



# Southern African Regional Network on Equity in Health (EQUINET) and Health Systems Trust (HST), South Africa



## EQUITY IN THE DISTRIBUTION OF HEALTH PERSONNEL

### *DRAFT Discussion Paper<sup>1</sup>*

#### **1. Introduction**

The biggest and most important component of any health system is its human resources (HR). Without a foundation of skilled human resources, health care systems cannot function adequately or effectively. The effective, equitable and appropriate production, training and deployment of health workers has been associated with periods of high health gain in southern Africa. Health workers have played an important role in organising social and community action for health, particularly within primary health care systems.

Despite this, many health systems in southern Africa now face a variety of HR problems. These include the overcrowding of skilled and costly health manpower in urban areas and the private sector; low morale and motivation in health staff; poor conditions of service; inadequate undergraduate training; and a lack of supportive in-service supervision.

The current availability of health personnel in Africa is considerably worse than in other regions of the world and health systems in southern Africa face a variety of health personnel problems. These include:

- an overall lack of personnel in key areas of the health sector,
- an inequitable distribution of those health personnel who are available, and
- a significant attrition of trained personnel from the health sector and from the region.

#### **2. The Human Resources for Health Network Programme**

Under the umbrella of the Regional Network for Equity in Health in Southern Africa (EQUINET) and co-ordinated through Health Systems Trust South Africa (HST), a consortium of institutions in southern Africa and internationally have come together in a Human Resources for Health (HRH) Network and are cooperating in a programme of work that will:

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<sup>1</sup> This discussion document was prepared by Antoinette Ntuli (HST), with input from Rene Loewenson (Equinet) and Christoph Kurowski (World Bank). It is based on an earlier Equinet discussion document: Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R. (2003) Health Personnel in Southern Africa: Confronting Maldistribution and the Brain Drain. Equinet Discussion Paper 3. Benaby Printers, Harare Available from the Equinet Website at [www.equinet africa.org](http://www.equinet africa.org)

- ⇒ Outline the major dimensions of equity/ inequity in the distribution of health personnel within southern Africa and between southern Africa and countries that are major recipients of southern African health personnel (eg UK, Australia and Canada)
- ⇒ Obtain and analyse determinants of the above dimensions of equity/inequity in health personnel, including policy or planning shortfalls that lead to push, pull, return and retention in both sending and receiving levels of health systems and countries
- ⇒ Explore possible and current policy options for dealing with these, policy mechanisms and their performance and perspectives of government, patients, civil society, health providers and health professional associations of the barriers to overcome towards more equitable practice in health personnel distribution
- ⇒ Explore differences between SADC countries and internationally in the dimensions, determinants of and responses to (in)equity in health personnel distribution, drawing also from experiences South-East Asia, Pacific, West Africa, East Africa, where available.
- ⇒ Facilitate discussion and review of the findings to promote policy convergence, policy dialogue and to strengthen policy action within southern African countries, within SADC and in countries that employ southern African health personnel
- ⇒ Build a critical mass of skills, networking and information dissemination on issues of equity in health personnel within southern Africa

In 2003 the Network published a discussion paper<sup>2</sup> reviewing available literature and identifying key issues in need of further work, which this paper summarises. The Network is now calling for expressions of interest to respond to specific areas for follow-up research and analysis. The call aims to attract a mix of organisations and perspectives, including academic research organisations, government and health planners, professional associations, trade unions and civil society so as to expand and enrich the HRH Network.

### **3. Overview of Current HR Issues and Problems in Southern Africa**

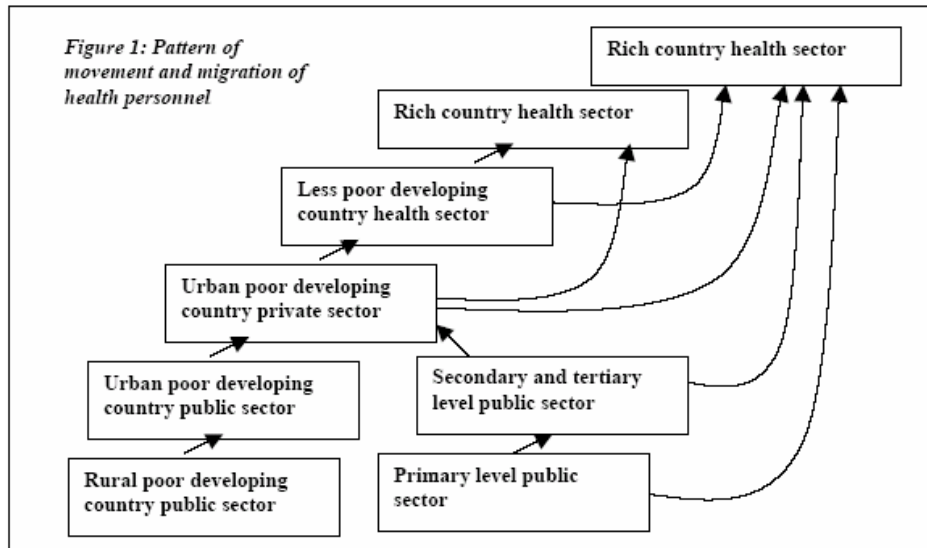
In Southern Africa there are inadequate ratios of personnel to population for key skilled health personnel, and a maldistribution of personnel between:

