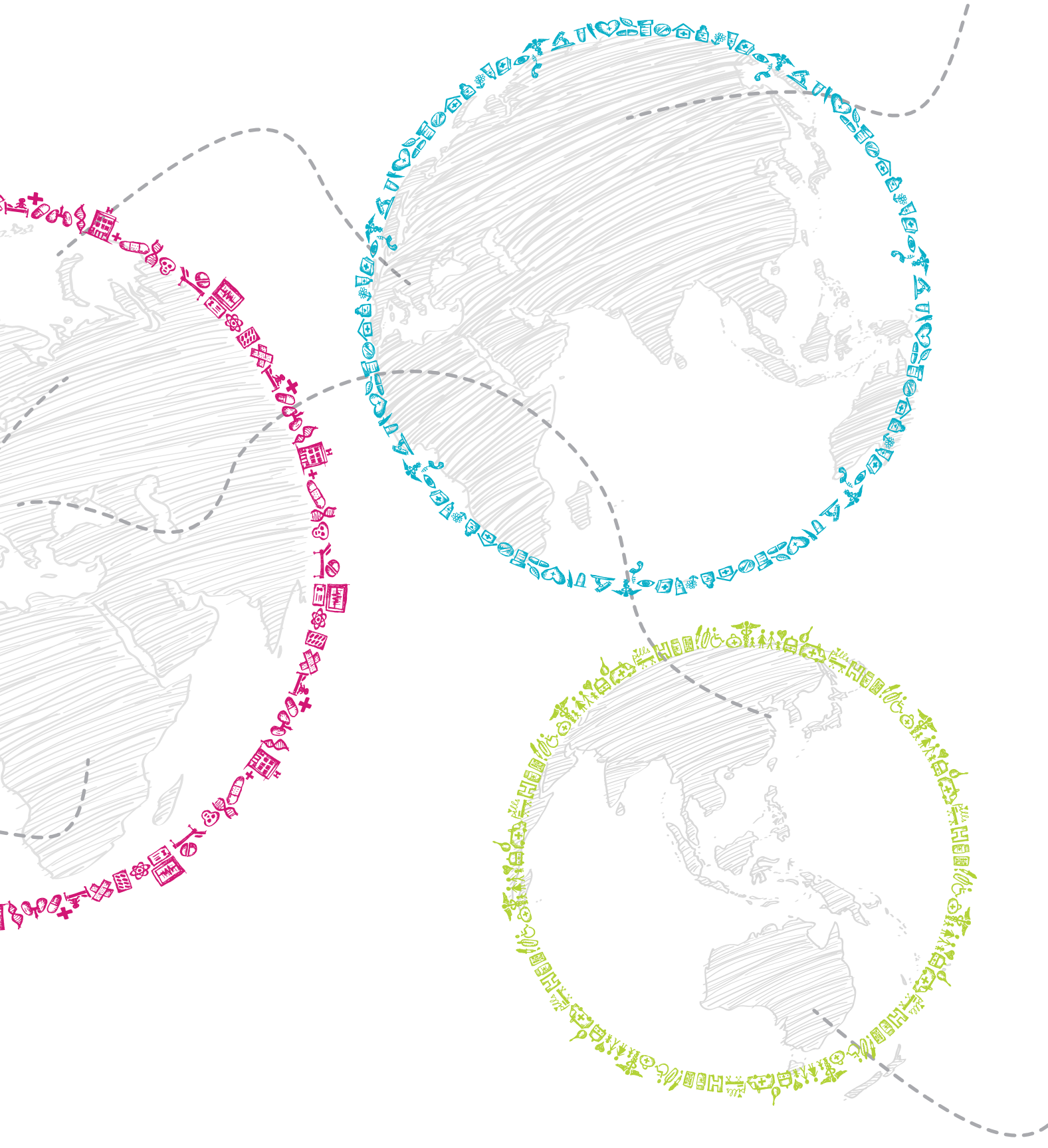


# MIGRATION OF HEALTH WORKERS

## WHO CODE OF PRACTICE AND THE GLOBAL ECONOMIC CRISIS

UERJ
UNIVERSIDADE DO ESTADO DO RIO DE JANEIRO
MPI
MIGRATION POLICY INSTITUTE
World Health Organization

# MIGRATION OF HEALTH WORKERS

## WHO CODE OF PRACTICE AND THE GLOBAL ECONOMIC CRISIS

EDITORS

AMANI SIYAM
Health Workforce Department,
Health Systems and Innovation,
World Health Organization,
Geneva, Switzerland

MARIO ROBERTO DAL POZ
Social Medicine Institute,
University of the State of
Rio de Janeiro, Brazil

UERJ
UNIVERSIDADE DO ESTADO DO RIO DE JANEIRO

MPI
MIGRATION POLICY INSTITUTE

World Health Organization

**WHO Library Cataloguing-in-Publication Data**

Migration of health workers: the WHO code of practice and the global economic crisis.

1.Health Personnel. 2.Emigration and Immigration. 3.Health Manpower. 4.Personnel Selection. 5. I.World Health Organization.

ISBN 978 92 4 150714 1 (NLM classification: W 76)
ISBN 978 92 4 150720 2 (CD-ROM)



Design and layout: L'IV Com Sàrl, Villars-sous-Yens, Switzerland.

Printed by the WHO Document Production Services, Geneva, Switzerland.

# Contents

# Abbreviations

| | |
|---|---|
| AMREF | African Medical and Research Foundation |
| ASEAN | Association of Southeast Asian Nations |
| Code | The WHO Global Code of Practice on the International Recruitment of Health Personnel |
| CSO | Civil society organization |
| DNA | Designated National Authority |
| DoH | Department of Health |
| ESB | English-speaking background |
| EU | European Union |
| HRH | Human resources for health |
| IEHP | Internationally educated health professional |
| ILO | International Labour Organization |
| IMG | International medical graduates |
| LFS | Labour force survey |
| LMICs | Low- and middle-income countries |
| MDG | Millennium Development Goal |
| MPI | Migration Policy Institute |
| NGO | Nongovernmental organization |
| NHS | National Health Service (UK) |
| NRI | National Reporting Instrument |
| OECD | Organization for Economic Co-operation and Development |
| UHC | Universal health coverage |
| WHA | World Health Assembly |
| WHO | World Health Organization |

# Acknowledgements

The present publication is the result of a collaborative effort between the World Health Organization, the Migration Policy Institute and the Social Medicine Institute, University of the State of Rio de Janeiro. The book was written by an international group of authors and organized by Amani Siyam and Mario R Dal Poz. A list of contributors to the chapters follows.

We would like to acknowledge the outstanding support of a number of individuals who contributed immensely to making this publication a unique product. Madeleine Sumption and Michael Fix who organized the second part of the book which consists of a four-country analysis of health workforce immigration since the global economic crisis. Thomson Prentice who provided the technical editing of the book and guidance to the final chapter. Thais Franco who helped in the initial organization of the book, communication with authors and drafting the introduction chapter. L'IV Com Sàrl for the graphics design and layout and the valuable support to the final stages of printing.

Our thanks also extend to Ties Boerma who supported the finalization of the book.

The named authors for each chapter are responsible for the views expressed in this publication.

## Contributors

**Jeanne Batalova,** Migration Policy Institute, Washington, DC, USA

**Christine Joan R Co,** Health Human Resource Development Bureau, Department of Health, Manila, Philippines

**Mario Roberto Dal Poz,** Social Medicine Institute, University of the State of Rio de Janeiro, Brazil

**Remco van de Pas,** Wemos Foundation, Amsterdam, Netherlands

**Jean-Christophe Dumont,** International Migration Division, Organization for Economic Cooperation and Development, Paris, France

**Giulia du Ponte,** African Medical and Research Foundation (AMRF), Rome, Italy

**Michael Fix,** Migration Policy Institute, Washington, DC, USA

**Delphine Sordat Fornerod,** Office Fédéral de la Santé Publique (OFSP), Substitute Head, Global Health Section, International Affairs Division, Bern, Switzerland

**Lesleyanne Hawthorne,** University of Melbourne, Australia

**Gatean Lafortune,** Health Division, Organization for Economic Cooperation and Development, Paris, France

**Linda Mans,** Health Workforce Advocacy Initiative (HWAI)/ Dutch Human Resources for Health (HRH Alliance)/ Wemos Foundation, Amsterdam, Netherlands

**Maria Angela Elias Marroquín,** Human Resources Development, Ministry of Health, San Salvador, El Salvador

**Yaw Owusu,** McMaster University, Hamilton, ON, Canada

**Thomson Prentice,** consultant writer and editor, formerly Managing Editor, World Health Report, World Health Organization, Geneva, Switzerland

**Javier Rivas,** International Labour Relations Office, Ministry of Labour and Welfare, Sonsonate, El Salvador

**Kenneth G Ronquillo,** Health Human Resource Development Bureau, Department of Health, Manila, Philippines

**Otto Christian Rø,** Department of Global Health, Directorate of Health, Oslo, Norway

**Amani Siyam,** Health Workforce Department, Health Systems and Innovation, World Health Organization, Geneva, Switzerland

**Madeleine Sumption,** Migration Policy Institute, Washington, DC, USA

**Arthur Sweetman,** McMaster University, Hamilton, Canada

**Ruth Young,** Kings College, London, United Kingdom

**Pascal Zurn,** Country Cooperation & Collaboration with the UN System (CCU), World Health Organization, Geneva, Switzerland

# Foreword

The adoption by WHO's Member States of the Global Code of Practice on the International Recruitment of Health Personnel in 2010, and its implementation by many countries, represented a critical step towards addressing the shortage of health-care workers around the world.

Many countries and international organizations have responded to the Code and made significant changes to national policies. This book describes many of these actions and lessons learned, which I hope can inform future actions. While the country response has had positive impact, there is still much to do to redress major inequalities in international migration of the health workforce. It underlines WHO's unwavering commitment to supporting the implementation of the Code and provides a wide range of detailed examples from the countries themselves of how they are tackling the many complex issues involved. It provides not just numerous insights into progress but also gives other countries valuable guidance and recommendations on how they, too, can implement the Code.

A strong qualified health workforce is essential for countries to be able to make progress towards the goal of Universal Health Coverage (UHC). UHC, defined as people receiving the quality services they need without incurring financial hardship, requires a health workforce that can effectively deliver a wide range of promotive, preventive, curative, rehabilitative, and palliative services to all people. This, amongst others, requires sound health workforce planning, quality transformative education systems for health professionals, innovative strategies of service delivery and regulation. Addressing local and international migration issues, as discussed in the publication, is part and parcel of these efforts. The crux of the Code is the development of human resources for health through all aspects of education, improved retention and fair recruitment practices while encouraging technical collaboration and financial support.

Readers are encouraged to learn from the shared experiences, domestic solutions and multi-lateral cooperation described in this book, and move ahead to support and advance the Code's principles. The book is recommended to health policy-makers and decision-takers in governments, nongovernmental organizations and other partners and stakeholders, including civil society.

**Dr Marie-Paule Kieny**
Assistant Director-General
Health Systems and Innovation
World Health Organization

# Preface

The global drive towards achieving universal health coverage (UHC) by improving access to affordable and effective care for all, cannot be achieved without a well-trained workforce, and having "the right staff in the right place". This publication examines in depth the central and often-controversial issues of the international migration of health workers before and since the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

This migration has sometimes been oversimplified as a linear "brain drain" from "poor" to "rich" countries, but the issue is more complex. This publication brings much-needed evidence and clarity to the changing patterns of migration over time, and the varied and changing reasons why health workers choose to migrate – or to stay in their own countries. Among these, the global financial crisis has influenced the trends and directions of health worker migration, and the impact of the crisis is reviewed at length in these chapters.

Against this global background, a range of better-informed policy responses is emerging locally, nationally and internationally. These responses include recognition of the rights of individuals to access to health and to the freedom of movement of health-workers. Many ethical issues have to be carefully weighed.

The Health Worker Migration Policy Council at the Aspen Institute is a leading advocate for achieving the right balance between protecting health system integrity, managing migration, and respecting individual rights. The Council, co-chaired by Dr. Francis Omaswa and former US Senator Tom Daschle, promotes and accelerates solutions by bringing political and thought leaders together to share and advance innovative practices and evidence-based solutions. It supports policy solutions while mobilizing global action to manage health-worker migration more effectively for the benefit of all. The Council's work has been largely inspired by country leaders and country actions that demonstrate what is possible.

The Council therefore welcomes and supports this book. It is a compendium of analysis, practical policy implementation, innovation and ideas. It sheds new light and raises new hope. Thus, the Council calls for action to continue to promote and address the issues related to health-worker migration laid out in these pages.

This book reports on the successful adoption and implementation of the Code in many countries. It shows that the implementation process itself has been a catalyst for bringing together stakeholders, including civil society. It also highlights the conditions for effective monitoring of health-worker mobility, which is a vital element in successful implementation. It makes the important connection between implementation and monitoring of the Code, and the regulation and licensing of health workers.

