

World Health
Organization

International Migration of Health Workers

IMPROVING INTERNATIONAL CO-OPERATION TO ADDRESS THE GLOBAL HEALTH WORKFORCE CRISIS

What are the main trends in the international migration of health workers?

What are the main drivers of international mobility of doctors and nurses?

What is the impact of migration on less developed countries?

How can countries respond?

How to strengthen international co-operation?

For further information

For further reading

Where to contact us?

Introduction

In 2006, the World Health Organization estimated that there was a shortage of more than 4.3 million health personnel across the world. Low-income countries were particularly hard-hit by shortages: of the 57 countries with a critical shortage, 36 were sub-Saharan African countries.

Because the international migration of doctors and nurses has become increasingly visible, it is often seen as the main culprit behind these shortages. This has led to a polarized debate between the negative aspects of migration and the individual rights of health personnel to leave any country including their own. In this context, policy discussions often occurred around the issue of compensation. The work jointly carried out by the OECD and WHO provides a detailed picture of the magnitude of health workers migration and shows that the global health workforce crisis goes beyond the migration issue.

The global economic crisis and events such as the A/H1N1 pandemic have recently increased the pressure on health systems and health personnel, and as a result are adding to the urgency to address the global health personnel crisis.

To tackle the health workforce crisis, there is a need to increase training capacity, to improve retention and management of the health workforce, to address concerns related to international migration of health workers and better monitor these flows. Recent G8 summits in Toyako (Japan, 2008) and L'Aquila (Italy, 2009) reiterated the need for progress in these areas and encouraged WHO to develop a code of practice on the international recruitment of health personnel.

This *Policy Brief* provides new insights on recent migration trends for doctors and nurses up to 2008, and discusses the main causes and consequences for destination and origin countries. It presents possible policy responses stressing the importance of international co-operation to address the worldwide scarcity of health workers. ■

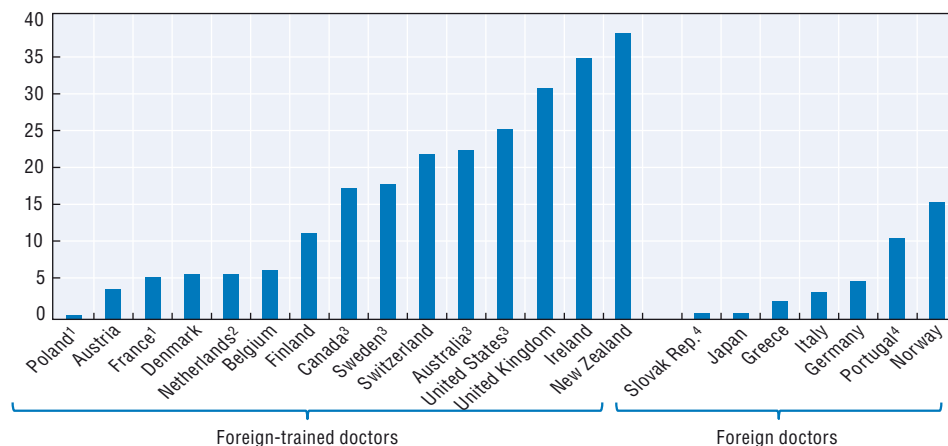
What are the main trends in the international migration of health workers?

The past decade has witnessed rapid increases in migration of health personnel, notably in most OECD countries (OECD, 2007). Despite recent trends showing signs of stabilisation or decline in a few countries, overall migration of health personnel to OECD countries is still on the rise (for updated statistics see www.oecd.org/health/workforce and OECD, 2009).

