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The Looming Crisis in the Health Workforce:
How Can OECD Countries Respond?
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Introduction and Main Findings

Introduction

OECD countries face a challenge in responding to the demand for health workers over the next 20 years. This challenge arises in a world which is already characterised by significant international migration of health workers, both across OECD countries and between some developing countries and the OECD area. Whether these migration flows increase or decrease over the next 20 years is likely to depend largely on what combination of human-resource management policies and migration policies is adopted by OECD countries.

Raising domestic training rates in OECD countries could contribute to filling the gap and would reduce the "pull factors" on migration. But, the duration of medical training will limit the potential impact of increasing training in the short run. Migration may continue to play a role, at least in some OECD countries, in managing temporary disequilibria or addressing regional imbalances. However, other domestic human resource policies can also contribute to meeting the increasing demand for health workers. Improving retention, adapting skill mix or making better use of people with foreign qualifications could, to some extent, help to match the supply to the demand for health workers. In this context, good practices need to be identified and their transferability evaluated.

In any case, the management of health human resources cannot be considered in isolation, due to the increasing interdependency between countries through international migration of highly-skilled workers in general, and health professionals in particular. Equity concerns with regard to lower income countries, some of which face severe shortages of doctors and nurses, are growing too. This suggests a strong case for better international co-operation.

Push factors in origin countries also contribute to generating high levels of migration. However, health workforce policies in origin countries are not the focus of this report. This is not to say that this report is oblivious of these complex and serious issues. In fact, to the extent that they shape the international debate on the management of health workforce, these "push factors" have informed the discussion of policies in this report.

This report analyses international migration and training of health workers in the context of other workforce policies, focusing on doctors and nurses.* It starts in Chapter 1 with a review of the recent and expected evolution in the density of doctors and nurses. Chapter 2 analyses education and migration policies and their interactions, in light of past

* Migration flows and workforce management also concern other important health professional categories, such as pharmacists, dentists, physiotherapists, as well as caregivers taking care of the dependent elderly. This report focuses on doctors and nurses, for which data have been collected and can be shown to support the analysis. Some data on foreign-born pharmacists and dentists collected for the year 2000 are however reported in other OECD work (Dumont and Zurn, 2007).

trends. Chapter 3 reviews other health workforce policies aiming at an efficient use of the available health resources. Challenges related to international equity and interdependency dimensions are discussed in Chapter 4. The last chapter concludes by offering options for addressing future health workforce needs.

Main findings

- The average growth in physician and nurse density in the OECD area slowed sharply in the past 15 years compared with the previous 15 years. The trends for physicians were accompanied by changes in lifetime hours worked, growing feminisation of the workforce, increasing specialisation, and a growing number of health workers' retirements.
- Circa 2000, several OECD countries reported shortages of doctors and nurses and published projections suggesting future shortages of health workers.
- UN population projections suggest that younger age cohorts will shrink in many OECD countries over the next 20 years, possibly increasing cross-sector competition to recruit the best and the brightest students.
- Despite differences in how medical and nursing education is organised, most OECD countries exercise some form of control over student intakes, either by capping the total number of places or by limiting financial support to medical education. Intake to medical schools has followed a U-shape curve in many OECD countries, with a downswing in the 1980s and early 1990s and an upswing around the end of the last decade. Because of the long delay in training, the upswing has only recently become identifiable in graduation rates in a few countries. In fact, on average across the OECD, the number of medical graduates in 2005 lies below the 1985 level.
- Despite recent upward trends in doctors' and nurses' training rates, potential gaps between the demand for, and the supply of, health professionals may emerge in the future in light of demographic changes and increasing income. This calls for a continuous policy emphasis on maintaining training capacity for both doctors and nurses.
- The contribution of foreign-trained doctors to changes in stocks of physicians is significant and has increased over time in many OECD countries. In several OECD countries, immigration jumped sharply at about the time that shortages were identified at the end of the 1990s. Continuing or even greater reliance on migration of health professionals could make health systems in certain OECD countries too dependent on immigration.
- Migration and training policies should not be considered as the only possible solutions. Other policies aiming at a better use of the available health workforce are also called for. These include: *i)* improving retention (particularly through better workforce organisation and management policies, in particular in remote and rural areas); *ii)* enhancing integration in the health workforce *(e.g.,* by attracting back those who have left the health workforce and by improving the procedures for recognising and as necessary supplementing foreign qualifications of immigrant health professionals); *iii)* adopting a more efficient skill mix *(e.g.,* by developing the role of advanced practice nurses and physicians' assistants); and iv) improving productivity *(e.g.,* through linking payment to performance). Different countries are likely to choose different mixes of these policies, depending, among other things, on the flexibility of their health labour markets, institutional constraints, and cost.

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- Increasing international mobility and the emergence of shortages of health professionals in many OECD countries and worldwide have raised concerns about international interdependency in the management of health human resources. There is indeed a risk for shortages to be exported within and beyond the OECD area, putting excessive burden on the poorest countries in the world. This risk exists also in the case where OECD countries attract health workers mainly from a limited number of large-supply origin countries which offer training programmes aimed at "exporting" health professionals.
- Even if the global health workforce shortage goes far beyond the migration issue, international migration can contribute to exacerbating the severity of the problems in some countries with low starting densities of health professionals. This raises equity concerns. However, strategies and practices implemented at both national and international level, such as codes of conduct, raise unresolved conceptual and practical implementation challenges. International development initiatives can help to strengthen health systems in origin countries, thereby mitigating factors which are pushing health professionals to leave.
- Possible solutions to address structural imbalances between the supply of and the demand for health professionals do not carry equal weight, since implementing them involves trade-offs between different policy objectives, both at domestic and international levels.
- A strong case can therefore be made for better international monitoring and communication about health workforce policy and movements of health professionals across countries, with a view to diagnosing potential imbalances between demand and supply in the global market for health workers and improving the prospects for international co-ordination.

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