This publication helps us take stock, reassert priorities, and agree the way forward. We must keep health workforce migration, its impact and implications at the forefront of multiple international agendas. There remains much work to be done, collectively, nationally and globally to fully address the issues and impact of health-worker migration, and secure and sustain the health workforce required to deliver Universal Health Care. This book shows us the way forward.

The Health Worker Migration Global Policy Advisory Council at The Aspen Institute: http://www.AspenInstitute.org/HWM


©GHWA

Health in Ukraine.

# Introduction

Acute global shortages in the health workforce today represent a crisis that looks certain to worsen in the years ahead. There is a chronic worldwide need for some 2.4 million more physicians, nurses and midwives, and for almost two million more pharmacists and other paramedical workers (WHO, 2006).

Currently there are almost 60 million health workers globally, but they are unevenly distributed across countries and regions. Typically, they are scarcest where they are most needed, especially in the poorest countries. In any case, the total number is incapable of meeting the demands of many populations for access to the health care they require. Both developed and developing countries are struggling to cope with the huge challenges posed by the imbalance between increasing demand and faltering supply (WHO, 2013) (Box 1).

### BACKGROUND TO THE HEALTH WORKFORCE SHORTAGE

**BOX 1**

Globally, health workforce shortages continue to be greatest in sub-Saharan African countries that together bear 24% of the world's disease burden today, but have only 3% of health workers and less than 1% of the world's financial resources to respond to this burden (WHO, 2006).

Compounding existing shortages and inequitable distribution of the health workforce, the past few decades have witnessed expansion in the international migration of health workers, with patterns of migration becoming increasingly complex (Nair & Webster, 2013; Taylor & Dhillon, 2011). In this period, developed nations have become more and more reliant on international migrants to fill health workforce positions across the skill spectrum, from home health aides and assistants to nurses, physicians, and medical specialists. With rising life expectancy and expanding elderly populations, this reliance is expected to continue in coming decades and – in several health occupations – intensify.

Migration, together with other factors in many source countries such as insufficient health systems, low wages, and poor working conditions, are key factors determining low health-worker density in countries with the lowest health indicators. WHO estimates that the basic health-care system of 57 countries is affected by shortage of human resources and about one-third of these countries are the emerging market economies (Nair & Webster, 2013).

The crisis has long been painfully familiar to health policy-makers and public health analysts internationally. The migration of health personnel – especially doctors and nurses – around the world is also a long-standing phenomenon, as they seek better salaries and conditions in other countries. In many cases they are actively recruited by the wealthy nations of Europe, North America, Australasia and elsewhere. As a consequence, the health infrastructure in migrants' own countries is liable to be seriously weakened.

The crisis, and the impact on it on migration, is aggravated by new complexities. The global economic downturn in recent years has resulted in austerity measures in some countries, including severe cuts in health and social services budgets. Inevitably, the health of many millions of citizens, rich and poor, is under new and growing threats.

Foreign-trained doctors and nurses make up a significant share of the health workforce in the major English-speaking destinations; these flows do not seem to have been strongly affected so far by the global economic crisis and are expected to remain strong in coming decades as aging populations further increase the demand for health services. While some governments – notably in the United Kingdom – have actively recruited foreign health professionals in the past, they can receive large inflows even without actively or deliberately recruiting them.

This publication examines the overall picture, but focuses particularly on the role and relevance of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The Code is an ambitious step in the evolution of what has become known as global health diplomacy. It seeks to redress the imbalances among health workers around the world by raising important issues of human rights, including access to health, equity and social justice. In the context of migration, the Code encourages "receiving" countries to consider the impact of their policies and actions on the countries from which health workers migrate. Crucial to the success of the Code is the willingness of countries to implement it, which in turn depends largely on national and international dialogue and cooperation, including the exchange of information and data.

The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. It is a multilateral framework for tackling shortages in the global health workforce and addressing challenges associated with the international mobility of health workers.

The adoption of the Code in 2010 by all 193 Member States of the World Health Organization (WHO) has put in place a new global health architecture. (Taylor & Dhillon, 2011). It identifies ethical norms as well as institutional and legal arrangements, to guide international cooperation on the issue of health-worker migration, and it serves as a platform for continuing dialogue.

This publication is a progress report on the Code's implementation, based on responses by many countries to a WHO-developed National Reporting Instrument (NRI), a self-assessment tool that covers key aspects of the Code. So far at least 56 countries, mostly in Europe, have completed and sent their NRIs to WHO. These are predominantly migration destination countries, together with a minority of source countries.

The findings contained here give valuable insights into how and to what extent countries are implementing the Code, and highlights some of the barriers to implementation that exist. The findings are relevant to government officials, policy-makers, researchers, civil society organizations (CSOs) and other stakeholders in all countries, whether or not they participated in the survey. The evidence presented here is also useful in the current global dialogue about universal health care (UHC) and the need to improve access to services (and the growing demand for them), especially for the most vulnerable populations and sections of society.

In addition, this report makes use of detailed country case studies to explain many aspects of migration policies and provides numerous examples of the extent to which countries are acting to implement the Code. Finally, the report offers some conclusions and recommendations for further action.

## A chapter-by-chapter guide to this book

The first part of this publication (chapters 1–7) focuses on the process of implementation of the Code in a range of countries, including the views and experience of civil society. The second part (chapters 8–12) presents country case studies from Australia, Canada, the United Kingdom and the United States of America, looking at the stock and flow of the migration of health workers during the economic crisis.

**Countries featuring substantially in this publication include: Australia, Belgium, Canada, El Salvador, Italy, the Netherlands, Norway, the Philippines, Poland, Romania, Switzerland, the United Kingdom and the United States.**

**CHAPTER 1** provides a brief background of the Code and the agreed process among Member States for WHO to monitor its implementation. This process is based on countries establishing, firstly, a designated national authority (DNA) to oversee implementation, and secondly, a NRI that provides WHO with information that enables monitoring.

The chapter then presents the main findings on how and to what extent the Code has been taken up by individual countries. It then concludes with an assessment and a number of key messages aimed at state and non-state agencies to reinforce the Code's relevance the changing context of global health priorities.

**CHAPTER 2** explains the relevance of civil society's contribution and advocacy for implementing the Code, and illustrates this with examples of how nongovernmental organizations (NGOs) in Europe have been active in the evolution of it. It points out the new challenges for European CSOs in relation to health workforce mobility. Case studies are presented from six countries (Belgium, Italy, the Netherlands, Poland, Romania, and the United Kingdom) highlighting the work of civil society and the barriers encountered since the Code was adopted. The chapter then proposes the next steps that need to be taken, and lessons and recommendations for civil society.

**CHAPTER 3** weighs the risks that the norms articulated in the Code may not be reflected in national and international laws, policies, and programmes. The WHO Code is a non-binding instrument; and like international instruments that are binding, it has important strengths and limitations as an international legal tool. This chapter presents a legal evaluation of the limits and possibilities for the Code's implementation in El Salvador, a country seen by WHO as having a critical health workers shortage. The chapter discusses each article of the Code in El Salvador's context, including migrations, health policies, and particular features of the national health-care system.

The next three chapters describe initiatives to implement the Code in three countries with different perspectives, namely, Norway, the Philippines and Switzerland. In general, Code implementation requires a multi-stakeholder dialogue to exchange perspectives, values and

objectives related to the international mobility and recruitment of health professionals. The stakeholders can be brought together by using a range of tools, mechanisms and opportunities, such as the NRI developed by WHO, and described earlier, or (inter)national meetings during which broader issues such as health systems strengthening, demographic changes, or labour policies are discussed (WHO, 2013).

**CHAPTER 4** describes the Philippines' participatory multi-stakeholder process for monitoring implementation of the Code. This process proved to be an efficient way to collect data for the NRI and for an additional report. It also served to raise awareness of the Code and the importance of the ethical recruitment of health personnel. It concludes with suggestions of how the process can be extended.

**CHAPTER 5** reports how Norway manages the Code's implementation, through a number of strategic directives. The first aims to put in place sufficient domestic educational capacity to meet nationwide health provision needs. The second concerns the way that regulations are being adapted to improve the utilization of health personnel in the workforce, such as transferring of part-time contracts to full-time and improving working conditions. The chapter discusses these directives and goes on to examine Norwegian support of a number of technical cooperation agreements focusing on strengthening health-systems performance, thereby reducing the push effect in a number of source countries.

**CHAPTER 6** describes Switzerland's commitment to the implementation of the Code. While it is not a legally binding instrument, Switzerland agrees with its general principles and is committed to putting it into practice. It has designated a national authority to coordinate the monitoring of the Code, and submitted its first report of implementation in June 2012. Switzerland is one of the net beneficiary countries (more inflow than outflow) of the cascade of international migration of health personnel, and the proportion of foreign health workers, especially nurses, is among the highest in member countries of the Organisation of Economic Co-operation and Development (OECD). This means that currently the Swiss health system cannot function properly without the valuable contribution of foreign labour.

In addition to each country's implementation and monitoring efforts, other measures are required. These include improving the availability and comparability of statistics on international migration of health workers. This information assists policy debates at both the national and international levels and helps to evaluate the impact of any policies and programmes put in place to affect migration patterns. The Code emphasizes the importance of a sound evidence base for the formulation of effective policies and plans on the health workforce.

**CHAPTER 7** introduces basic principles for the monitoring of international migration of health personnel, bearing in mind the key criteria of relevancy to both originating and receiving countries, and the feasibility of regular data collection. It also reviews available data sources in OECD countries (including work permits, recognition of foreign credentials and licensing, professional registers, specific surveys of health personnel, labour force surveys and population censuses) that can be used for monitoring health workforce migration, providing an overview of their main strengths and limitations.

International migrants play an important role in the health workforce of developed nations. In recent decades, immigrant-destination countries have relied upon foreign-born and foreign-trained professionals to fill positions across the spectrum of health-care skills. The drivers of health workforce migration are enormously complex. Migration flows respond to a wide range of push and pull factors that affect all forms of migration (such as opportunity differentials between sending and receiving countries, and historical, political and trade relationships).

**CHAPTER 8** opens the second part of this book, which consists of a WHO four-chapter analysis of immigration and the health workforce since the global economic crisis as evidenced by four OECD countries that account for the majority of internationally mobile doctors and nurses: Australia, (Chapter 9) Canada (Chapter 10), the United Kingdom (Chapter 11), and the United States (Chapter 12). This analysis explains how recent trends in immigration, health-workforce policies, and economic conditions have shaped the migration of health professionals in these four major destinations in recent years. In an overview, Chapter 8 compares the specific migration corridor of each country, the policies and the routes into the health workforce for foreign professionals; and it reviews the most important policy changes that have taken place in the last 5–10 years. It then identifies the links between immigration policy, professional registration and skills use, and compares the impact of the global economic crisis on immigration in these countries and points out the factors that will be important in determining the pressure for health workforce migration in the coming decades.

The following four chapters describe the economic, demographic and policy developments influencing immigrant admissions, workforce integration, and labour market outcomes for immigrant health-care workers of each country.

**CHAPTER 9** reports the nature, the scale and the routes into Australia's health-care sector of foreign-born and foreign-trained health workers, and examines the actions taken to increase the domestic supply of health workers in recent decades. The scale of skilled migration to Australia has grown rapidly in recent years, during which Australia has developed an extraordinary dependence on international medical graduates (IMGs). In the coming decade, skilled migration is set to remain a national priority with strong relevance to the health professions. Long-term workforce demand will be met through dramatically expanded domestic training. Australian health ministers have set a goal for domestic self-sufficiency by 2025. Their policy imperative is thus to recruit migrant professionals who can contribute effectively within the next 13 years.

**CHAPTER 10** gives the background of Canada's health-care and immigration systems and then explores recent trends in the migration of internationally trained health professionals, with a particular focus on physicians and nurses and their location and education. The chapter concludes that, thus far, the recession appears to have had no appreciable effect on the admission of new immigrants and the integration of health professionals into Canadian practice. However, in the near future, financial constraints will affect the mostly publicly funded and/or subsidized health workforce as government debt and deficits are addressed. The large and increasing number of internationally educated health professionals (IEHPs) in Canada suggests that shortages in some less well-off countries may be exacerbated.

**CHAPTER 11** examines the characteristics of the United Kingdom's immigration and health-care policies fields before and since the global economic crisis. It shows that the number of health-care professionals coming to the United Kingdom on work visas has fallen steeply since the mid-decade, although most of this decline predated the crisis. The size of the health-care workforce in the United Kingdom has remained roughly stable, sheltered from the brunt of the economic crisis, and avoiding the high unemployment associated with some other occupations.

As a result, immigrant health-care workers have fared better than many other immigrants in recent years. Demand for health care is expected to increase in coming years, although a very tight fiscal environment will reduce growth in the National Health System (NHS) budget (and hence the workforce) down to extremely low levels. Since most health care in the United Kingdom is publicly funded, the future economic and fiscal outlook will be crucial in determining whether the international migration of health-care workers will rebound.

**CHAPTER 12** provides a portrait of foreign-born and foreign-trained health-care workers in the United States, focusing particularly on doctors and nurses during the 2007–2009 recession. The chapter examines more recent immigrant policy developments; the range of temporary and permanent visa options for health-care workers, and the pathways and barriers to practice. It also estimates the number of doctors and nurses from countries defined by WHO as facing critical health-care worker shortages.

