HEALTH PROFESSIONAL MIGRATIONS LA-UE

OPORTUNITIES FOR SHARED DEVELOPMENT

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MINISTERIO DE SALUD PÚBLICA

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CONSEJERÍA DE SALUD

ESTUDIO MULTICÉNTRICO MICRACION CALIFICADA EN LA SUBREGION ANDINA

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EXECUTIVE SUMMARY

The multi-centric study of skilled health worker migration in the Andean region is an example of comprehensive research in which various efforts came together. On the one hand, the efforts of investigative groups located in Bolivia, Colombia, Chile, Ecuador, Peru and Venezuela. On the other hand, numerous institutions like the Pan-American Health Organization (PAHO), the European Union (EU), the Andalusian School of Public Health and the Social Observatory Foundation of Ecuador (SOFE).

This investigation was financed equally by the PAHO, its regional and sub-regional funds, those of each Andean country, as well as the European Union.

The study used multiple data collection instruments, validated in Ecuador, to meet the objectives previously defined by the EU, the same which were analyzed and tested in the specific realities of each one of the five remaining Andean countries. The results obtained were included in two separate and exhaustive partial reports and a final summary report.

Four topics were addressed: (1) magnitude and flow of information and the respective gathering of the same from local sources.(2) Information systems (3). Approval process for the qualifications of doctors and nurses in Andean countries and Spain (4). Human resource planning and allocation of medical professionals and nurses by country, as well as their course of study (5) Socio-demographic and motivational characteristics of immigrant doctors and nurses and students who intend to immigrate. SOFE also included a section reviewing the state of the art of conceptual reflection related to the immigration of skilled health personnel.

The methodological dynamics used allowed for the integration of 25 investigators in 7 countries- Spain and the six Andean nations- who gathered information based on a central nucleus led by SOFE which defined the methodological strategy and created the conceptual framework for the research. These groups' prior experience in making The Toronto Challenge baselines for the regional policy on human resources in Health, headed by the PAHO, allowed the network to operate in an integrated fashion.

Primary Findings

1. Migratory movements from Latin America's periphery have a long history dating back to the 1950's. Until a few years ago, immigration of skilled health workers was seen as an escape valve, given the limitations of job opportunities in these countries. In fact, such immigration was incentivized. Today, the problem has reached a level that worries certain Andean authorities. This occurs in nations where the State has assumed the primary role of social protection given that, in the medium term, the lack of health professionals creates difficulties in providing adequate service and in building public health programs. Nevertheless, it is important to note that in half of the Andean nations involved in the study, the impact of skilled health worker immigration has yet to be felt.

2. Unlike what occurs in other kinds of immigration among doctors and nurses, state regulatory and recruitment policies play a major role in promoting and increasing this kind of immigration. (Bach, 2003:4). These policies indicate the desire, at least on the part of the destination state, to have such skilled workers immigrate. This fact determines the migratory experience: routes, networks, migrations and life and job placement in the final destination.

3. The immigration of skilled health workers ends up becoming a 'perverse subsidy', and is referred to as such by the WHO and PAHO (WHO/PAHO, 2006:41) since, in order to satisfy demand for professionals in the rich countries, health care systems in poorer nations lose skilled human resources which local governments have invested in training.

4. In order to somehow slow the growing wave of skilled health worker immigration, the WHO created a code of ethics (March, 2010) which creates a space to discuss the issue.

5. Despite a lack of systematic data which allows for measuring the size of migratory flows from all Andean nations, by using the official register of qualifications in Spain during the last seven years, it is possibly to come up with an approximate figure: the number of doctors registering their credentials increased 14 times: from 246 in 2002 to 3,534 in 2009. Regarding nurses, the number of registered credentials went from 89 to 538; a seven fold increase.

6. Three migratory destinations were identified: the European Union, most importantly Spain, where doctors and nurses from all Andean nations arrive. Italy has a lower proportion- mostly nurses and few doctors- and a lesser number immigrate to Australia. Immigration to the United States continues, overwhelmingly by doctors, and movement to other nations in South America and Mexico has been noted.

