

Postmodern Openings

ISSN: 2068 – 0236 (print), ISSN: 2069 – 9387 (electronic)

Coverd in: Index Copernicus, Ideas RePeC, EconPapers, Socionet,
Ulrich Pro Quest, Cabel, SSRN, Appreciative Inquiry Commons,
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Postmodern Openings, 2012, Volume 3, Issue 4, December, pp: 109-120

The online version of this article can be found at:

<http://postmodernopenings.com>

Published by:

Lumen Publishing House

On behalf of:

Lumen Research Center in Social and Humanistic Sciences

Migration of Health Personnel: Source of Inequalities in Health in Romania

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Abstract

Although the international migration of healthcare workforce is not itself a cause of global crisis in health workforce, yet it stresses this problem in some countries. At global level, the migration can reduce in some destination countries the health inequalities by covering the shortage of medical personnel, but international migration of healthcare personnel from countries which have already lack of medical personnel stresses the global inequalities concerning the access to healthcare services. The aim of this study is to analyze to what extent the Romanian medical migration stresses the inequalities in the Romanian health care system in term of patient access to quality health services. Also, possible solutions for the equitable distribution of health services due to migration of health care personnel were identified. The findings of the study are based on documentary analysis of national and international source of information as official statistics, legislative frame, public reports of Eurostat, OECD, WHO, studies of National Institute of Statistics, critical and comparative analysis, case study: Romania. The migration of Romanian health personnel is one of the factors contributing to growing inequalities in health. This study outlines the need for improved health policies that could correct the shortage of medical personnel caused by migration, in order to meet the current needs of health services of each person fairly.

Keywords:

inequalities, health care personnel, migration, policies, access to health care service

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Introduction

Mastering the highest level of health is one of the fundamental rights of every person, no matter the mankind, the religion, political, economical faith or social condition (The Constitution of the World Health Organization). The right to health is mentioned and guaranteed by several human rights instruments, both at national and international level. The Romanian Constitution establishes this right through Article 34: The right to protection of health: „The right to protection of health is guaranteed. The state is forced to take measures to provide the hygiene and public health.” Also The Universal Declaration of Human Rights states that „every person has the right to a standard of living that ensures the health and his family’s welfare.” The international agreement on the economic, social and cultural human rights claims that all the states that are signatory to this convention recognize the right which every person has to enjoy the best physical and mental health possible; states are responsible (Sandu, Alexa, Ponea, 2012) to ensure the best conditions so everyone could have medical services and help in case of an illness.

The access to health services is recognized and guaranteed also by The Charter of the fundamental rights of the European Union (EU), Article 33: „Every person has the right to access the preventative medical assistance and to receive medical care in terms of the national legislation and practices.” Those policies and actions of the EU follow to guarantee a high level of protection of human health, which must be sustained also by national legislation and government actions in accordance with the health needs of people.

The concept of inequalities in health

Inequality represents a fundamental aspect of human development (The 2005 Human Development Report) and health inequalities are a reflection of the existing inequalities within a society. Equality and inequality are referring to measurable quantities, while equity and inequity are political concepts that express a moral commitment to social justice. *Health inequality* is the generic term used to designate differences, variations and disparities in the health achievements of individuals and groups (Kawachi et al.2002).

Inequalities in health are unfair (unjust, inequities) in so far as they are preventive and represent the result of social arrangements and not of

personal choices (Report of the College of Romanian physicians, 2010). For this, health policies and stakeholders from the health system play an important role in preventing inequalities in health (Cehan, 2012).

Most of health inequalities are unjust within social groups because they reflect an unfair distribution of the social determinants of health (as access to education, safe jobs, health care) (Woodward, Kawachi, 2000).

Inequalities in health raise ethical challenges in global health and require policies appropriate to the needs. Both actions at the national and at the international level in reducing disparities in health must be grounded in ethical norms voluntarily applied. People are to sacrifice a part of their resources and autonomy for the use of others, as every individual right has some limitations dictated by the moral duty and social responsibility.

European inequalities in health

The annual report on the state of global health from 2008, The World Health Organization (WHO) established that inequalities in medical results and the access to health care „are higher now than in 1978”, but European countries have achieved major gains in the field of population’s health over the last decades. The EU population is getting older, but the life expectancy at birth between European countries varies quite a lot, the gap between the countries with the highest life expectancy at birth and those with the lowest being about 8 years for women and 14 for men, and the infant mortality rate varies by more than six times.