Finally, the main findings of country responses to the NRI are examined and discussed, conclusions, and key messages are drawn, and recommendations made.

**References**

Nair M, Webster P (2013). Health professionals' migration in emerging market economies: patterns, causes and possible solutions. Public Health. 2013 Mar;35:157-163. http://www.ncbi.nlm.nih.gov/pubmed/23097260

Taylor AL, Dhillon IS (2011). The WHO Global Code of Practice on the International Recruitment of Health Personnel: The Evolution of Global Health Diplomacy. Global Health Governance, Vol. V, No. 1. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1970315

WHO (2006). Health workers: a global profile. In: The World Health Report 2006 – Working together for health. Geneva: World Health Organization. http://www.who.int/whr/2006/whr06_en.pdf

WHO (2013). WHO policy dialogue on international health workforce mobility and recruitment challenges: technical report. Copenhagen: The WHO Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0007/200698/WHO-policy-dialogue-on-international-health-workforce-mobility-and-recruitment-challenges-technical-report.pdf

CHAPTER 1

# Assessing global progress in implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel

AMANI SIYAM

MARIO ROBERTO DAL POZ

©GHWA

Surgery in China.

The chronic shortage of health workers in dozens of countries around the world today, outlined in the Introduction, has serious consequences for the populations concerned, and implications that stretch far beyond their borders. Without adequate numbers of motivated, skilled, well-trained and well-motivated health workers located and supported where they are most needed, national health systems cannot function, and global improvements in health, and the goal of universal health coverage (UHC) is seriously threatened.

In addition to shortages of personnel, many health systems are plagued by inefficient and inequitable use of resources – unmotivated, inappropriate and costly skill mixes of health personnel are among the top 10 leading sources of inefficiency in uses of health resources (WHO, 2010a). Expanding, improving and supporting the health workforce – collectively part of human resources for health (HRH) – is of fundamental importance. Extending health coverage to more people and offering more services is already almost impossible in many of the worst affected countries (WHO, 2006).

The international migration of health workers seeking new careers is an important factor aggravating the workforce shortage in their countries of origin. For many countries, the "brain drain" of their trained health professionals can cause serious economic damage, especially when the education system in those countries is incapable of replacing those who went abroad (ILO, 2009). This chapter assesses global progress implementing the Code. The main findings are contained here, and further discussed in the Conclusions.

The process leading to the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted in May 2010, started in 2004, when WHO was asked by the World Health Assembly (WHA) to develop it. In the subsequent years, and through multiple stages, this included numerous international and national consultations involving Member States, civil society organizations (CSOs) and many other organizations, and WHO itself (Taylor & Dhillon, 2011; Robinson & Clark, 2008).

Key principles governing the Code include the right of all people to the highest attainable standard of health and the right for any individual, including health personnel, to leave any country and to migrate to any other country that wishes to admit and employ them (WHO, 2010b; 2010c). The presence of, and equitable access to, health personnel can be considered central to the full realization of the right to health and to the common goal of UHC. The Code

emphatically does not aim to stop migration, but rather to guide countries to address some of the aspects of health workforce migration that may have a detrimental impact upon countries, and particularly source countries.

## Monitoring the Code's implementation

Based on the WHA resolution, WHO invited countries to report on their implementation of the Code, in a two-stage process. Firstly, each country was called upon to designate a national authority best equipped to oversee the international exchange of information regarding health personnel migration and the implementation of the Code. Countries were encouraged to choose an existing organization with a strong interest and qualification in health workforce issues, was sustainable, had the capacity to build intersectoral action, and possessed adequate information technology and communication means (Box 2).

### WHAT THE CODE COVERS

BOX 2

The Code contains 10 articles covering the following objectives; nature and scope; guiding principles; responsibilities, rights and recruitment practices; health workforce development and health systems sustainability; data gathering and research; information exchange; implementation of the Code; monitoring and institutional arrangements; and partnerships, technical collaboration and financial support.

For the Code to be successful, the three articles on information exchange, implementation of the Code and monitoring institution arrangements are perhaps the most important. These articles incorporate legal and institutional mechanisms to promote cooperation and implementation of the Code that actually are more robust than similar mechanisms found in some contemporary treaties, including the WHO Framework Convention on Tobacco Control.

At the time of writing (March 2014), 85 countries (Table 1) had successfully designated a national authority. Three out of four of these are based in the ministry of health, and the others are located in institutes of public health, health authorities, health boards and HRH observatories. Secondly, and through multiple consultations with countries and relevant stakeholders, WHO developed the NRI. It is a country-based, self-assessment tool covering key aspects of the Code, and disseminated through the network of WHO's regional and country offices.

As many as 56 countries, mostly in Europe, have completed and returned their NRI (tables 1 and 2). These countries represent more than 80% of the world's population living in destination countries, and a minority of the known source countries.

## DESIGNATED NATIONAL AUTHORITIES BY WHO REGION: NUMBER ESTABLISHED AND NUMBER THAT REPORTED USING THE NRI, 2012–2013

TABLE 1

| WHO region | Designated national authorities | National reporting reports received |
|---|---|---|
| Africa | 13 | 2 |
| The Americas | 11 | 4 |
| Eastern Mediterranean | 8 | 3 |
| Europe | 43 | 40 |
| South-East Asia | 4 | 3 |
| Western Pacific | 6 | 4 |
| **Total** | **85** | **56** |

## MEMBER STATES WITH DESIGNATED NATIONAL AUTHORITIES AND THOSE FROM WHICH REPORTS WERE RECEIVED USING THE NRI

TABLE 2

| |
|---|
| **Africa** |
| Angola, Cameroon*, Congo (the), Democratic Republic of the Congo, Ghana, Kenya, Mauritania, Mauritius, Namibia, Rwanda*, Seychelles, Swaziland, Uganda |
| **The Americas** |
| Canada*, Chile, Colombia, El Salvador*, Guatemala, Mexico*, Nicaragua, Panama, Paraguay, St Vincent & Grenadines, United States* |
| **Eastern Mediterranean** |
| Lebanon*, Oman, Pakistan*, Qatar, Saudi Arabia, Sudan (the) *, Syrian Arab Republic, Yemen |
| **Europe** |
| Albania*, Armenia*, Austria*, Azerbaijan*, Belarus*, Belgium*, Bosnia and Herzegovina*, Croatia*, Cyprus*, Czech Republic*, Denmark*, Estonia*, Finland*, France, Georgia*, Germany*, Hungary*, Ireland*, Israel, Italy*, Kazakhstan*, Kyrgyzstan*, Latvia*, Lithuania*, Monaco*, Montenegro*, Netherlands*, Norway*, Poland*, Portugal*, Republic of Moldova*, Romania, Russian Federation*, Slovakia*, Slovenia*, Spain*, Sweden*, Switzerland*, Tajikistan*, Turkey*, Turkmenistan*, United Kingdom*, Uzbekistan* |
| **South-East Asia** |
| Indonesia*, Maldives*, Myanmar, Thailand* |
| **Western Pacific** |
| Brunei Darussalam, Japan*, Micronesia *, Philippines*, Republic of Korea , Singapore* |

* Countries that completed and returned NRI.

## Communication and sharing information about the Code

Overall, 37 countries have taken a range of steps towards implementing the Code (Table 3). Already, 33 have reported taking actions to communicate and share information on health-worker recruitment, migration issues and the Code among relevant ministries, departments and agencies. In some cases, the Code has been translated into the national language (e.g. in Finland, Norway and Thailand). Countries have adopted multiple approaches to raise awareness of the Code and promote dialogue concerning it.

Seventeen countries have sought to involve all stakeholders in decision-making processes involving health-personnel migration and international recruitment. Some changes to relevant laws or policies are being considered. However, only 10 countries say they maintain records of all recruiters authorized by competent authorities to operate within their jurisdiction, and only nine say that good practices are encouraged and promoted among recruitment agencies.

TABLE 3

**STEPS TAKEN BY COUNTRIES IN SUPPORT OF THE CODE IMPLEMENTATION**

| | Total n=56 |
|---|---|
| Has the country taken steps to implement the Code? | 37 |
| 1) Actions have been taken to communicate and share information across sectors on health-worker recruitment and migration issues, as well as the Code | 33 |
| 2) Measures have been taken to involve all stakeholders in any decision-making processes involving health-personnel migration and international recruitment | 17 |
| 3) Actions are being considered to introduce changes to laws or policies on the international recruitment of the health personnel | 15 |
| 4) Records are maintained of all recruiters authorized by competent authorities to operate within their jurisdiction | 10 |
| 5) Good practices are encouraged and promoted among recruitment agencies | 9 |

## Responsibilities, rights and recruitment practices

The findings displayed in Table 4 suggest that health personnel do enjoy the same legal rights, responsibilities, recruitment processes and opportunities as those of domestically trained health professionals, showing clear evidence of equity and fair treatment by receiving countries. Broadly speaking, recruitment is based on recognition of qualifications particularly in four cadres: doctors, dentists, nurses and midwives. In some cases, countries require health personnel to undertake a national examination, followed by an application to a national professional council to obtain a licence to practice.

### MIGRANT HEALTH PERSONNEL (MHP): RESPONSIBILITIES, RIGHTS AND RECRUITMENT PRACTICES

TABLE 4

| Criteria | Countries n=56 |
|---|---|
| MHP enjoy the same legal rights and responsibilities as the domestically trained health workforce. | 51 |
| MHP are hired, promoted and remunerated based on objective criteria on the same basis as the domestically trained health workforce. | 43 |
| MHP enjoy the same opportunities as the domestically trained health workforce to strengthen their professional education, qualifications and career progression. | 37 |
| MHP are recruited internationally using mechanisms that allow them to assess the benefits and risk associated with their employment positions and to make timely and informed decisions. | 21 |

## Data gathering and research

Half of the reporting countries indicate the existence of government and/or non-government programmes or institutions undertaking research in health personnel migration that commonly exists within more than one entity (Table 5). Thirty-six countries keep statistical records of health personnel whose initial qualification was obtained in a foreign country.

Thirty-four countries have mechanisms to regulate the authorization to practice by internationally recruited health personnel and maintain statistical records on these authorizations. In contrast, only 11 countries have a database of laws and regulations related to international health personnel recruitment and migration. Surprisingly, only 13 countries indicate the existence of technical agreements and provision (or receipt) of financial assistance related to recruitment or management of health professional migration.

### COUNTRIES REPORTING ON DATA GATHERING AND RESEARCH

TABLE 5

| | Total n=56 |
|---|---|
| Countries with any mechanism or entity to regulate or grant authorization to practice to internationally recruited health personnel and maintain statistical records. | 36 |
| Countries with any mechanism or entity to maintain statistical records of health personnel whose first qualification was obtained overseas. | 34 |
| Countries with any (government and/or non-government) programmes or institutions undertaking research in health personnel migration. | 27 |
| Countries with any technical cooperation agreement that provides or receives financial assistance related to international health personnel recruitment or the management of and migration. | 13 |
| Countries with a database of laws and regulations related to international health personnel recruitment and migration. | 11 |

### Health workforce development and health systems sustainability

Most current bilateral, multilateral and regional agreements on the recruitment of health personnel precede the Code, and some have been developed or refined since it was adopted. Examples include agreements between neighbouring countries such as Cyprus and Greece; Egypt and Sudan; Denmark, Finland, Iceland, Norway and Sweden; Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan and Uzbekistan; as well as between countries of different income levels such as Italy and Tunisia; Croatia and Germany; Romania and Qatar; Finland and the Philippines.

Multilateral agreements include "mobility partnerships", which are non-legally binding frameworks for well-managed movements of people between the European Union (EU) and individual countries. Member States of the EU join these partnerships on a voluntary basis. Prominent regional agreements include those between Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Thailand and Viet Nam as part of the Association of Southeast Asian Nations (ASEAN) network. Agreements cover doctors and nurses and, in a few cases, midwives. Many agreements were concluded at national level, others at subnational level, such as agreements between Canada and Philippines, and Rwanda and Egypt.

## Discussion

Only about one in four WHO Member States responded to the first round of monitoring the WHO Code implementation. This somewhat restricts assessing the lessons that have been learned so far and limits generalizations about them. Part of the explanation for the low response may be that information about the Code has not yet reached all the key actors at national level. It is also worth noting that countries (especially source ones) with developing HRH information systems struggle to maintain data on migration and hence are less likely to respond to the NRI. The NRI was adequate in terms of the completeness and comprehensiveness of the answers to the questions addressed, and it would be further developed in future rounds of monitoring to capture subtle differences in the extent to which source and destination countries implement the Code.

What is important to glean from the NRIs received is that cooperation on health workforce development in the context of the Code tends to go beyond purely migration-related issues. Countries have reported on a range of broader financial and technical cooperation agreements. Support for the Code is well illustrated in a number of global health initiatives particularly those supported by the US government (Box 3).