For example, in the United States, the number of overseas-educated doctors passing Step 3 of the USMLE exam (the stepping stone to full registration to work as a medical doctor in the United States) has increased by 70% between 2001 and 2008. Over the same period, temporary migration of doctors has increased two-fold in Australia and by 40% in Canada. In these two countries, regulations on permanent migration for doctors have been relaxed and flows have been increasing rapidly. Inflows of foreign doctors with long-term permits have also increased markedly in Switzerland (+70% between 2001 and 2008), mainly from Germany. On the contrary, the number of new full registrations of foreign-trained doctors has been declining in the United Kingdom since 2003, when it peaked at about 14 000. In 2008, only just over 5 000 new registrations were recorded. This still leaves, however, the United Kingdom as the second largest destination country for foreign-trained doctors after the United States.

Changes in the share of foreign-trained health workers reflect the cumulative impact of past migration flows, sometimes with a delay because of the time taken for full registration. In most OECD countries, the share of foreign-trained doctors has been increasing in recent years. In 2008 (or the latest year available), the percentage of foreign-trained doctors ranged from below 1% in Poland to 39% in New Zealand (Graph 1). High percentages are also recorded in the United Kingdom and Ireland where around a third of all doctors were trained abroad. In Australia and the United States, this percentage was respectively 23% and 26% in 2007.

Graph 1.
SHARE OF FOREIGN-TRAINED OR FOREIGN DOCTORS IN SELECTED OECD COUNTRIES IN 2008 (OR LATEST YEAR AVAILABLE)
 Percentage



1. 2005.
 2. 2006.
 3. 2007.
 4. 2004.

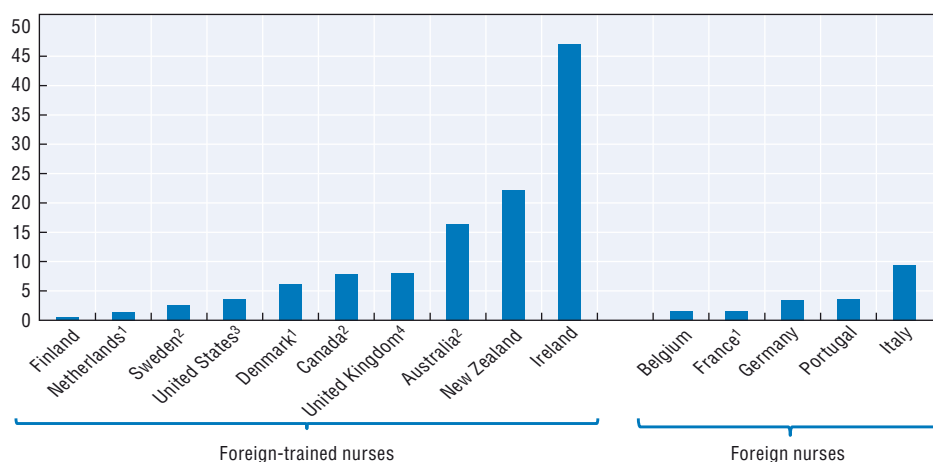
Source: www.oecd.org/health/workforce.

The share of foreign-trained nurses tends to be lower than for doctors (Graph 2). In Sweden, for example, less than 3% of nurses were foreign-trained in 2008 compared with over 18% for doctors. Similar findings apply to most OECD countries but not in Ireland which has the second highest nurses-to-doctor ratio in the OECD (5 to 1) and where about 47% of the nurses were foreign-trained in 2008 compared with almost 36% for doctors.

That being said, migration of nurses has increased in many OECD countries since 2000. However, in the United Kingdom and Ireland, between 2001 and 2008, new registrations of foreign-trained nurses decreased by a factor of 4 and 2.7, respectively. In the meantime, permanent migration of foreign registered nurses to Australia increased six-fold, while it was multiplied by three in Canada. In the United States, the number of foreign-trained nurses passing the licensing examination has quadrupled between 2001 and 2007, before decreasing significantly in the last two years. In Sweden, Denmark and Switzerland, inflows of foreign-trained nurses peaked around 2003 before decreasing significantly until 2006. Since then, growth in migration flows seems to have resumed.