The Romanian report „Nonequities in Romanian health system” from 2011 shows that Europeans are increasingly more healthy and life expectancy has increased by 6 years since 1980. In the same time, premature mortality has dropped significantly as the study „Health at a glance: Europe 2010” published by European Union in collaboration with Organization of Economic Co-operation and Development (OECD) stated. Life expectancy at birth in European Union countries has increased by 6 years since 1980 and in 2007 was of 78 years. On average in the 27 member states, the life expectancy for a three year period 2005-2007 was 74,3 years for men and 80,8 for women. If France has the highest life expectancy at birth for women (84,8 years), Romania has the lowest life expectancy at birth for women (76,2

years). The infant mortality varies around 3 deceases per 1000 live births.

Romanian situation concerning inequalities and access to health care services

As presented in a World Bank-Policy note, Romania has large regional disparities in health outcomes which are masked by national averages. The mortality rate on counties varies from 9 (in Bucharest) up to 25 (in Ialomita) deaths per 1000 births. This results appeared due to socio-economical differences between regions, but also reflect the large disparities in distribution of public resources for health.

People from rural areas have difficulties in accessing medical services and most of them do not benefit of the health system. This is due to some factors like: noncontribution to health insurance, lack of medical service providers in their area of residence or limited facilities or few hours of health care assistance.

Another important report for Romania's situation appeared in 2008 and it was a Presidential Commission Report for analysis and policy making in the field of public health named „A health system centered on citizen's needs” and its conclusion showed that Romania has the most reduced indicators concerning the access to basic health services, the number of doctors, pharmacists and nurses per total population and also a low number of consultation per inhabitants.

The differences in the health state and in the access to health care services is not only in comparison to other countries, but also to different regions from Romania. The highest discrepancy is in the rural area where medical personnel is less than in urban area, and also there are few pharmacies, hospitals, health centres, having less equipment and poor technology. Providing population with doctors in rural areas is over three times lower compared to the average rate of doctors in urban areas, and there are almost 100 localities without doctors.

The fact that in the last decade the migratory flow of health personnel from Romania increased, lead to emphasizing health inequalities between people from rural and urban areas, as without health care personnel the providing of medical care services is impossible.

The importance of reducing global health inequalities

Reducing global health inequalities and improving the health state of people all around the world are main aims of healthcare strategies generally. Privations in health mean inequalities in people's capacity to function. If basic capacities (as health), which are important to human well functioning, are unavailable, than other capacities are inaccessible too. The society should create conditions for each individual to acquire a certain threshold of his health state functioning, and this mean adequate policies, investment in human and financial resources, equality in accessing health care services.

For european actions health became a priority domain for investment. For Lisbon agenda the disease reduction performed in Europe is important because it will reduce the economic losses and will increase the quality of life.

European Commission adopted in 2009 the Communication „Solidarity in health: reducing inequalities in health inside EU” which identifies some of the key domains that require additional measures as: audits of policies to establish their impact on reducing inequalities in health and encouraging research on this matter, improvement of measurements and monitoring of health inequalities, supporting member states to better use the possibilities provided under the EU cohesion policy in order to approach the factors of health inequalities.

There are different arguments to justify health policies aiming to elude unfair inequalities in health, such as normative arguments, economic and social ones (Kaya, Efişonayi-Mäder, 2007). One of the normative arguments is based on equity, as health inequalities are unacceptable in that they are avoidable and unfair, taking into account the socio-economic factors as access to the health system; another one refers to equality and non-discrimination, and also respect for human rights. The right to health is guaranteed and protected by national and international legislation, and protection involves assuring equal acces to healthcare services. The social argument would be that inequalities in health damages also the relationships among people within a society. Healthier, egalitarian societies have a stronger degree of social cohesion that encourages people's sense of belonging to the same community and help them face the same challenges (Kaya, Efişonayi-Mäder, 2007). Towards the economic argument, a healthier society supposes a

reduction on public funds in health system, and people with a good physical state are an important resource for the labor market that leads also to good development.

Migration of health personnel

International migration of healthcare professionals has increased in the last decade, emphasizing the question of medical staff crisis in some countries. According to the World Health Organization, in 2006 there was a deficit of more than 4, 3 millions of medical staff worldwide, the developing countries being the most affected by this. Under these circumstances, the lack of health care professionals is associated with the phenomenon of migration, although the OECD and WHO reports underline other factors too, which accentuate the lack of human resources in the medical field, such as the world economic crisis, pandemics, deficiencies in the health care systems, etc.