## Conclusions

As a **voluntarily adopted** instrument, the Code is still in its early years. Yet, its implementation has stimulated small but encouraging moves from principles to actions. There are three key messages. Countries have shown successful approaches to the historical obstacle of engaging stakeholders as a significant step towards greater internal coherence and meaningful implementation of the norms articulated in the Code. Technical cooperation on health workforce development in the context of the Code tends to go beyond purely migration-related issues.

## EXTRACT OF THE NRI SUBMITTED BY THE UNITED STATES (2012)

BOX 3

The United States government's Global Health Initiative includes building sustainability through health systems strengthening as one of its seven core principles. The Government is engaged in a number of activities to strengthen health systems globally, such as its microfinance programmes and many activities in sub-Saharan African countries under the President's Emergency Plan for AIDS Relief (PEPFAR). The U.S. DoH and Human Services' (HHS) Health Resources and Services Administration (HRSA) Global HIV/AIDS Programme (GHAP) strengthens health-service delivery and systems of care in resource limited-countries through the establishment of training centres and collaborative partnerships with local universities and organizations. HRSA-supported programmes increase workforce capacity through technical assistance, task shifting, strengthening medical and nursing education systems to train and retain health workers in their home countries, and strengthening health systems by building local capacity and utilizing local human resources to ensure sustainability. The HHS Centers for Disease Control and Prevention (CDC) has been improving the key elements of health systems and managing interactions in ways that achieve more equitable and sustained improvements across health services and outcomes. Central to all of CDC's health systems strengthening activities are the tenets of working with ministries of health and other public health institutions to create sustainable health outcomes, and ensuring the coordination and integration of HHS activities at the country level.

The health system strengthening goals of the Code of Practice are reflected in America's Medical and Nursing Education Partnership Initiatives (MEPI and NEPI) with countries in sub-Saharan Africa. These programmes are designed to improve and expand the medical and nursing educational systems and are considered a key component of PEPFAR's goal of increasing the number of new health-care workers by 140 000. A wide range of US government organizations participate in both MEPI and NEPI.

A global action and consensus on how to best measure health workforce mobility is needed to create a comparative and multi-purpose information base.

Greater global collaboration among state and non-state actors is needed for countries to recognize the relevance of the Code in addressing their HRH challenges. For example, implementation of the Code has to be strategized and expanded through the core functions of the health workforce regional and national observatories. Grass-roots movements for improving the conditions of workers across borders and the civil society work in raising awareness and bringing political attention to health workforce issues are conduits for change at national and international levels. Through these mechanisms, the principles of the Code can be promoted by various capacity building and policy development interventions to improve the understanding of health workforce production, recruitment, deployment, retention and mobility.

Health workforce migration is part of the globalization of the labour market and warrants better measurement and policy options to be managed rather than a problem to be solved. Out-migration is difficult to tackle in a reality of numerous challenges and the inescapable paradox of remittances that migrant workers generate. Migration patterns change, but not fundamentally, even in times of financial crisis in many high-income countries, including many in the EU.

Increasing awareness of the global impact of health personnel mobility is paramount to the implementation of the Code. A few countries have indicated that they have made efforts to assign task forces or committees to bring together and raise the awareness of governmental and nongovernmental stakeholders alike. The HRH national and regional observatories networks are well positioned to facilitate that function.

Almost all reporting countries have provided clear messages that more efforts and technical cooperation are needed to extend knowledge and research, and to improve existing health workforce information systems, including information on laws and regulations related to health personnel recruitment.

Partnering with CSO is crucial for global and national dialogue as demonstrated in the European region where their efforts have influenced policy-makers and parliamentarians and gained commitment to implementing the Code. The political imperative of moving towards universal health care and monitoring its progress (WHO, 2014) provides opportunities that can be seized for much greater integration between health workforce planning on the one hand and policy-making and overall efforts at strengthening health systems on the other. It also calls for the establishment of linkages with other sectors, civil society and the political establishment.

**References**

ILO (2009). Strengthening migration governance: implementation of OSCE commitments related to migration by OSCE participating States. Geneva: International Labour Organization, Organization for Security and Cooperation in Europe. http://www.osce.org/eea/72021

Robinson M, Clark P (2008). Forging solutions to health worker migration. Lancet. 2008;371:691–693.

Taylor A, Dhillon I (2011). The WHO Global Code of Practice on the International Recruitment of Health Personnel: The Evolution of Global Health Diplomacy. Global Health Governance, Vol. V, No. 1 (Fall). http://www.ghgj.org

WHO (2006). The World Health Report 2006 – working together for health. Geneva: World Health Organization. http://www.who.int/whr/2006/en/

WHO (2010a). The World Health Report – health systems financing: the path to universal coverage. Geneva. http://www.who.int/whr/2010/en/index.html

WHO (2010b). WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva. http://www.who.int/hrh/migration/code/code_en.pdf

WHO (2010c). User's guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva. http://whqlibdoc.who.int/hq/2010/WHO_HSS_HRH_HMR_2010.2_eng.pdf

WHO (2014). What is universal health coverage? Geneva. http://www.who.int/features/qa/universal_health_coverage/en/

CHAPTER 2

# Civil society's contribution and advocacy for implementing the WHO Global Code in the European Region: Six country case studies

LINDA MANS
REMCO VAN DE PAS
GIULIA DE PONTE



Health Worker for All and All for Health Workers.

This chapter presents cases studies of the work of CSOs in six European countries since the Code was adopted in 2010: Belgium, Italy, the Netherlands, Poland, Romania and the United Kingdom.

## The changing forms of civil society engagement on international mobility of health workers

Low- and middle-income countries (LMICs) have suffered the effects of the health workforce brain drain in two ways that continue to damage the overall health and prosperity of their populations: rural-to-urban migration and international migration. The poorest rural communities have seen their doctors, nurses and others gravitate to the big cities, and then many leave the country altogether, probably never to return. These two trends have long been recognized as major impediments to the achievement of the health-related Millennium Development Goals (MDGs) in those countries.

Researchers have highlighted as "push factors" the effects of loan conditions for macro-economic development by the World Bank and the International Monetary Fund (IMF), and the World Trade Organization's General Agreement on Trade in Services causing people to migrate. These loan conditions included fiscal ceilings on public sector spending as well as limited education, training and deployment of health-care workers in many LMICs. As a result, many health workers in these countries "moved" to the private sector in urban areas or migrated to work in richer countries, including in Europe, where demographic changes caused demands for health care to rise. It has been estimated that this incurred a loss of US$ 184 000 per migrating African professional (Labonte et al., 2004). This brain drain has been described as a "perverse" subsidy from LMICs to high-income countries and there has been growing advocacy for internationally binding regulations on recruitment, equal access to health care as well as compensation for the incurred losses (Mensah et al., 2005).

In the lead up to the eventual adoption of the Code, European NGOs were closely involved at both national and international level to raise the issues of fair recruitment, retention strategies, data sharing, freedom of movement and the right to work, as well as the obligation by states to provide essential health care for all its citizens. This advocacy was conducted in conjunction with, among others, the World Medical Association, the International Council of Nurses and Public Services International.

The organizations called on states to respect and fulfil human rights as part of international agreements on health-worker migration. The request for a binding convention has found its way only partly into the WHO Code, a voluntary "soft law" tool that is aimed at stimulating action from governments and other parties, but cannot enforce work on sustainable health workforce practices. On the other hand, the Code encourages states to develop national legislation as well as bilateral and multilateral agreements on workforce migration. Civil society actors want these regulatory frameworks to be further developed and have proposed a number of models (Dhillon, Clark & Kapp, 2010). Other human rights conventions such as CEDAW[1] and migration-focused treaty bodies may serve as well as guidelines for further recognition of human rights.

After adoption of the Code by the World Health Assembly (WHA) in 2010, the CSOs in Europe have recognized a number of new challenges relating to health workforce mobility. First, their role as advocates has changed to one of cooperation and promotion of the Code at national level at a time that national health systems are under pressure to cut budgets because of economic austerity measures.

Second, as a result of the Treaty of Lisbon that facilitates mobility of employees within the EU as well as more stringent EU migration policies, the attention has now shifted towards *internal imbalances* within the distribution of health workers in the EU. Besides, migration to the EU predominantly takes place from countries in southern and eastern Europe that are part of the WHO European Region. This implies that fewer health workers are now migrating to the EU from the so-called 57 crisis countries as defined by WHO in its *World Health Report 2006.*

Third, the NGOs involved in health workforce migration often have a background in international development cooperation. A serious effort is required to unite organizations, which also work on health system sustainability at national level, such as patient federations, labour unions and professional associations. From the government side several ministries should be engaged, such as foreign affairs, health, education, labour and migration. The need for this multisectoral approach, which would move beyond the responsibilities of health ministries alone, makes it difficult to get the right people involved in *national stakeholder processes.*

Finally, the onset of the financial crisis partially changed the context in which CSOs advocate for Code implementation. European countries have responded in various ways, some of them adopting austerity policies, including large-scale cuts and public sector reforms. These policies were imposed as a pre-condition by the so-called "troika" for financial rescue packages, in countries that needed such bailouts – i.e. Greece, Ireland, and Portugal (Karanikolos et al., 2013), but have also been taken as a reference by other EU countries.

Austerity policies can have a direct impact on the relationship between health workforce mobility and investments in health workforce development, which are at the heart of the Code. Some European countries (e.g. Cyprus, Greece, Ireland, Lithuania, Portugal and Romania) reduced or froze (e.g. England and Slovenia) the salaries of health professionals, or reduced the rate of salary increase (e.g. Denmark) (Mladovsky et al., 2012). Greece also faced important reductions in its health workforce (Economou, 2012). These policies could exacerbate wage imbalances between or within countries, and therefore have the potential to increase health-worker brain drain (Karanikolos et al., 2013).

1 Convention on the Elimination of Discrimination against Women; more specifically General recommendation No. 26 on women migrant workers.

This new context means that European CSOs are now often called to open a dialogue with respective governments not only on global health workforce issues, but also on the need to preserve domestic workforces from budget cuts and salary reductions, from the perspective of sustainability proposed by the Code.

Overall, therefore, civil society actors remain very much involved in mitigating the issue from a rights-based approach that balances individual health-worker's rights with sustainable and equitable strengthening of health systems. The cases below highlight the work of civil society in six countries since the Code was adopted.

## Belgium[2]

The immigration of doctors, nurses and other medical personnel is a relatively recent phenomenon in Belgium, starting around 2000 and growing slowly but steadily. Although recent figures are not conclusive, of a total of around 400 000 people working in the health service,[3] around 18% of all doctors and 4.4% of nurses are of foreign origin (Wets, De Bruyn & Geets, 2011). Each year 300–500 doctors and 250–880 nurses enter the country. For both professions, around two-thirds are from European countries and 15% of African origin. Only 30% of the foreign-born doctors and 15% of the foreign-born nurses have not obtained their degree in Belgium (Wets, De Bruyn & Geets, 2011).

Some experiences of recruitment in Lebanon, Poland, Romania and Tunisia by hospitals such as the University Clinic in Antwerp and the Europe Hospital in Brussels were soon abandoned because of time-consuming coaching and difficulties in integration. As for migration from "export-countries" of health personnel such as the Philippines, the declaration of non-conformity of their certificates blocked their entry into Belgium. In general, language difficulties also seem to be an obstacle (Flemish Parliament, 2011). The strict conditions required to get a work permit generally do not facilitate the recruitment of personnel from outside the European continent.

Recruitment by private recruitment agencies, such as Limarex, Link2Europe, Express Medical and Moving People, concerned only a few dozen candidate-migrants and did not have the expected outcome. For "ethical reasons" these agencies confined their activities mainly to the European continent. There is no evidence so far that the economic crisis has influenced the employment of health personnel from abroad. On the other hand, there are indications that doctors of foreign origin often serve in less attractive positions such as hospital emergency-services, or are on duty during weekends and holidays in general practices.

In terms of foreseen health workforce needs, while press articles mention a need for an additional 120 000–140 000 jobs in the Belgian health care sector, more cautious estimates are around half of this figure[4]. Although some studies indicate that, in theory, there is not currently a shortage of nurses, and may not even be a shortage in the future, (Pacolet, 2010), there is an evident gap between the number of qualified health personnel and the full-time equivalents active in the different health services,[5] due to the high percentage of women health agents

2 By Marti Waals, Memisa, Belgium.

3 Representing 9.43% of the total working population, out of a total population of around 11 million people.

4 Although most of the health institutions are actively recruiting people, others do not even attempt to do so. Curiously, however, some hospitals have to discharge people, due to budget restrictions.

5 In the French-speaking part of Belgium only 35–50% of the graduate nurses are practising their profession.

(Be-cause Health, 2012). Moreover, the actual *"numerus clausus"* of 1025 doctors trained per year provides limited possibilities to replace the retiring workforce by a younger generation. In the period 2014–2020, it would need to be elevated to at least 1150 per year, and to 1350 per year for the period 2020–2030, only coming down to 1000 per year after 2040, when the large group of doctors who obtained their degrees between 1975 and 1990 will have been completely replaced (Daue & Crainich, 2008). A similar situation applies to nurses.