It is unlikely that the recent economic crisis will affect drastically the international migration of health personnel. Employment in the health sector is more resilient to a cyclical downturn than is employment in most other sectors of activity and the demand for healthcare is certainly not decreasing in the short-term due to the crisis. Push (i.e. reasons why people might want to emigrate) and pull (reasons why a country might seek to attract immigrants) factors for migration could nonetheless be affected. On the one hand, the deterioration of the economic conditions in countries of origin could provide further incentives to look actively for employment opportunities abroad. On the other hand, people who have recently left the health workforce in OECD countries to take up other types of jobs, may

Graph 2.
SHARE OF FOREIGN-TRAINED OR FOREIGN NURSES IN SELECTED OECD COUNTRIES IN 2008 (OR LATEST YEAR AVAILABLE)
 Percentage



1. 2005
 2. 2007
 3. 2004
 4. 2001.

Source: www.oecd.org/health/workforce.

consider returning to the health sector because of the greater job security. In the medium-term, however, the economic crisis is putting severe strain on public finances, which could affect the number of health workers being trained or recruited in the future. There is little evidence that any of these effects have been significant, at least so far.

These short- or medium-term effects should not distract attention from some of the more structural reasons why some OECD countries rely on migration of healthcare professionals. In particular, the ageing of the health workforce will continue, depriving countries of cohorts of educated and experienced staff. Demand for health services shows no sign of slackening and indeed may well increase in line with population ageing. OECD countries will need to continue their recent efforts to improve training and retention of staff. Migration might help them cope with shortages in the short-term, but is not a credible response to the longer-term trends. ■

What are the main drivers of international mobility of doctors and nurses?

The work recently undertaken by the OECD and WHO provides some new insights into the causes and consequences of the international mobility of doctors and nurses (OECD, 2007; OECD, 2008). In particular, countries that have more migration in general, and notably those which have more highly skilled migration, tend to have more migrant health workers. In other words, while international migration flows in recent years tend to be selective towards the highly skilled, they are not specifically oriented towards health professionals.

Rising incomes, new medical technology, increased specialisation of health services, and population ageing are pushing up demand for healthcare workers in OECD countries. In response, there was a prolonged growth in physician and nurse density in OECD countries in the 1970s and 1980s, but the growth rates have slowed sharply since the early 1990s. Cost-containment policies, such as control of entry into medical school, and closure of hospital beds in the case of nurses, may explain much of the slowdown. In addition, trends such as the growing feminisation of the physician workforce, higher rates of part-time working and early retirement are also likely to have reduced hours worked by the average health personnel.

By 2000, several OECD countries were reporting shortages of doctors and nurses, at least in some parts of the country. In this context, a recourse to recruiting professionals from abroad has been seen as an attractive option, at least in the short-term. Part of the recent increases in migration can thus be explained by the fact that migration was used as a “quick fix” for unanticipated health workforce needs, whereas training extra doctors and nurses takes many years to have an effect.

Recently, many OECD countries have made significant efforts to increase training rates for doctors and nurses. Since 2000, the number of nursing graduates has increased at least by 50% in Australia, France, the United Kingdom and has doubled in Canada. In the first three previous countries, the number of places in medical schools have doubled since the late 1990s. In Canada, it was increased by more than 50%. However, as it can take more

than ten years to fully train doctors and from 3 to 5 years to train a qualified nurse, in most cases the effects of these policies will only be visible in a few years.

From the perspective of potential migrants, the push and pull factors driving the migration of personnel broadly coincide with those that apply to highly skilled workers in general. Despite the lack of doctors and nurses in many developing countries, the first motivation for migration is often linked to more and better employment opportunities abroad (encompassing salaries, working conditions, career advancement, etc.). Wage differentials across countries play an important role, but is not the only determinant, as other factors such as the possibility to offer a better and safer future to their children may also be determinant. Very often indeed, migration of health workers will be a symptom of the difficulties faced by the health system, and more generally the society, of the country of origin rather than its direct cause. ■

What is the impact of migration on less developed countries?