- public and private health sectors
- urban and rural areas
- wealthy urban and underserved peri-urban areas
- tertiary and primary levels of the health system.

Healthcare workers are moving from areas of poverty and low socio-economic development, to more highly developed areas. The flows follow a hierarchy of 'wealth' and result in a global conveyor belt of health personnel moving from the bottom to the top, increasing inequity. Inequalities in the distribution of health workers are compounded by skewed skill levels, with concentrations of higher skilled workers in better-served areas. Personnel migrate from rural to urban areas, from public to private sectors, from lower to higher income countries within southern Africa and from African countries to industrialised countries. International migration further increases and exacerbates inequities that exist between the public and private sector and between urban and rural areas. The knowledge and skills loss from the poorer to the richer countries is considered as a form of reverse (poor to rich) subsidy.

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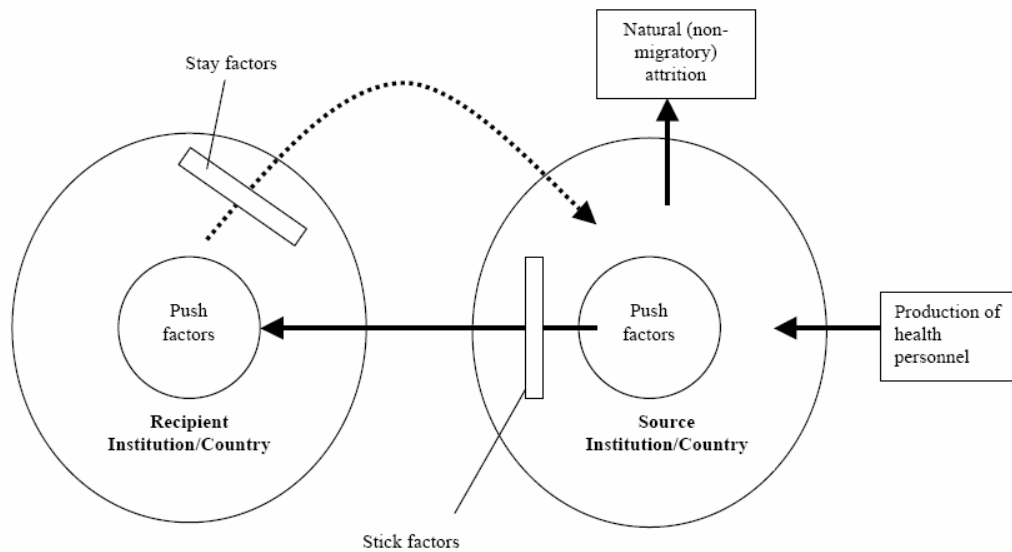
<sup>2</sup> Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R. (2003) Health Personnel in Southern Africa: Confronting Maldistribution and the Brain Drain. Equinet Discussion Paper 3. Benaby Printers, Harare Available from the Equinet Website at [www.equinet africa.org](http://www.equinet africa.org)



There are a variety of push and pull factors that impact on the movement of healthcare workers, arising both within and beyond the health system. Factors endogenous to the health care system are low remuneration levels, work associated risks including diseases like HIV/AIDS and TB, inadequate human resource planning with consequent unrealistic work loads, poor infrastructure, sub-optimal conditions of work, lack of further education and career development opportunities and minimal or absent support and supervision structures. In Malawi for example it is estimated that there are less than six people in the civil service who are trained and specialised in human resource planning<sup>3</sup>.

Exogenous push factors are also noted, including political insecurity, crime, taxation levels, repressive political environments and falling service standards. Movement is also influenced by pull factors, including aggressive recruitment by recipient countries, improved quality of life, study and specialisation opportunities and improved pay. Facilitating factors impacting on personnel movement include the availability and accessibility of information and the increased mobility of the population.