In order to forecast the evolution of the health workforce at European level, Belgium, through its Federal Public Service of Health, took the initiative and the lead in the "EU Joint Action on Health Workforce Planning" which has around 30 associated European partners and 20 collaborating partners. At national level, initiatives such as "Project 600", which allows care assistants employed in the sector to train as nurses while keeping their wages, are designed to make up for the lack of nurses. However, budget restrictions have forced this successful initiative to scale down. Creative solutions to attract more young people into the health service and keep the active personnel in the market will therefore be needed.

The Belgian platform of development cooperation actors "Be-cause Health", which includes representatives from the Ministry of Health, Ministry of International Cooperation, universities, medical NGOs and others, focuses on migration of foreign health personnel worldwide and on the WHO Code implementation, among other themes. In November 2012, it presented a *Charter on the recruitment of and support for the development of human resources for health in partner countries* (Be-cause Health, 2012).

Based upon the same basic values and principles of the Code, the group underlined specifically the integration of their activities within partner countries' structures, the participation in consultations, the increase of predictable support for the development of national qualified human resources for health services (with a special interest for gender issues and inequities in the geographical distribution of health workers), the need to strengthen professional motivation, capacity strengthening through training, and compensation for negative consequences of brain drain.

In Belgium, the Charter raises the awareness of public and private actors, to reinforce collaboration with diaspora communities and universities and to capitalize and share experiences. This Charter was signed by 19 Belgian organizations (Be-cause Health, 2012) with the support from the ministries of health and cooperation and the International Organization for Migration. The Charter was sent to the Minister of Health with a request to initiate similar initiatives within different services. Presently, the group is working on an evaluation matrix in order to assure the follow-up on the different points of engagement. Through interviews in Belgium and a field study in the Democratic Republic of the Congo, the University of Liege is monitoring the evolution of this engagement.

## Italy[6]

The Italian health service is undermined by public budget constraints caused by the financial crisis, and Italy runs the risk of slowly becoming a net exporter of health professionals. Italy currently ranks among the first countries in the world for density of practicing physicians[7], but is

6 By Monica Di Sisto, AMREF Italy.

7 There are more physicians per capita in Italy than in most other OECD countries. In 2009, Italy had 3.7 practicing physicians per 1000 population, above the OECD average of 3.1 (OECD, 2013).

one of the last considering the number of professional nurses at work. There are around 391 000 nurses, according to a Ministry of Health survey (Mastrillo, 2013), with the proportion of nurses and doctors close to parity, compared with the average OECD rate of 2.5. The Italian nurses' professional organization, IPAVSI, calculates that the health system needs 71 000 more nurses at work to make the situation acceptable. Furthermore, the deficit is expected to widen: every year, 17 000 nurses retire but only 8000 are recruited. (European Migration Network, 2009).

A worrying signal is the recent downsizing of the planned *"numerus clausus"* for nurses training, quantified by the national Conference of Regions. This reduction is evidently linked to the progressive national and regional health budget cuts and to rising unemployment in the sector. Professional organizations estimated that 21 399 university training posts were required for nurses in the Academic Year 2013–2014 to ensure the sustainability of the health system. The regions (i.e. the health sectors employers) provide a lower estimate of 19 537 posts (there were 19% more in 2012–2013). Moreover, the University National Conference will have barely sufficient funding to increase the 16 119 training posts made available in 2013 (Mastrillo, 2013).

On the other hand, the number of unemployed graduates has doubled in five years: although 87% of nurses with bachelor degrees are at work, the employment rate between 2010 and 2011 fell by 10% (Il Sole 24 ore Sanità, 2013). In the current context of lack of financial and human resources and widespread insecurity, foreign-trained health workers who entered the national health service in the last decade remain today a vital resource for the health system: at the end of 2010 there were 38 315, that is 10.2% of all nurses, while in some regions, foreign-trained nurses can easily exceed 15% of the total number. Clearly, then, these nurses contribute significantly to covering the shortfall in training and to ensuring the provision of services in the Italian health-care system (IPASVI, 2012). However, the interest of new foreign-trained health workers in being employed in Italy has been falling very rapidly since the onset of the economic crisis: while these new registrations were 35.3% in 2007, they declined to 15.3% in 2012, thus indicating that Italy is no longer a desirable destination country (IPASVI, 2013). At the same time, indications of an increase in requests for certificates of good standing by Italian nurses to work abroad are already flowing in from IPASVI provincial levels[8], although national level data are not yet available.

Between March and June 2012, AMREF Italy[9] promoted the campaign *"Personale sanitario per tutti"*, focused on the shortage of health workers, and co-promoted by relevant health professional organizations (AMSI, CeSPI, IPASVI, FNOMCeO, OISG and SIMM). The campaign produced a *Manifesto for Health Workforce Strengthening* containing recommendations related to the obligation by the Italian state and health system to implement the Code.

The *Manifesto*, together with the signatures from more than 80 organizations supporting it, was presented to the Ministry of Health, Ministry of Internal Affairs and Ministry of Foreign Affairs and to regional health authorities (who are the real budget-holders in Italy's decentralized health system) in a dedicated public event solidly linked to WHO's Code monitoring process. The event prompted an institutional dialogue on health workforce strengthening and brain drain, which continued at regional level in the following months; since 2013, within the framework

8 AMREF Italy, L'Italia e la mobilità del personale sanitario ai tempi della crisi *(trad: Italy and health workforce mobility at the time of the crisis)*, 2013. http://www.manifestopersonalesanitario.it/wp-content/uploads/2013/09/L%E2%80%99Italia-e-la-mobilita%CC%80-del-personale-sanitario-ai-tempi-della-crisi_web1.pdf

9 AMREF is an international NGO headquartered in Kenya, working to produce lasting health change in Africa as a driver for a multidimensional, sustainable development.

of the Health Workers for All and All for Health Workers initiative, new policy analysis and public dialogue were promoted in order to connect the debate on disinvestments in the health workforce and consequent brain drain with the discussion on austerity measures in the country.

An additional opportunity for dialogue is provided by the *EU Joint Action on Health Workforce Planning*[10]: Italy leads the work package on *"Exchange of good practices in planning methodologies"*, through which models of effective health workforce forecasting will be identified. Those public processes must be monitored and participated in by CSOs with the aim of increasing intersectoral coherence.

## The Netherlands[11]

Dutch stakeholders, especially trade unions, but also politicians and NGOs such as development organizations, have always held the position that the Netherlands should be self-sustainable in its health workforce (Tjadens, 2011). However, recruitment of theatre assistants from India (Grutters, 2009) and nurses from Spain (2012)[12] suggests that when shortages occur in the Netherlands, active recruitment of foreign health personnel is used as a solution.

In the longer term, growing shortages in the health sector are to be expected in the Netherlands, especially among nurses and caretakers for the elderly. A 2009 estimate predicted that 450 000 workers in care and welfare will be needed in 2025 (Zorginnovatieplatform, 2009). The Ministry of Health anticipates the shortages and calculates that, in 2025, 25% more medical doctors will be needed. Measures taken to face the challenge include the increased admission of medical students, medical specialists and nurse specialists (Netherlands, n.d.).

The Dutch government regards the health system as self-regulatory and takes a controlling, rather than a guiding role on its development. Migration of health personnel and ethical recruitment are not considered as important subjects. The CSO Wemos[13] does, however, and has put it on the agenda in different ways. In 2009, it initiated the Dutch multisectoral Human Resources for Health (HRH) Alliance that works on sustainable health workforce issues at national and international level. The Alliance aims to limit the recruitment of foreign health employees and stimulate the development of covenants for diversifying and expanding the national workforce (Netherlands, 2010). Via the media, its work has influenced parliamentarians, health-workers, board members of health care institutes and the Ministry of Health.

The Alliance produced a policy brief with recommendations for actions and policy coherence for a sustainable workforce (Wemos & Jansen, 2010) and this has been taken as an example in several countries. Based on this document, the Alliance discussed Code implementation with the respective ministries and the Designated National Authority in 2010 and in 2011. This has raised awareness of the problem, and measures to reduce migration from outside the EU. An education fund was established for hospitals to train theatre assistants nationally Netherlands, 2010).

10 It is a platform for collaboration and exchange among EU Member States to prepare the future of the health workforce in the continent, launched in April 2013.

11 By Linda Mans, Wemos, the Netherlands.

12 Spaanse verpleegkundigen in Maastricht. Summum gazet 22 Feb 2012. [Spanish nurses in Maastricht.]

13 A CSO advocating for the right to health and health equity within international policies.

Newly developed policies and legislation are changing the Dutch health workforce landscape. Budget cuts of up to 40% in home care will in the short-term cause unemployment among public sector nurses and caretakers, prompting the Minister of Health to reinvestigate the expected shortages of health personnel[14]. In the private sector, however, recruitment agencies[15] are anticipating the needs for care of elderly and chronically ill people and are already actively recruiting qualified foreign personnel from other European countries. A magazine for the general public published an article about the advantages, disadvantages and regulations for hiring foreign home-care providers[16].

The Netherlands can benefit from the free movement of services and people in the EU. A recent 31-country study on formal and informal home care stressed, however, that while workforce migration can be valuable to some countries, the east-west migration in Europe can have a negative effect on human resources in eastern Europe, as may rural-urban migration (Genet et al., 2012). Wemos takes up this challenge and seeks collaboration with national authorities, professional organizations, recruitment agencies and other stakeholders at national level. It will try to ensure through dialogue that actions taken in the Netherlands do not have unintentional and undesirable effects in European countries and beyond. This NGO has facilitated the link between European and global-level advocacy on health workforce via its membership of Medicus Mundi International and the Health Workforce Advocacy Initiative. Wemos' collaboration with other NGOs that address the ethical recruitment of health personnel has resulted in a joint EU-funded project Health Workers for All and All for Health Workers.

## Poland[17]

Considering its national profile of health-worker migration, Poland appears to be an unusual country on the EU map. Due to a complex health-care system, its strict conditions, and low salaries, Poland, if compared with other Member States, is a source country rather than a destination one.

Poland acceded to the EU in May 2004: it had been expected that the opening of the EU labour markets for Polish citizens would increase the scale of long-term emigration of Polish health-workers. In fact, there was no mass outflow. However, Poland is not unaffected by today's health-workforce crisis. According to statistics conducted by the Polish Chamber of Physicians – and based on the number of requests for certificates of good standing[18] – 8857 medical doctors and 939 dentists could have left the country between May 2004 and February 2013. Compared to 2006 data, the number of certificates issued has increased. However, there is no register of migrating health personnel.

In 2008, a survey conducted among medical students in their last years of education showed that 62.1% of respondents considered emigrating at the end of their education (Krajewski-Siuda et al., 2012). Conditions of study in Polish medical universities are not greatly different from those in western European countries, and students are well prepared for entering the western

14 The first results will be available in summer 2013.

15 Such as Direct Personeel voor de Zorg, World Wide Assistants & Nurses and Global Care Capacity.

16 'Er was nooit echt aandacht voor mij, nu wel.' Plusmagazine, Feb 2013. ["They never really paid attention to me; now they do."]

17 By Szymon Nowak and Dagna Chwarscianek, Humanitarian Aid Foundation Redemptoris Missio, Poland.

18 Certificates of good standing are meant to confirm professional qualifications and professional conduct of health workers. They are issued upon their request, as they are required in EU Member States as evidence that a health worker is fit to practice.

labour market, which is more attractive to them, as it provides better working conditions and higher salaries. At the same time, university fees and the cost of living in Poland are lower than in western Europe, therefore attracting foreign students towards a Polish education. Upon graduation, they may stay in Poland but more often they choose to work in other countries, depending on their origin, interests and knowledge of languages.

In 2009–2010, the Centre for Migration Research of Warsaw University participated in the MoHProf Project,[19] which investigated "push-and-pull" factors that influence the decision on whether to work in Poland or emigrate. In recent years, there have been growing conflicts in the Polish health-care system due to a lack of agreement and cooperation between medical staff and the Polish National Health Fund. More and more patients and their families come into conflict with medical staff and pursue legal rulings. Low salaries are a major problem, especially for young medical doctors and mid-level health personnel, such as nurses and midwives: postgraduate doctors start on a basic monthly salary of about 480 Euro, which has remained unchanged since 2009. Unless working conditions improve, these factors are likely to increase the outflow of health workers in the coming years.

Poland agreed in 2010 to adopt the WHO Code, but since then has taken no specific initiatives aiming at its implementation. In early 2013, a Polish NGO, Humanitarian Aid Foundation Redemptoris Missio, advocated for implementation through the Health Workers for All and All for Health Workers partnership, bringing together eight EU countries and supported by a European Commission grant. It is therefore working to influence governmental and nongovernmental actors, health policy decision-makers and to develop cooperation among national stakeholders to work collectively to achieve the Code's objectives.