Three main findings emerge from the OECD/WHO work with regard to the impact of health workers' migration on origin countries. First, a significant share of international movements is occurring between OECD countries, even though the bulk of migration flows is originating from developing and emerging countries. Around 2000, nurses born in the Philippines (110 000) and doctors born in India (56 000) accounted for the bulk of the immigrant health workforce in the OECD, but the second and third most important origin countries were the United Kingdom and Germany. As of 2000, slightly under 40% of all migrant doctors and 30% of migrant nurses in OECD countries originated from another OECD country.

Secondly, the outflow of health personnel from large origin countries such as India or Russia – albeit large in absolute terms – remains low compared with the size of their total workforce. In addition, some countries with a percentage of their health personnel abroad manage to maintain relatively high numbers of health workers at home. This is the case notably for countries that train nurses for export, such as the Philippines, some Caribbean states and, increasingly, China.

The situation is, however, quite different in the case of some smaller countries and African countries. Countries with expatriation rates of doctors above 50% (which means that there are as many doctors born in these countries working in the OECD countries as there are working in their home country) comprise small island states in the Caribbean and the Pacific, along with five African countries: Mozambique, Angola, Sierra Leone, United Republic of Tanzania and Liberia. Several French-speaking African countries also have high expatriation rates, above 40%.

Thirdly, the needs for health workers in developing countries, as estimated by WHO, largely outstrip the numbers of immigrant health workers from those countries working in OECD countries. In 2000, all African-born doctors and nurses working in the OECD represented no more than 12% of the total shortage for the region, as estimated by WHO. The corresponding

percentage was even lower in Southeast Asia (9%). International migration is neither the main cause of healthcare shortages in developing countries, nor would its reduction be enough to address the worldwide health human resources crisis. It is true, however, that in less developed countries that have particularly high emigration rates, emigration contributes to exacerbate the acuteness of health workforce problems and further weaken already fragile health systems. ■

How can countries respond?

Receiving countries need to expand education and training capacity. The objective should not necessarily be “self-sufficiency” but should be to avoid becoming excessively dependent on foreign health personnel to fill domestic needs. In addition, OECD countries could adopt a portfolio of policies aimed at making the best use of the existing health workforce by i) improving retention (particularly through better workforce organisation and management policies); ii) enhancing integration in the health workforce (such as by attracting back those who have left the health workforce); iii) adopting a more efficient skill mix (such as by developing the role of advanced-practice nurses and physicians’ assistants); and iv) improving productivity (by, for example, 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.

Source countries need to strengthen health workforce retention. Such policies should focus on rural areas, as there seems to be a link between internal and international migration. (Most international migrants come from urban areas although the most acute shortages tend to be in rural areas.) To address this concern, WHO has been developing a programme of work, including a set of global recommendations, on health workforce retention in rural and remote areas (see www.who.int/hrh/migration/retention/en/index.html). Although from a financial perspective improving retention in developing countries is rather challenging – lower income countries are not in a position to close the wage differential with higher income countries – other measures have been shown to be effective to improve retention, such as improving working conditions and health workforce management, providing better equipment, and facilitating professional development. Scaling-up domestic training of health workers will often also be required. These policies require better governance and long-term financial commitments that, in many cases, will not be achievable without support from the international community. ■

How to strengthen international co-operation?

Strengthening international co-operation is therefore one of the key policy responses needed. A number of “codes of practice” on the ethical recruitment of international health workers have been created over the past few years (Box 1). These initiatives have served to raise awareness in public opinion and among policymakers, as well as to improve policy coherence for development.

Member States at the 2004 World Health Assembly asked WHO to develop a Code of Practice on the international recruitment of health personnel. A draft code was prepared and discussed in various international fora and more consultations were conducted at national and regional levels. The WHO

Executive Board of January 2010 decided to submit the draft code of practice to the World Health Assembly of May 2010 for deliberation and possible adoption by member states. This code would be voluntary, global in scope and applied to all health personnel. It would set forth principles and encourage the setting of voluntary standards in a manner meant to promote an equitable balance of interests among health personnel, source countries and destination countries, with a particular emphasis on the negative effects of health worker migration on those countries experiencing a health workforce crisis.