<sup>3</sup> Aitken, J.M and Kemp, J (2003) HIV/Aids, Equity And Health Sector Personnel In Southern Africa, R Loewenson, C Thompson (Ed) EQUINET Discussion Paper Number 12 EQUINET and OXFAM GB, Harare [www.equinet africa.org](http://www.equinet africa.org)



These push and pull factors are mitigated by ‘stick’ factors in source countries, which lead to greater personnel retention, including family ties, psychological links with home, migration costs, language and other social and cultural factors. ‘Stay’ factors influence decisions to remain in recipient countries and influence rates of return of personnel. These include reluctance to disrupt family life and schooling, lack of employment opportunities in host country and a higher standard of living in the recipient country.

The reported costs of migration to the source country are significant. One way of estimating the cost of health personnel outflow from a country is in terms of the cost of the training investment that is required to replace those health personnel.

The outflow of health personnel can have a number of very significant ‘knock-on’ effects that are often not captured as costs. This includes the negative effect on the overall functioning of the health system and consequent increases in mortality and morbidity. The lack of health personnel can also mean that other healthcare investments become wasted, such as when healthcare facilities lie dormant because there aren’t any personnel to staff them.

Counter-productive behaviours may also result from staff shortages, including absenteeism; salary-augmenting behaviour (second job); pilfering of public property; poor treatment of patients; under-the-counter fees, and the sale of drugs that should be free. The ‘loss of institutional memory’ from large scale resignations and other turnover factors result in a duplication of work and wastage of resources. The brain drain of academic and experienced personnel can also lead to deficiencies within training institutions thereby affecting the future production of health personnel. An exodus of skilled people from a country leads to a perception of political and economic instability. Researchers have also contended that ‘national output measures are negatively affected though a loss of high-income earners’.

There are also costs in unmanaged disease burdens, and the costs to households of seeking care at higher levels where personnel are found, rather than at primary or secondary levels of care.

Previous EQUINET work<sup>4</sup> has highlighted that macro-economic and health sector reforms in southern Africa have enabled more powerful business, medical and middle class interest groups to exact health sector concessions at the cost of the poorer, less organised rural health workers, or the urban and rural poor. At national level equity oriented policies are strengthened in processes that also strengthen the voice and influence of workers and users of primary healthcare and public health systems. Dealing with these issues implies more than evidence; it also implies political choice. This calls for alliances, networking, debate and advocacy.

#### **4. Current Policy Responses**

A more rigorous framework for policy analysis is needed, both to stimulate relevant innovation and to avoid measures and incentives counteracting each other. This evidence demands stakeholder review. Available literature signals but does not adequately elaborate the role of institutional and governance factors in policy development on human resource issues, but provides sufficient evidence that it is an area where stakeholder perceptions and interests cannot be ignored. Analysis is needed of the extent to which the current institutional environments and processes enable the relationships of trust between health authorities and health workers to solve the complex problems arising.

Policy responses from health sectors can themselves mitigate or exacerbate outflows. The use of medical practitioners in managerial capacities has, for example, contributed to the human resource crisis in that valuable skills are diverted away from mainstream healthcare into administrative functions and tasks.

The net impact of policy measures, such as bonding (for example the bonding of doctors in Zimbabwe in the 1980s and the South African community service initiative), as push factors in the 'command and control' signals they send, or as stay factors in raising barriers to early exit from health systems is unclear. Neither is it clear what impact different measures (for example, paying for staff accommodation, providing relocation expenses, converting housing benefits into cash, payment of a rural allowance and other pay and non-pay incentives) have had on the deployment and movement of healthcare workers towards areas of high need. While this is likely to be specific to different circumstances and countries, more thorough analysis is needed to back policy development on managing internal personnel flows

The extent to which a rights discourse informs policy development and the framing of options for the sector is less evident in the current literature. Nevertheless, many of the issues generating debate on health personnel include balancing rights of individuals, workers, communities, patients and countries, and corresponding obligations to public health and to avoid unfair inequalities in either the costs or benefits of the current distribution and flows of health personnel. Notions of fairness imply a need for social debate on rights and obligations around movement and migration of health personnel, in relation to the personnel themselves, to their employers in low income and industrialised countries, to users of health services and to training and labour market institutions.