## Romania[20]

Human resources for health are a key component of health systems and Romania faces several challenges in this area, with a very low number of physicians and nurses per capita, compared both to other EU countries and to health spending levels. Furthermore, the situation may get worse: applications to medical schools are down, the number of graduates has fallen, and more physicians are leaving the country. The official income for physicians is very low in Romania and average incomes in the health sectors have deteriorated compared to other sectors within the past years, due to the economic crisis. This situation worsened in July 2011, when the government issued a law introducing a 25% salary reduction for people working in public institutions; this has been applied also to medical doctors and nurses and hence resulted in an incentive to move abroad (The Foundation Centre for Health Policies and Services, 2011).

The scale of emigration started to rise in 2007, with the EU accession (1421 requests for certificates of good standing) and has increased every year since. In 2010, when the economic crisis affected Romania, more than 2500 requests for certificates were recorded (Galan, Olsavszky & Vlădescu, 2011). Even if emigration is a matter of serious concern, most data related to the mobility of Romanian medical doctors can be retrieved only from specific studies, based on data provided by the Romanian College of Physicians (RCP). According to RCP (2013), between 2007 and 2013 around 14 000 medical doctors left their jobs in the national public

19 http://www.mohprof.eu/LIVE/

20 By Adriana Galan, Dana Farcasanu, Center for Health Policies and Services, Romania.

health system and chose to practice abroad; therefore, Romania spent (and subsequently lost) for the specialist training of these professionals more than 3.5 billion Euros.

The RCP recently published an open letter to the Prime Minister, raising the issue of the lack of qualified health personnel having reached alarming levels. In 2012, it went down below the critical level of 40 000 medical doctors licensed to practice in Romania: at the beginning of 2013, Romania had only 39 813 medical doctors compared to 41 799 in 2012 and 55 000 in 1990 (Romanian College of Physicians, 2013).

Romania has no accurate information on international inflows and outflows of health professionals. This is particularly true for nurses. To conclude, there is no valid and reliable monitoring system on health professional mobility (Galan, Olsavszky & Vlădescu, 2011).

There is no policy document on health professionals in Romania. An effective health workforce strategy does not exist. Several actors in the health system are involved in the management and planning of human resources for health, including in the mobility of health professionals. Some CSOs are also involved. However, the Ministry of Health continues to be the main centre of power for direct and indirect control of the number of medical doctors, dentists, nurses and other health professionals, and for monitoring the implementation of the WHO Code.

In this context, the voice of NGOs in the political debate related to health workforce policies has been rather subdued, even if there have been some attempts to raise awareness and advocate on the issue of external migration of medical doctors and nurses over recent years. As the health workforce emigration effects become more and more visible and are affecting access to health care especially in rural areas, there are now more civil society representatives and initiatives aiming to push the issue to the top of the political agenda. The Centre for Health Policies and Services is conducting stakeholder dialogues concerning the development of a national health workforce strategy, the mobility of health workers and the ways in which they can be retained in the national health system and particularly in remote areas, in line with the WHO Code. The project, Health Workers for All and All for Health Workers, is a timely opportunity to strengthen the voice of Romanian civil society towards the promotion and implementation of the WHO Code and the WHO Global Policy Recommendations on Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention.

## United Kingdom[21]

The United Kingdom has a long history of actively recruiting health workers. Between the late 1990s and the mid-2000s, the number of internationally trained doctors and nurses migrating to the United Kingdom increased rapidly, when the Department of Health (DoH) recruited international health workers as part of an attempt to scale up the numbers of National Health Service (NHS) staff (Buchan et al., 2009). The United Kingdom has traditionally taken a 'boom and bust approach' to health-worker migration (Boseley, 2011). New full registrations of internationally trained doctors and nurses peaked in 2000[22], after which they started to decline again, seemingly due to a combination of increasingly restrictive immigration policies, changes

21 Natalie Sharples, Health Poverty Action, United Kingdom.

22 Although data from the UK General Medical Council suggest that new full-time registrations of internationally trained doctors peaked in 2003, it has been suggested that – rather than representing an actual spike in new registrations – this is an artefact resulting from changes to registration procedures (Buchan et al., 2009).

to Nursing and Midwifery Council Guidelines (Buchan & Seecombe, 2012), and the economic climate. The Royal College of Nursing (RCN), however, does note a small rise in registrations of nurses from outside the United Kingdom (EU and non-EU) since 2010. The College also notes that the economic crisis may have prompted the recent rise in registrations from nurses from EU countries such as Portugal and Spain (Buchan & Seecombe, 2012).

The DoH developed guidelines on international recruitment in 1999 and introduced a United Kingdom code for the international recruitment of health-care professionals in 2001, and strengthened it in 2004. This code covers the NHS and some private sector employers, but some studies have questioned its impact (Action for Global Health, 2011). The DoH submitted its report on the implementation of the WHO Code in 2012. Monitoring would benefit from greater collaboration between the DoH and the Department for International Development (DFiD), and clarity is needed on DFID's work to support health systems strengthening, along with higher prioritization of the issue.

In the development sector, the Action for Global Health (AFGH) Working Group on Human Resources for Health has been closely involved with policy-makers since the lead up to the adoption of the Code in 2010. The NGO, VSO, published the report *Brain Gain – Making Health Worker Migration Work for Rich and Poor Countries* in 2010. AFGH produced a study on domestic and development policies addressing the health workforce crisis. The RCN has been monitoring health-worker migration and changes in the nursing workforce very closely through annual reviews of the nursing labour market. The working group also has close relations with the United Kingdom All-Party Parliamentary Group (APPG) on Global Health. In 2012, the APPG released a report on improved skill–mix within the health workforce as a way to overcome the global crisis (APPG on Global Health, 2012). Health Poverty Action published a report on the health workforce crisis (Jensen, 2013).

## Lessons learned and recommendations

Based on the six-country experiences described above, a number of lessons and recommendations can be taken forward while working on fair and rights-based development of the workforce at national, EU and global level.

- CSOs' work so far has proved very important in raising awareness – among relevant national-level stakeholders – of the existence of the Code and of the commitment to implement it. However, further efforts will be required in order to transform commitment into implementation.
- To do so, development NGOs working on global health workforce issues should liaise much more with other civil society actors that have a stake in national workforce development - e.g. labour unions, medical associations, patient and consumer organizations - aiming to build with them an active constituency demanding Code implementation by national authorities. The manifestos described in the country case studies above contain concrete entry points for such cooperation.
- WHO can play a key role in supporting CSOs' advocacy activities at national level, by giving them legitimacy, supporting their work through a solid international monitoring process they can refer to, and by sharing the results of the monitoring process, including NRIs submitted by Member States.

- CSOs should promote and advocate for health workforce policies, which are not addressed in isolation by national health departments, but become part of national global health strategies. These should be drafted by multisectoral ministerial groups, including migration and economic affairs, and in consultation with NGOs, professional associations and others, and should be discussed and approved by the individual parliaments. Part of their focus should be on mobility and its inequities within the EU, and the need for self-sustainability in each of the Member States.
- Within this frame, CSOs can promote and monitor fair, binding, bilateral and multilateral agreements on a balanced health workforce, within the EU and with other countries. These should be coherent and/or aligned with other international legal agreements on migration, labour and trade that include protocols on health services and knowledge exchange.
- CSOs can promote and become part of national HRH observatories that systematize and monitor data on health workforce developments and mobility. EU Member States can learn from the Latin-America region where this has been developed in some countries.
- CSOs can look further into the mobility of informal and less-formalized health workers such as auxiliary nurses or volunteer caregivers within a social or family context. The stress on social protection systems causes a push for more care to be conducted in the informal sector, where there is a growing trend of workforce mobility within and to the EU. Similarly, well-off Europeans are able to move to another country where they can receive (for example) elderly care that is relatively cheap, but this can then put pressure on the local health workforce capacity. In short, CSOs need to further analyse cases of migrant health workers ending up in receiving countries in: (a) different sectors; (b) the same sectors but lower-qualified jobs; or (c) illegal labour arrangements. CSOs should do this from a gender-specific point of view, given that more women than men work as auxiliary nurses or volunteer caregivers within a social or family context.

## The way forward

These country case studies and lessons learnt indicate that European civil society has been playing a considerable role in monitoring health workforce migration. The next steps will consist of a more coordinated action between the countries to exchange data, tools, good practices and understanding: this consolidated work will be taken forward from 2013-2015 by the initiative Health Workers for All and All for Health Workers, a partnership bringing together civil society actors from eight EU countries (Belgium, Germany, Italy, the Netherlands, Poland, Romania, Spain and the United Kingdom) and supported by the European Commission. Advocacy activities of this partnership – carried out in alignment with WHO – included so far the development and dissemination of tools for policy analysis (as users' kits, stakeholder analysis and a collection of best practices). It intends also to create a community of practice of national and international stakeholders (through workshops at national level, the involvement of health workers' representative bodies, the engagement of the European Parliament, and the launch of a call to action), in order to achieve a sustainable health workforce.

Considering that the European Commission (2012) estimates a shortage of one million qualified health professionals by 2020, the initiative Health Workers for All and All for Health Workers intends also to develop a dialogue at EU level, building on the Action Plan for the EU Health Workforce, proposed by the European Commission (2012). In particular, it will monitor the way in which Member States equip themselves to foresee future shortages of health workers and

plan accordingly, from the perspective of a sustainable domestic health workforce provided by the WHO Code. Collaboration with the EU Joint Action on Health Workforce Planning, involving over 30 European governmental and nongovernmental partners, will provide this opportunity, as the Joint Action participates in complying with the data gathering and information exchange provided for by the Code.

In parallel, CSOs will have a role in the coming years in monitoring the use of the European Blue Card, which has so far been adopted by 24 EU countries and is designed to attract third country highly educated professionals – including health professionals – to the EU, by giving them preferential access to residence and work permits[23]. The EU Blue Card Directive allows Member States to reject applications in order to ensure ethical recruitment from countries suffering from a lack of qualified workers in the health sector: there are however indications that Member States – who can choose to use this possibility – do not always associate the use of the Blue Card with an analysis of the impact of recruitment on countries of origin.

It should be noted, however, that all these aspects of health workforce development are discussed at a time when financial austerity is the mantra in Europe and directly affects health budgets[24]. The question underlying European – and EU Member States' – capacity to provide for a sustainable health workforce, which is a major part of health expenditure, is closely linked to their capacity to complete the path towards UHC, and – ultimately – to claim fiscal space as a condition to advance on this path.

The question is, therefore, whether these countries are willing to make progress on further regulation of the financial sector and on reform of their fiscal policies, to agree on global redistribution mechanisms, curb the massive amount of untaxed wealth, and hence free considerable resources to fund their health services, provide for training and pay sustainable health workforces (Van de Pas, 2013).

## References

Action for Global Health (2011). Addressing the Global Health Workforce Crisis: Challenges for France, Italy Germany, Spain and the UK. Brussels.

APPG on Global Health (2012). Improving health at home and abroad: how overseas volunteering from the NHS benefits the UK and the world – report. London: All-Party Parliamentary Group on Global Health.

Be-cause Health (2012). Charter proposed by Belgian development cooperation actors on the recruitment of and support for the development of human resources for health (HRH) in partner countries. http://www.be-causehealth.be/media/37374/RHCharter%20English_FINAL%20revised%20accepted.pdf

Buchan J, Seecombe I (2012). Overstretched. Under-resourced. The UK nursing labour market review. London: Royal College of Nursing.

23 In October 2007, the European Commission adopted two proposals. The first was to establish a Framework Directive for the purpose of the admission of highly educated migrants to the EU, later known as the EU Blue Card Directive. The second proposal was a directive to simplify migration procedures by funnelling applicants into a single application procedure, known as the EU Single Permit Directive. In May 2009, the European Council adopted the EU Blue Card Directive. In December 2011, the Single Permit Directive was adopted. Together, they establish the EU Blue Card Scheme, that is, a demand-driven residence and work permit.

24 In Greece, for example, the troika has demanded that public spending on health should not exceed 6% of GDP, thus setting precedents on acquisition of control over national health systems in individual countries, despite health being deemed a matter of internal governance (Fahy, 2012:344).

Buchan J et al. (2009). Does a code make a difference – assessing the English code of practice on international recruitment. Human Resources for Health; 7:33.

Boseley S (2011). Nursing dream fades for Filipinos as UK jobs dry up. The Guardian, 23 February.

Daue F, Crainich D (2008). Hoe gezond is de gezondheidszorg in België [How healthy is the health care in Belgium?]. Brussels: Itinera Institute publicatiuon.

Dhillon IS, Clark M, Kapp R (2010). Innovations in cooperation – a guidebook on bilateral agreements to address health worker migration. Realizing Rights/Global Health & development. Washington, DC: Aspen institute.

Economou C (2012). The performance of the Greek health-care system and the economic adjustment programme: "economic crisis" versus "system-specific deficits" driven reform. Int J Soc Political Theory. 2:33-68.

European Commission Staff Working Document on an Action Plan for the EU Health Workforce (2012). Strasbourg, European Commission.

European Migration Network (2009). *Politiche migratorie, Lavoratori qualificati e Settore sanitario [Migration policies, skilled workers and the Health sector].* Rome: Idos. http://www.emnitaly.it/down/ev-52-07.pdf

Fahy N (2012). Who is shaping the future of European health systems? BMJ. 344:e1712.