The migration of health personnel phenomenon could have both positive and negative effects (Buchan, 2008), or even a mixture of them. The source countries that lost health care professionals and its investment in their education may have a lack of medical personnel, or this could be emphasized if it already exists, undermining of quality and acces to health services, low morale and heavier workloads of the remaining medical staff. On individual level, this phenomenon could create profesional opportunities for the medical personnel (continuing education, improvement of career, a better working environment, easiest workload) and raising the standard of living because of better financial gains (higher remuneration, access to qualitative health insurance). The source country, even though it loses some personnel, could also have benefits in knowledge and skills of those who emigrated, that collaborate with their colleagues in the country in research projects, trainings, or who returned and the migration was temporary. In this situation, if the increase in education seekers is higher than the increase in emigrants, the „brain drain” phenomenon could be compensated by „brain gain” (Beine et al., 2008).

On the other hand, the migration of health personnel could be a solution for the destination countries that have a greater medical jobs’ offer and in this situation benefits are more obvious: more health personnel without any investments in education, migrant workers who may accept lower salaries and compensation packages than in their own

country (Watkins, 2005), and they may accept to work in geographic or service areas that national workers tend to avoid (Bevan, 2005).

James Buchan (2008) suggested the following solutions to mitigate the negative effects of this migration: monitoring of the phenomenon, taking into consideration the motives for emigration to sustain new policies, the management of migration.

The migration of the Romanian health workforce is a current phenomenon in the social reality in recent years, particularly after the accession of Romania to the EU.

Certain provisions and European directives as Directive 2005/36/CE concerning the recognition of professional qualification and Directive 2006/100/CE for adaptation of certain directives in the domain of freedom of movement, taking into account the adherence of Bulgaria and Romania to EU, have facilitated the flow of Romanian medical migration to European countries.

After Romania joined EU the migratory flow of doctors outside the country had increased a lot and consequences are felt in the health system, with great impact on ensuring the access to health services. In 2007 the number of Romanian doctors who choosed to practice abroad was 1500 and until 2010 it became 2500. Their favourite destinations were: France, Great Britain, Ireland, Sweden, Germany and Belgium. If this rhythm of migratory flow continues, Romania will face major imbalances in the provision of health services in accordance with the needs of society and in the next decade we could witness a real collapse of the health system (Vasilescu, 2010). The 2011 Report of the College of Romanian Physicians showed that we have 2,2 doctors to 1000 inhabitants, which is under the European average of 3,3 (Mediafax Agency). So Romania has currently a shortage of doctors.

The migration of doctors from Romania, in the context of EU accession and recognition of diplomas in European space, determined a difficult providing of medical services because of the decreasing number of healthcare personnel, especially in rural areas (Dragomirișteanu, 2011). In 2009 there were sygnificant inequalities for some personnel categories which provide primary care services, for which the access should be equitably between rural and urban areas. But in urban areas there are 63% of family doctors, 87,5% of dentists, 84,8% of pharmacists, that is over the average of „equality” rural-urban, and providing medical care

becomes more difficult in rural areas, so patient's right to health is jeopardized.

The current situation with an increase number of doctors who migrate leads to the conclusion that the measures taken by the stakeholders in the system do not correspond with doctors' needs and it is necessary to establish new directions in health policies, which should nationally be effectively implemented.

Strategies in the medical human resource couldn't be more specific and aimed, as there is still not enough data on the situation of migratory flow of health personnel, the existing information are poor and disparately, and there aren't studies and researches focused on the determinants of leaving, as the role of doctors in the society and his responsibility is higher than other professions.

The Romanian shortage of personnel is worsened by the phenomenon of active recruitment from foreign agencies which offer alluring working packages to Romanian doctors to determine them to leave their country. Active recruitment from a developing country also raises ethical discussions, that needs to be regulated at international level.

The relationship migration-inequalities

International migration is a powerful symbol of global inequality concerning wages and labor market. Not only the inequalities between source countries and destination countries promote migration but also the inequalities between areas within the source countries.

International migration of health professionals from the developing countries worsens the extreme global inequality in health services (Mackintosh, 2007). The right to health recalls a responsibility of the states to ensure good quality health care services, which is to be achieved through, among others, the employment of skilled medical and nursing personnel. Health system quality, including sufficient qualified personnel, is not the only determinant of health in a country nor does it remove inequalities in health, but it is important.