7. General characteristics of the immigrants are: highly skilled immigration- be it by doctors with prior specialization– especially those who traveled to the EU – or those with wide-ranging experience, like in the case of nurses who averaged more than 6 years of experience

in their jobs before immigrating. Accordingly, as is confirmed by the PAHO, the loss of these professional skill sets weakens local health systems and local populations in turn become more vulnerable due to the lack of specialists. (PAHO, 2006:42).

8. Public universities tend to be the formation centers for those who immigrate. Within the health professional's education and culture there is a perception that the best practices are in those places with the highest technological complexity at the expense of places with greater social need, like working in the primary health care. This kind of education seems to create a 'get out' mentality, as most doctors, in particular, travel in search of high technological development. Also, when these professionals return to their home countries, they are not prepared for the local level of technology.

9. Three reasons emerge as the most powerful ones for immigration: among doctors, the search for academic excellence as related to social prestige upon returning to their home countries; secondly, the desire for better economic conditions, a priority situation for nurses, and thirdly, escaping political conflict and insecurity in the home country.

10. Prevalence of the intent to immigrate is greater among medical students as opposed to nursing students. It is also more frequent among those that don't have children related to those that do and those with prior immigration networks.

11. None of those immigrants that returned home had difficulty in reintegrating themselves into the health system or in finding work.

12. Immigration has direct consequences on the allocation of resources in Andean nations. Nevertheless, the region does not have any retention policies. A comparison made of human resource allocation by population, found that no Andean country- with the exception of Chile- complies with the PAHO's recommendations, based on the Toronto challenges, of 25 doctors and nurses for every 10,000 inhabitants. In Chile, the ratio is 32.7 per 10,000 inhabitants. In the case of Bolivia, the proportion was 8.9; in Ecuador it was17.4; in Peru 19.5 and in Colombia, there are 23.8 doctors and nurses for every 10,000 inhabitants.

13. All Andean nations lack a system for professional workforce planning. This invisibility of human resources is also reflected in the lack of an immigration monitoring system with information on size, causes, routes, work obtained, etc. These deficiencies highlight the precariousness of the strategic approach to managing human resources in the Andean region.

14. In general, there are great similarities in the conception and design of the norms for registering credentials in the Andean countries. There is the required legal and institutional infrastructure and situation based rules, which are all favorable characteristics for the advancement of the formulation of concrete proposals which will progressively allow a real

and effective approval of health credentials on the part of Andean nations. This is not the same as a work permit in order to practice one's profession anywhere in the region, in America or in the EU. Nevertheless, it is a first step to legally practicing said profession in destination nations.

15. The theoretical/methodological perspective for the analysis of skilled worker immigration described in this investigation, should be able to identify in the future: where, how and which arrangements exist in a two-way problem, in which destination and home nations are interconnected by their own human resource necessities as related to skilled health workers.

16. Finally, we are left with the question the immigrants' testimony gave us: what do these skilled immigrants do with the feelings of rootlessness and isolation they always refer to in in-depth interviews, which is really nothing more than the deep pain they feel for having left their homeland, their relations and their roots?

This study's recommendations are:

1. Control production vs usage of human resources in health in the countries of origin.

2. Improve working conditions beyond mere salary increases, by offering training, technology, secure jobs and healthy careers.

3. Develop these nations' ability to achieve strategic management of human resources in health.

4. Promote and strengthen the areas of education management integrating training and education at work fin order to achieve health system goals and meet the needs of the Andean population.

5. Change the relationship of nurses with local health systems and push for their greater autonomy according to qualifications and expertise.

6. Move forward with structural changes that allow for more development in the home countries, not only in terms of the fight against poverty and inequality, but also improvement of the justice system, political and social stability and guarantees for human rights.

7. Promote regional and international relations in order to reach agreements on skilled workforce needs and immigration opportunities in the destination countries, ensuring at the same time, optimal care conditions for the home countries' populations without harming the health system.

8. Design a skilled immigration policy with the participation of host and home countries to preserve the right to decent work and freedom of movement and to not adversely affect the home countries, due to the high cost invested by them in undergraduate and graduate studies and the development of work experience.