Flemish Parliament (2011). Notes of the meeting of the Commission on Welfare, Health, Family and Poverty.

Galan A, Olsavszky V, Vlădescu C (2011). Emergent challenge of health professional emigration: Romania's accession to the European Union. In: Wismar M et al., editor. Health professional mobility and health systems. Geneva: WHO and European Observatory on Health Systems and Policies.

Genet N et al., editors. (2012). Home care across Europe, current structure and future challenges. Copenhagen: World Health Organization. http://www.euro.who.int/__data/assets/pdf_file/0008/181799/e96757.pdf

Grutters I (2009). Ook AMC werft ok-assistenten in India. Skipr, 13 Nov. http://www.skipr.nl

Il Sole 24 ore Sanità (2013). Professioni sanitarie: occupazione in calo [Health professions: decreasing employment]. http://www.sanita.ilsole24ore.com/art/lavoro-e-professione/2013-04-03/professioni-sanitarie-occupazione-calo-065044.php?uuid=AbcdeojH&fromSearch

IPASVI (2012). Albo 2010: Rapporto stranieri [2010 Roster: report on foreign nurses]. Rome: Federazione Nazionale Collegi Infermieri. http://www.ipasvi.it/static/area-press/area-press-report.htm

IPASVI (2013). Analisi dei nuovi iscritti. Rapporto 2012 [An analysis on new registrations. 2012 report]. http://www.ipasvi.it/archivio_news/attualita/1001/IPASVI%20-%20Albo%202012%20-%20Analisi%20dei%20nuovi%20iscritti.pdf

Jensen N (2013). The health worker crisis: an analysis of the issues and main international responses. London: Health Poverty Action. http://www.healthpovertyaction.org/wp-content/uploads/downloads/2013/11/Health-worker-crisis-web.pdf

Karanikolos M et al. (2013). Financial crisis, austerity, and health in Europe. The Lancet. 381:1323–1331.

Krajewski-Siuda K et al. (2012) Emigration preferences and plans among medical students in Poland. Human Resources for Health; 10:8.

Labonte R et al. (2004). The brain drain. In: Labonte R. et al. Fatal indifference. The G8, Africa and global health. Cape Town and Ottawa, ON: University Press and International Development Research Centre:58–61.

Mastrillo A (2013). Elaboration on data provided by Ministry of Health (27 March). http://www.aitn.it/index.php?option=com_docman&task=doc_download&gid=354&Itemid=69

Mensah K et al. (2005). The "Skills Drain" of health professionals from the developing world: A framework for policy formulation. London: Medact.

Mladovsky P et al. (2012). Policy summary 5. Health policy responses to the financial crisis in Europe. Copenhagen: World Health Organization (on behalf of the European Observatory on Health Systems and Policies).

Netherlands (n.d.). Opleiden van zorgpersoneel [Education and training of health workers]. http://www.rijksoverheid.nl/onderwerpen/werken-in-de-zorg/opleiden-van-zorgpersoneel

Netherlands (2010). Letter by the minister of health dated 23 November 2010. Parliamentary Papers II 2010/11, 29 282 nr. 109. http://www.wemos.nl/files/Documenten%20Informatief/Bestanden%20voor%20HRH/kst-29282-109.pdf

OECD (2013). Health Report 2012. Paris, Organisation for Economic Co-operation and Development. http://www.oecd.org/els/health-systems/oecdhealthdata2012-countrynotes.htm

Pacolet J (2010). Hoe lang zullen wij werken? Zeven jaren langer? Over vergrijzing en de Arbeidsmarkt [How long shall we work? Seven years longer? About ageing and the labour market]. Leuven: HIVA studies, Conference Universiteit Derde Leeftijd.

Romanian College of Physicians (2013). Open letter to Government of Romania. Bucharest. http://www.cmr.ro/scrisoare-deschisa

Spaanse verpleegkundigen in Maastricht. Summum gazet (2012). [Spanish nurses in Maastricht] 22 Feb.

The Foundation Centre for Health Policies and Services (2011). Report Analysis of Human Resources for Health Issues in Romania. Washington, DC: The World Bank Group.

Tjadens (2011). The Netherlands: mobility of health professionals. Bonn: Scientific Institute of the Medical Association of German Doctors (WIAD).

Van de Pas R (2013). The political context of Universal Health Coverage. MMI Network News, February. http://www.medicusmundi.org/en/mmi-network/documents/newsletter/201302

Wemos, Jansen C (2010). Chances for change: Dutch measures to improve the global distribution of health personnel. Amsterdam. http://www.wemos.nl/files/Documenten%20Informatief/Bestanden%20voor%20HRH/Chances_for_Change_web.pdf

Wets J, De Bruyn B, Geets J (2011). La Migration: la solution aux pénuries de personnel dans le secteur des soins et de la santé? [Migration: which solution to health workforce shortages in the health and care sectors?] Brussels: King Baudouin Foundation publication.

Zorginnovatieplatform (2009). Zorg voor mensen, mensen voor de zorg. Arbeidsmarktbeleid voor de zorgsector richting 2025. [Care for people, people for care. Labour market for the health sector towards 2025]. The Hague. http://www.zorgvoorinnoveren.nl/upload/file/ZIP_Zorg_voor_mensen-mensen_voor_de_zorg.pdf

CHAPTER 3

# Challenges and hindrances in the application of the Code from a legal perspective: The case of El Salvador

MARIA ANGELA ELIAS MARROQUÍN

JAVIER RIVAS

©GHWA

Health workers in El Salvador.

El Salvador's Constitution states that the health of the population is a public good, to be preserved and maintained by the State and the people, with State responsibility to establish the national health policy, and control and oversee its compliance. However, despite these efforts and the provision of care free of charge, the majority of Salvadorians, particularly the rural poor, do not have regular access to health services (Acosta et al., 2011).

This has prompted the Health Ministry to make changes to the legal and technical tools of El Salvador's national health system, starting in June 2009, so that health-care provision, including coverage of the population and quality of services, were considered a basic human right. The National Health Policy (2009–2014) confirms this; human resources are one of the top eight priorities for health reform and the cornerstone of the system; and thus four of its strategies are targeted on them (MINSAL, 2010).

On the other hand, the health system is segmented, with *per capita* inequality in each sector, mostly so under the Ministry of Health. In fact, health services are regularly provided to about only 40% of the overall population; in addition, El Salvador is among the 57 countries considered as having a critical level of scarcity of health professionals.

Over a quarter of El Salvador's population is estimated to have emigrated or fled during the civil war that lasted from 1979 to 1992. According to the Ministry of Foreign Affairs, about 1.5 million Salvadorians now live and work in the United States; 39 000 are in Canada; some 20 000 in Australia; and 12 000 in Italy. While migration rates have decreased since the civil war ended, some 25 000 people (4.7 per 1000) still emigrate each year, according to El Salvador Central Bank data in 2002; El Salvador ranks third among Central American countries with the largest number of physicians who take their medical residency training in Spain (Nuñez et al., 2012).

As part of the inter-institutional approach on human resources, the National Committee on Human Resources has been active since 2010. Its main purpose is to assess human resources needs, but one of its main additional activities has been to evaluate the legal implications of the application of the WHO Code. This paper presents the findings of a legal-technical assessment made by the International Labour Relations Directorship (DRIT). DRIT advises senior level policy-makers on international issues in the labour sector on benefits for workers and employers, by preparing legal studies to support the Ministry of Labour and Welfare in the proper application of labour legislation (MTPS, 2011).

## The Code in El Salvador's current context

The WHO Code is intended to be applied worldwide, and to guide Member States and their health-care and health-services providers in the international hiring of emigrating health personnel (WHO, 2010).

El Salvador's Government Plan 2009–2014, which considers health as a human right, includes health as an area for action, and a cornerstone of the country's social protection policy. The Plan establishes a National Health Policy to ensure health-care rights for the entire population. This is to be achieved through a national health system that effectively: provides public health care and regulates the private provision of care; provides access to health promotion, prevention, care and rehabilitation services; and ensures a safe and secure environment, which includes the establishment and maintenance of efficient, problem-solving, equitable-access, and quality health-care services for all people. To achieve this, priorities are defined through a Comprehensive Health Care Reform, based on primary health care, as a strategy to achieve UHC, equitability, quality and sustainability, thus setting the grounds for a Unified Health System (MINSAL, 2010).

One of the eight priorities of the Reform is human resources, considered an essential element of this reformed system. Concern with the scarcity of health personnel as a threat to the performance of the health systems, mentioned in the Code's preamble, is addressed in Strategy 18 of the Health Policy. This relates to the design and implementation of policies on the development of human resources, and states the need to establish mechanisms to reach the health-related MDGs, to which health personnel are absolutely necessary.

Although human resources are included in the national health system, and a National Policy on Human Resources is currently being defined, the Ministry of Health should consider the Code as a consultation tool in formulating this Policy and in further health-related regulatory instruments.

The Code's purposes are presented in very broad terms, which poses a challenge for compliance. To put its recommendations effectively into practice, the coordination and commitment of different public institutions is required; for this reason an inter-sectorial approach to human resources should be sought. In addition, for the Code to be applied, the conditions of the countries of origin, the countries of destination, and, above all, the interests of the migrating individual need to be taken into account.

Changes in the national legislation are a long-term process, and it is feasible to ask other countries or different development agencies for support, in order to carry out the appropriate reform, if deemed necessary.

On the other hand, the Health Policy strategy on Human Resources Development related to the MDGs is consistent with those established by the Code, particularly in the promotion of national and international actions, so that countries affected by migration retain their health personnel, and prevent their shortage.

El Salvador's Health Policy also establishes cooperation mechanisms between educational institutions and health services, in order to set priorities in health-training programmes, and to reorganize the syllabus of undergraduate and graduate education. This includes comprehensive

primary health care; focus on the right to health care, social determinants of health, equitability and community needs, and new trends in health education. This analysis recognizes that the government of El Salvador is aware of the importance of providing effective, timely and quality health care to the entire population, particularly targeting the most vulnerable. This should lead to greater progress, and their greater participation in every sector of the country's economic life.

In El Salvador, the academic education of health professionals contributes to the development of the country and benefits society at large, and specialized training of future health professionals is an important aspect. Hiring more health professionals is a government priority, as evidenced by an increase in the ratio of health professionals per 10 000 population (identified by WHO studies) from 18 to 20 by 2012.

### The Code's nature and reach

Compliance with the Code is not obligatory, so it can only be used as a guideline to regulate future hiring contracts of health personnel. However, a country that adopts the Code is required, up to a certain point, to comply with its regulations, so in fact the Code can have a binding effect between the interested parties.

The Code's global reach means that international health personnel hired by a country can use it to support their rights in the event of a breach of contract. It also allows the possibility of a third party to demand the effective application of the Code, by establishing that one of the parties that it regulates is willing to make such a contract.

The "ethical principles" mentioned in the Code regarding the contracting of health personnel to act on particular cases requires a broader explanation. Furthermore, the expressed purpose of complying with these principles is to strengthen the country's health system, which should be beneficial for both the country of origin and the country of destination. This is particularly relevant, as El Salvador is a country in development.

The Code needs a glossary of terminology. Because it is intended for global use, the terms should be defined to prevent arbitrariness at the time of application. Its use is voluntary, but once the Code is adopted, it should be applied in its entirety.

## The Code's guiding principles

The formulation of a policy for contracting international health personnel is the responsibility of the Ministry of Health. A comprehensive assessment should therefore be conducted on the possibility of developing such a policy in the mid- to long term. The policy should include the protection of the rights of health personnel, particularly their labour rights. The Ministry should count on the support of technical experts in making its assessments on implementation of the Code.

To develop and strengthen health systems, proper management of the hiring and migration of health personnel is essential in order to achieve favourable results; otherwise, the rights of health professionals may be violated.

Putting mechanisms in place to discourage qualified Salvadorian health professionals from emigrating, as has been recommended, also needs to be weighed against introducing incentives for them to remain in the country, such as by offering them better career opportunities. A further incentive is that by staying, these health professionals benefit the health of their fellow citizens. The Office of International Labour Relations identified the obligation of Member States to have legal instruments to promote and regulate fair labour practices for all health personnel. This is included in the Salvadorian legislation, and ensures foreign workers have the same labour rights as its nationals, thus promoting equity and transparency in labour contracts.

Strategies for training, capacity building, and maintaining health agents to reduce the need to hire foreign health personnel should be included among the policies formulated by the Ministry of Health. The Ministry can work with the Ministry of Justice, the Public Safety General Office for Migration and Foreigners, and the Ministry of Labour and Welfare in the collection of domestic and international data, and the exchange of information on the international hiring of health personnel. In the latter case, this relates only to information brought to its attention in accordance to Article 7, II of the Labour Code.

## Contracting responsibilities, rights and practices

The main players responsible for health coverage in El Salvador are: the Ministry of Health (MINSAL), the Salvadorian Welfare Institute (ISSS), the Military Hospital, the *Bienestar Magisterial*, the Institute for Comprehensive Rehabilitation, and private organizations or institutions, both for profit and not-for-profit, which employ health personnel. Equality of employment and labour conditions should be ensured for foreigners, in accordance with Article 11 of El Salvador's Labour Code, so that there is no distinction or restrictions in legislation on the granting of rights to both foreign and national health professionals.