While national constitutional, public health and employment law frameworks provide some basis for resolving competing rights, there is criticism that international and global frameworks are currently skewed away from social, public health rights, and provide underdeveloped options for protecting and equitably financing public goods, such as health

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<sup>4</sup> EQUINET Steering Committee (2000) Equity in Health in Southern Africa: Turning Values into Practice. EQUINET Policy Series No 7, Benaby printers, Harare.

personnel training. This calls for debate to build a widening understanding and consensus on how rights are protected and balanced at national, regional and international level. While there is growing commitment to setting codes of practice and ethics in this area, significantly more attention needs to be given to how such codes are implemented and enforced, to avoid these codes becoming 'bandaids' on a gangrenous wound. Further analysis is needed of how such codes are implemented in the context the World Trade Organisation General Agreement on Trade in Services and the commitments made in this agreement in southern Africa.

## **5. Areas for further Research, Analysis and Advocacy**

Steps need to be taken on a global basis to assess the scale, causes and impact of the skills drain before appropriate interventions can be devised and evaluated. There is a need to systematically analyse trends, develop perspectives, define response strategies and generally develop a coherent plan to meet the challenge in Africa. The extent to which health professionals are leaving southern Africa to work overseas is difficult to determine. Most countries have difficulty monitoring migration patterns due to insufficient data related, in part, to registration and recording problems. Data on the size and characteristics of the drain and comprehensive indicators reflecting the consequence of the drain on health must be collected and collated if there is to be any understanding of who is suffering as a result of the drain and how to address it. Much of the migration information in the literature is dated and 'there is no uniform system of statistics on the number and characteristics of international migrants'.

Further such analysis needs to be accompanied by cost-benefit evaluation of the losses and gains of current flows to health workers, to communities, to health systems and to countries, both to assess the benefit incidence of current policies and conditions and to use this to define more effective incentives and policy levers.

It is important to provide clearer analysis for policy on specific issues. While generic factors are identified, there is inadequate specific assessment of the relative impact of these factors in different settings with different mixes of personnel, or of how different policy measures have impacted on them. In particular there is inadequate evidence of the impact of current policies and trends on the primary health care and district health system levels of southern African countries. Although broad areas of promising practice and policy can be identified, it would appear that more country-specific analysis is needed, given the range and variability across countries of health sector and exogenous (non health sector) conditions that influence human resource outcomes. In some settings, specific areas of sectoral analysis may be needed (for example, to examine the stay factors in mission services; to identify the push factors for pharmaceutical personnel and other areas of critical scarcity and so on).

### *5.1 Production of Health workers*

Policy development on production of health personnel demands information systems and planning capacities within public health authorities, that are able to synthesise information across public and private sectors, and to track critical blocks, inequities and gaps.

For various reasons, largely macroeconomic and beyond the scope of the health sector, the quality and output of training institutions of many southern Africa countries has come under threat. The movement and migration of health personnel is itself affecting health-training institutions.

Health personnel from South Africa appear to make up the bulk of the total number moving and migrating out of the SADC region, although smaller numbers lost from other African countries may represent a larger share of the overall personnel numbers from those countries.

For example Zambia has retained only about 50 of the more than 600 Doctors trained in the country since independence<sup>5</sup>. Because of the lower production volumes of doctors in the smaller and poorer African countries, the loss of even a small number of doctors can have a disproportionately large impact. There is need to look at the categories of personnel migrating out of countries and their relative impact on national health systems, particularly in terms of capacity to deliver major public health programmes and capacity to lever and benefit from other health inputs. The burdens of health personnel losses across the region thus need to be mapped in relation to the capacity to produce and replace personnel.

Various student recruitment initiatives have been suggested as means of improving the distribution of health personnel. Making a special effort to recruit medical students from rural areas has been posed as one way of helping to solve the problem of poorly staffed rural health facilities, as they are judged more likely to want to work in their rural setting after graduation. This policy assumption would need to be verified in the context of the current conditions. In South Africa, a policy to reduce the numbers of white medical students has been suggested to be likely to result in a lower proportion of doctors emigrating, given that white medical graduates are more likely to leave the country.

Another important factor that is reported to have had an (unquantified) impact is the mix of health personnel being produced. Given fiscal constraints and the scale of priority for public health problems, countries have at different times made decisions over the 'right' balance of highly trained medical specialists, general medical officers, professional nurses, auxiliary nurses, medical assistants and community health nurses. It has been suggested that many countries have emphasised the production of fully qualified professional nurses and doctors who are expensive and time-consuming to produce, at the expense of community health nurses and medical assistants. The adverse role of civil service reforms particularly in relation to the production and retention of health workers has also been noted, while wider public sector expenditure limits are noted to have constrained efforts to deal with shortfalls in pay and levels of health personnel.