Co-operation in managing migration can also take the form of bilateral or multilateral agreements between countries or health institutions. Such agreements can favour regional migration and facilitate circular or return migration. Some countries have signed such agreements and some of them appear to have worked. Reviewing and assessing more systematically these agreements, with a view to identify and promote good practice, will be an important priority for further work.

Finally, improving the availability and international comparability of migration statistics for health personnel is crucial if countries are to develop evidence-based policies. Ideally, international migration of health personnel should be monitored by tracking the number of individuals – with the education and training to practice a health profession – moving from one country to another on an annual basis. In reality, few countries are currently in a position to provide such data. Improving data-collection in this area should therefore be a high priority. This would first require consensus on key indicators to collect, to strengthen health workforce information system in countries, to develop innovative approaches to evaluate and analyse international health worker migration, and to facilitate the dissemination and sharing of information. ■

For further information

For further information regarding this *Policy Brief*, please contact:
Jean-Christophe Dumont (OECD), e-mail: jean-christophe.dumont@oecd.org,
tel.: + 33 1 45 24 92 43 or
Pascal Zurn (WHO), e-mail: zurnp@who.int, tel: + 41 22 791 37 76.

Box 1

CODES OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL

Several codes of practice on the international recruitment of health workers have been developed over the past few years with the aim of better protecting migrant health workers, and minimising the negative impact of out-migration of health personnel for the source countries. These codes are not legally binding but rather set out agreed voluntary principles and responsibilities. These are so far limited in their geographical scope (e.g. the Commonwealth Code of Practice from 2003, the Pacific Code of Practice from 2007, the UK Code of Practice from 2001/2004 and the Scotland Code of Practice from 2006), or focused on specific health services (e.g. EPSU/HOSPEEM Code of Conduct for health personnel working in hospitals within the EU). To date, there is no code with worldwide coverage. A WHO code of practice would thus be the first code with a worldwide scope applicable for both source and destination countries.



For further reading

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Where to contact us?

OECD HEADQUARTERS

2, rue André-Pascal
75775 PARIS Cedex 16
Tel.: (33) 01 45 24 81 67
Fax: (33) 01 45 24 19 50
E-mail: sales@oecd.org
Internet: www.oecd.org

GERMANY

OECD Berlin Centre
Schumannstrasse 10
D-10117 BERLIN
Tel.: (49-30) 288 8353
Fax: (49-30) 288 83545
E-mail:
berlin.centre@oecd.org
Internet:
www.oecd.org/berlin

JAPAN

OECD Tokyo Centre
Nippon Press Center Bldg
2-2-1 Uchisaiwaicho,
Chiyoda-ku
TOKYO 100-0011
Tel.: (81-3) 5532 0021
Fax: (81-3) 5532 0035
E-mail: center@oecdtokyo.org
Internet: www.oecdtokyo.org

MEXICO

OECD Mexico Centre
Av. Presidente Mazaryk 526
Colonia: Polanco
C.P. 11560 MEXICO, D.F.
Tel.: (00.52.55) 9138 6233
Fax: (00.52.55) 5280 0480
E-mail:
mexico.contact@oecd.org
Internet:
www.oecd.org/centrodemexico

UNITED STATES

OECD Washington Center
2001 L Street N.W., Suite 650
WASHINGTON DC. 20036-4922
Tel.: (1-202) 785 6323
Fax: (1-202) 785 0350
E-mail:
washington.contact@oecd.org
Internet: www.oecdwash.org
Toll free: (1-800) 456 6323

The OECD Policy Briefs are prepared by the Public Affairs Division, Public Affairs and Communications Directorate. They are published under the responsibility of the Secretary-General.