Some specific aspects of inequalities in health are attributed to differential access to, and standards of, health care. It is therefore important that access to health services is equitably distributed if health inequalities are to be reduced. Inadequate access to health services is only one of many determinants of the observed inequalities in health (Health Committee Report, 2009). We can not say to have equitable

distribution of health services or even quality of health care for everyone, while the balance is damaged by massive migration of Romanian doctors, and financial and human resources seem to be insufficient for the demand according to citizen's needs. In the same time, as the existing medical personnel is mostly concentrated in urban areas, for those in rural districts besides difficult economical possibilities, poverty, lifestyle factors, the shortage of personnel comes to point out the inequalities in health.

By investment in human capital, redistributive policies and ensuring comprehensive access to health care, a greater equity in health will be achieved (Woodward, Kawachi, 2000).

The inequality is clearly a major driver of migration also. People use to move across borders seeking to reduce what they see as the gap between their own position and other's in wealthier places (Gent, Black, 2005). So the power of influence in the relationship migration-inequalities works both ways. Due to incidence of inequalities in health, to avoid damaging the health state or for improving their own health status, people often chose to migrate from a region to another within a country, or even go abroad.

Policy proposals to mitigate the negative effects of health personnel migration and inequalities that it produces in Romania

The health of one country is the result of a multifactorial context, depends on political actions of the government, stakeholders, policy makers, measures taken in the health system, the financial resource to sustain the health system and human resources that makes it work.

Every health policy must be centered on the patient and his current health needs. To have suitable policies there is a need of initial and continuous assessment of health needs to which they could respond and of determinants of medical migration. In this way the health outcomes could be optimized. The structural funds could be used in informed campaigns to prevent health risks and to promote a healthy life style, and also should be centered on reducing inequalities in health. There is a need for a national plan to remove injustice and give equal chances to people in accessing the health system, with a special focus for rural areas. The organizing of the health system should facilitate intersectoral cooperation that is essential to addressing health determinants with an increased impact on human health.

A good human resource management in the national health system is needed, that could have coherent sectorial policies, continuous training of health workforce, as system is developing and balanced allocation of human resources in the country and with all medical specialities covered. Certain professional tasks could be redistributed in the competency of other professional category (for example nurses). Also changing the way of providing medical services- initiative in forming multidisciplinary teams that could increase the quality of medical act, and with impact in medical education system could be a good solution for future policies.

The financial resource is as much important as the human one is and must be equitably distributed in regions and districts all over the country; certain incentives could be given to doctors to work in isolated areas to have a better covering for health services and sustain the access to health there.

Migratory flow needs monitoring and efficient strategies to avoid losing more health personnel, strategies focused on doctors' expectations of better working conditions, professional opportunities, better wages. Having permanent monitoring enables a balance between the places in institutions of medical education to cover the necessary on different specialties in the whole country and on each region, and the number of medical doctors that leave the country to practice abroad. To reduce the shortage of medical personnel, the immigrant personnel could be a solution, but only with certain performance parameters, in order to avoid placing insufficient trained staff in the system.

National policies on migration are better to be in accordance with the European one concerning health personnel, training and developing, diplomas' recognition, minimum standards of quality and creation of common databases to manage the migratory flows.

Conclusions

The migration of Romanian health personnel is one of the factors contributing to growing inequalities in health. This study outlines the need for improved health policies that could correct the shortage of medical personnel caused by migration, in order to meet the current needs of health services of each person fairly, to help reduce inequalities and first of all to guarantee people access to health services.

Although freedom of movement is also a recognized human right, it was proved to be a factor leading to an imbalance in providing medical care to people, as human resource is at the base of each health system. Monitoring the flow of migration would help to keep under control the situation of this phenomenon, and retaining policies or importing medical doctors could be a solution to lower the shortage, so that both rural and urban areas could benefit from a balance of existing medical force and access to health services will be also provided.

The policies from the health system it's important to be coordinated with other policies from the educational, financial sector, because the current situation in the health system is a result of a socio-economical and political context.

We can not have a certainty that if within a country wouldn't be a shortage of health personnel, this could remove all the inequalities in health, but it will significant reduce them. Because people are born with different capacities, that makes them react different to the external ambient and to the socio-economic context, the results in their health status will differ too. But the access to health care services to mantain a good health when patients decide is needed must be offered equally to everyone.

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