## 5.2 Availability and Distribution

The HRH discussion paper highlights that one constraint to designing policies that neither punish workers nor leave poor communities unfairly underserved is the availability of timely and accurate information on health personnel distribution and movements across private, public and traditional sectors, supported by evidence of relationships with identified determinants of health personnel distribution, including impacts of HIV/AIDS, wider resource allocation systems, public-private differentials in wage and non wage factors as well as social and value based determinants. In the same way as national health accounts are making visible the total resource flows within health systems, public sector planning for health personnel needs to get a wider and more holistic sense of health personnel distribution and determinants.

The literature gives a general impression that the current pattern of health personnel movement and distribution is regressive (increasing inequities and representing a poor-to-rich transfer), harmful and debilitating to already struggling and under-resourced health systems. Maldistribution itself implies a gap between need or demand and supply, while differences based on area, income or factors other than health need or planning imply distortions within health systems that may undermine the capacity to meet health needs. Attempts to measure and quantify the impact have, however, been difficult due to a lack of data and because of

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<sup>5</sup> Couper, I, P Worley (2002) 'The Ethics of International Recruitment'. *International Journal of Rural and Remote Health*

methodological difficulties. This is a problem as a lack of rigorous economic evaluation has been used to cast doubt on the damage to health systems.

There is some evidence of the extent to which inequalities lead to a negative cycle of reduced capacity to demand and use resources, unless deliberate steps are taken to redress this. This association between resource allocation and health personnel could be usefully mapped in other southern African countries.

It would be important to know the extent to which HIV/AIDS-related losses intensify internal competition for skilled personnel, and thus the inequitable resource–health personnel relationship. EQUINET is currently carrying out work in this area through its theme work on HIV and AIDS<sup>6</sup>. Further, the role of traditional health personnel in mitigating (and to some extent sustaining) gaps in western health services, including staffing, has been poorly explored and understood.

### *5.3 Movement and Migration*

Much of the available information focuses on flows between countries and there are gaps in the evidence on within-country migration and migration between SADC countries, which need filling. While there appears to be similarity in the factors affecting flows within and outside countries, and while there is an often seamless link between internal and external flows, the specific factors affecting internal and external movements need to be further explored. The precise directions and volumes of health personnel movement within each of the southern Africa countries, their impact on equity and performance of health services, the factors influencing these flows and the extent to which they are linked with wider between- and out-of-country flows is not well documented. This is an area for follow up work, both to document, analyse and develop strategic responses to these flows.

The migration of skilled people, primarily to South Africa, from other SADC countries in the early 1990s, was sufficiently large to raise concerns about a regional brain drain into South Africa, which would reinforce regional inequities. This prompted a subsequent policy response within SADC to limit regional recruitment of health personnel in higher income SADC countries. The statistics on this need to be further explored, particularly by skills group. Official immigration into South Africa is reported to have declined, both from the SADC region as well as from other parts of the world. What is not clear is the extent to which this decline is true for health professionals, nor how the considerable amount of illegal immigration since 1994 has impacted on health personnel.

It would be important in analysis to identify the relative impact of push-pull-stick-stay factors in different dimensions of health personnel flows and distribution, both as measured from data and as perceived by key policy stakeholders. Specific study is needed of the replicability of the often unique pull and stay factors within missions to the wider health system. In addressing any of the problems above presentation and analysis is needed of what has worked within the region and more widely to address problems and its replicability in other settings.

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<sup>6</sup> Loewenson R, McCoy D, Ntuli A, Ijumba P, Kemp J, Chopra M, Aitken J, Ray S (2003) ART Treatment access and effective responses to HIV and AIDS - Providing new momentum for accessible, effective and sustainable health systems Southern African Regional Network for Equity in Health (EQUINET), Issues and Options Briefing November 2003; [www.equinet africa.org](http://www.equinet africa.org)  
Aitken, J.M and Kemp, J (2003) HIV/Aids, Equity And Health Sector Personnel In Southern Africa, R Loewenson, C Thompson (Ed) EQUINET Discussion Paper Number 12 EQUINET and OXFAM GB, Harare [www.equinet africa.org](http://www.equinet africa.org)

Policy making would be supported by research that not only identifies the different causal layers underpinning each of the primary determinants but also why these determinants are unfavorable in underserved areas. It must be noted that this is an area where a blend of objective and subjective reporting is critical for policy development if old problems of thinking 'for' rather than 'with' health workers and of policy imposition are to be avoided. Any research process carried out would need to be located within a context of promoting dialogue within affected stakeholders and of building policy consensus.