establishment of new medical schools
- 2010– PPACA creates Health Workforce Commission

The US bottleneck - residencies

- Some 18,000 medical students matriculate at US Medical schools, with 4 new schools in 2009 and 150 added slots in 12 existing schools
- BUT: 110,000 resident positions in the US; funded by the Medicare program to the tune of $9.1 billion annually for resident costs, supervision, and higher operating costs of teaching hospitals
- This payment stream was capped by Congress in 1997 at the then current level plus 10%
- Despite lobbying from physician groups to adjust this number upward, it was removed from PPACA

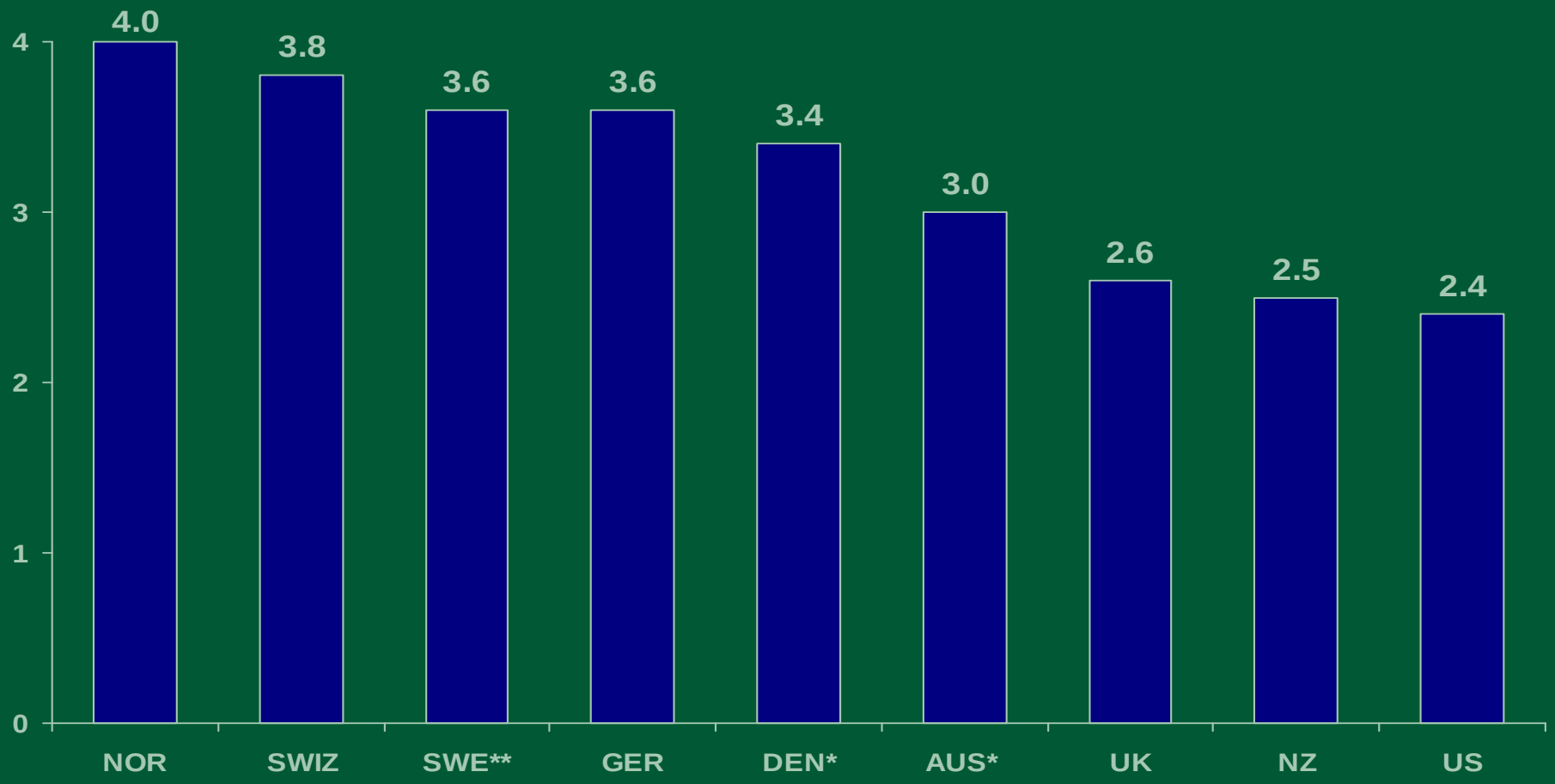
US will continue to experience shortages

- AAMC projects a shortage of 150,000 physicians in next 15 years
- Even with new medical schools and increased class sizes, “it will probably take 10 years to even make a dent in the number of doctors we need out there”–

Atul Grover, American Association of Medical Colleges

Wall Street Journal, 4-13-10

Number of Practicing Physicians per 1,000 Population, 2008



Source: OECD Health Data 2010 (Oct. 2010).

Conclusion

- US physician workforce policy assumes continued reliance on international medical graduates for the foreseeable future
- The role of the National Workforce Commission, although already appointed as a result of PPACA 2010, is unclear at this time as a result of blocked appropriations to carry out its work
- The Future? The more things change, the more they remain the same