All matters on responsibilities, rights and hiring practices should be in accordance with the hiring practices established in the Manual on Personnel Selection and Contracting, and should also take into consideration the legal salary scale established by the Ministry of Health, and the Social Security agreement.

## Developing health personnel and sustaining public health systems

Reciprocal results are to be expected from the contracting of foreign health personnel. For bilateral agreements to be made, and be as equitable and fair as possible, a number of points should be taken into account. These include: the delivery of effective and proper technical care; support to retain health professionals; social and professional recognition of health personnel; training support in the countries of origin that match the morbidity profile of these countries; and twinning of health facilities. In addition, capacity-building support in the design of proper regulatory frameworks, access to specialized training, technology and knowledge transfer, and support to return migration, either temporary or permanent, need to be considered.

Three basic cooperation mechanisms between countries would be very helpful for the public health system of Member States: the exchange of health professionals between countries; the possibility of working abroad; and the possibility of having training and education abroad. Regarding the latter, the training of professionals should be expanded by designing innovative study plans to meet the current health needs of the population, and also to keep an active public health workforce. This workforce should be able to keep pace with advances in health

and be adjusted to an equitable and effective geographical distribution of qualified labour within each country, in accordance with the specific needs of the area, particularly rural areas, where there is less qualified labour.

## Data collection and investigation

The exchange of databases is extremely important for decision-making and the development of protective and supportive public policies consistent with the reality of the country. According to the Code, such exchange applies globally, on a voluntary basis. The organization manuals and functional structures of the Ministry of Health should be taken into account, particularly because of the special regulations included, among them those referring to comprehensive primary health care, primary health care management, integrated health services and human resources development. It is important to determine if the hiring of workforce regulated by the Code is for public health institutions or for autonomous and private-sector institutions only, as there should be a balance in the type of labour that is hired.

## Exchanging information

The process for granting temporary residence permits and multiple-purpose visas to foreigners in El Salvador rests with the Ministry of Justice and Public Safety General Office for Migration and Foreigners, and also involves the Ministry of Labour and Welfare. In order to update the information system data on the migration of health personnel, the impact of information exchange needs to be measured. The Ministry of Health should be the national authority responsible for information exchange on the migration of health personnel. The Ministry determines what information is made public and what is not. The registry of representatives assigned by each Member State which send to WHO will allow ongoing monitoring of the activities of the institutions, and provide a focal point that should respond to requests for information to be sent to WHO from time to time.

## Application of the Code

The Code is very broad when it indicates that, for its application, the interested parties are health professionals, the contracting party and employers, health professional organizations, NGOs, and international, regional and sub-regional organizations. Perhaps its field of application should be reduced. One of the key measures for the successful application and compliance of the Code is to monitor and evaluate all contracting parties authorized by the Ministry of Health.

## Monitoring and institutional mechanisms

Within Member States, the Ministry of Health is responsible for monitoring and reporting on the adopted measures, results achieved, hurdles encountered, and lessons learned, and, in particular, statistical information on health personnel who migrate. The Code includes, among its articles, one on modifications or changes that it might undergo in the future, based upon changes and developments experienced by Member States over the years.

As part of the institutional monitoring of the Code, this paper proposes that the WHO Director-General work jointly with the International Labour Organization (ILO) to support the Code's effective application, and through ILO, negotiate cooperation and follow-up in each country.

## Joint work, technical collaboration and financial support

Application of the Code is voluntary, so there are no mechanisms to ensure reciprocity between countries. Thus, it will be very difficult to apply the clauses related to the cooperation of Member States on the provision of technical and economic aid by the countries of destination to the countries of origin so that these could enhance the latter's health system.

Legislation should be in place that supports health professionals in performing their jobs. This requires an agenda to strengthen the role of health practitioners by providing more incentives that in turn lead to the provision of better health care for all people in El Salvador.

It should be firmly noted that, in El Salvador, the entire body of legislation includes health care-related clauses, as the Constitution of the country, among its basic objectives, ensures a comprehensive development of the Salvadorian society at the economic and, particularly, the social level.

The Ministry of Health is responsible for establishing, planning and carrying out the national policy on health; issuing the proper regulations, organizing, coordinating and evaluating the execution of health-related activities, looking into the development and improvement of academic regulations for health-related disciplines, and promoting the technical training and the specialization of the personnel involved with health facilities.

In El Salvador, in accordance with the Constitution, professional practices that deal directly with the health of the population will be supervised by legal entities or boards formed by academic experts of each discipline. These entities or boards will have the power to suspend the professional practice licence of its members who lack the skills to perform or act in a clearly immoral way. The suspension of practitioners can take place only if made by the competent bodies upon robust proof of malpractice.

Based on the Law for the Higher Council on Health and the Law for Boards of Health Professions and their regulations, the professional practice of health-related disciplines is overseen by the Higher Council on Public Health, through the different boards. Among its main tasks, the Higher Council should keep a record of all students graduating from or attending the school of their discipline at the National University of El Salvador, or those graduating from schools of other universities legally established in the country.

In accordance with the Constitution of El Salvador, all individuals are entitled to enjoy civil rights, without distinction of race, religion or nationality. Thus, the provisions of the Labour Code, in order to harmonize the relationship between employers and workers to improve the life conditions of the latter, are to be applied to everyone who falls within their scope, without distinction. These regulations include both rights and obligations.

The Labour Code establishes obligations for the Ministry of Health and Social Welfare regarding the hiring of foreign workers. Finally, the Labour Code also establishes that foreigners should enjoy the freedom to work similar to Salvadorian citizens, with no limitations other than those established by law. Nevertheless, to maintain the balance of labour mobility in Central America, the Ministries of Labour and Welfare, and of the Interior, can take measures deemed convenient, unless there are agreements or treaties in effect.

## Conclusion

From this analysis of the WHO Code, it can be concluded that its clauses do not affect or limit the constitutional order of the Republic of El Salvador or secondary legislation on labour issues. However, the Code must be submitted to public health officials for a technical analysis, and then presented to the legislative body for adoption, if appropriate.

It is important to mention the roles of the Salvadorian Congress and the President of the Republic for the enforcement of the Code: "It is the competence of the Congress: to ratify treaties of agreements that the Executive signs with other States or international organizations, or deny its ratification". According to Article 168 number 4: "The attributions and obligations of the President of the Republic: Sign treaties and international conventions, submit them for ratification of the Congress, and monitor their compliance"; and Article 145: "Treaties that limit or somehow affect constitutional clauses, unless ratification is made with the corresponding reservations. The clauses of treaties under reservation are not laws of the Republic".

The Code is very adventurous. It presents a number of propositions but does not exactly establish the mechanisms to fulfil each of them. Given the current conditions in El Salvador, it would be risky to adopt such a complex legal instrument. Nevertheless, and considering that one of the challenges of the "Regional Goals for Health Human Resources" is to regulate the migration of health workers to ensure health care to all of the population, the Code serves as point of reference for the formulation of different health-related policies.

In addition, it can be noted that the ILO does not provide any conventions that particularly address health personnel in general; only Convention 149 regulates the working role of nursing personnel.

Furthermore, the possible adoption of the Code would support the implementation of Recommendation 5, Strategy 18, of the 2009–2014 National Health Policy of El Salvador. The Government of El Salvador intends to provide labour stability of health workers, in support of the ILO's Decent Work Agenda.

**References**

Acosta M, Sáenz MR, Gutiérrez B, Bermúdez, JL (2011). Sistema de salud de El Salvador. Salud Pública de México. 53(Suppl. 2):s188–s196. http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0036-36342011000800014&lng=en&tlng=es. 10.1590/S0036-36342011000800014

MINSAL (2010). Política Nacional de Salud. San Salvador, Ministerio de Salud.

Nuñez et al. (2012). Panorama de la Migración de Médicos y Enfermeras de la Región Centroamericana y República Dominicana. San Salvador: Pan American Health Organization. http://www.observatoriorh.org/sites/default/files/webfiles/fulltext/2013/libro_migracion_ca/libro_migracion_ca.pdf

WHO (2010). User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organization. http://whqlibdoc.who.int/hq/2010/WHO_HSS_HRH_HMR_2010.2_eng.pdf

CHAPTER 4

# Monitoring the Code: The Philippines' multi-stakeholder approach

CHRISTINE JOAN R. CO

KENNETH G. RONQUILLO




Multi-stakeholder meeting.

## Health professionals' migration trends

In 2011, about 10.5 million Filipinos were working overseas, mainly in China, Hong Kong SAR, Qatar, Saudi Arabia, Singapore and the United Arab Emirates. Annually, 17 000 to 22 000 health professionals leave the country to work abroad (WHO, 2013), most of them nurses, who represented 29% of the total number from 1993 to 2010.

According to the Philippine Overseas Employment Agency, between 1993 and 2010 most nurses went to Saudi Arabia (90 382), 15 701 followed to the United Kingdom and 14 895 to the United States. More current trends show that Singapore and the United Arab Emirates have been major recipients in more recent years.

International labour markets have grown, marked by an increase in the number of hired nurses from 11 805 to 17 236 between 2010 and 2011. Remittances from overseas Filipino workers greatly boost the Philippines economy, providing US$21.4 billion, or about 10% of the country's GDP (Bangko Sentral ng Pilipinas, 2012, processed by HHRDB-DOH).

## The WHO Code: An ethical recruitment framework

The global demand for health professionals from the Philippines has increased the country's international partnerships with recipient countries. However, the country's gains from bilateral agreements have not been felt by its health sector. From 2007, the Philippines through its HRH Network, has been advocating for the inclusion of ethical recruitment practices in international legal instruments. When the WHO Code was adopted in 2010, the Philippine DoH had started to utilize its provisions to influence international agreements and other policies with recruiting countries.

In 2011, the WHO issued a NRI to guide Member States in monitoring implementation of the Code. Recognizing the importance and implications of having an ethical recruitment framework, and appreciating the Code's multisectoral perspective, the Philippines engaged in a multi-stakeholder approach to monitoring it (DoH, 2012).

The Code was the country's only tangible guideline defining the dimensions of ethical recruitment, and thus was seen as an opportunity for education, advocacy and the creation of awareness among actors in the global movement of health professionals.

This chapter describes the steps taken by the Philippines in forging partnerships and engaging stakeholders in the participatory process of monitoring the Code.

## The Philippines' monitoring process

The NRI has five components, namely: multisectoral thrusts to sustain the health workforce and strengthen health systems; migration research and information; health personnel's rights and responsibilities; multisectoral recruitment and employment practices; and policies for health professionals' recruitment, employment and migration. Capturing a clear picture of these components in the Philippines requires the involvement of government and non-government offices engaged in the recruitment process, policy-makers, academia, and other organizations interested in the welfare of migrant workers.

### The collaborative environment

The DoH, as the designated national authority, engaged in a partnership with the Department of Labour and Employment (DOLE), the WHO Western Pacific Regional Office, WHO Country Office, and the ILO in Manila – through the Decent Work Across Borders (DWAB) project. The partnership brought together national and international leaders in health and labour relations to discuss mechanisms by which the NRI can be utilized and interpreted.

Fortunately for the Philippines, the chosen partners are actively engaged with existing networks of stakeholders. The Health Human Resource Development Bureau (HHRDB) of the DoH is convener and secretariat to the Human Resources for Health Network Philippines, a multisectoral network of 16 government and non-government agencies whose structure adopted the WHO Working Lifespan Strategies Framework. The DOLE and ILO tripartite system created a bridge between social development agencies/organizations and recruitment agencies and trade unions. It was also of benefit that the WHO country office is located within the DoH, whereas the WHO Western Pacific Regional Office is located in Manila. These strategic office locations facilitated technical assistances and support for the collaborative process.

### The planning process and partners' roles

The partnership was formalized through an ILO Manila-hosted consultative meeting among partner organizations to discuss the intentions, potentials and strategies of the monitoring process. An analysis of the NRI revealed that apart from the five identified components, questions might be subject to different interpretations. The meeting concluded that a series of participatory engagements with stakeholder networks was appropriate to accomplish the NRI. The partnership decided to involve five groups of stakeholders:

- national government agencies of the HRH Network Philippines
- trade unions
- recruitment agencies

- hospitals (national government, local government and private)
- professional associations (medicine, nursing, physical therapy, occupational therapy, pharmacy, and medical technology).

It was deemed necessary to develop a modified tool to facilitate the policy dialogue, capture relevant discussions for each item, and to provide opportunities for stakeholders to comment on the instrument questions. This was then developed by the DoH through the HHRDB, working with the DOLE and ILO Manila.

WHO's role was limited to technical support to strengthen the Philippines' capacity as a leader in the policy dialogue process. As a technical support office, WHO was responsible for providing clarifications on the purpose and intentions of the Code, its tool and other support reference documents.

## Modified tool (Philippine worksheet)

The modified tool used was a two-part worksheet. Part I focused on the 15 questions in the NRI and aligned them with respective provisions of the Code.

Part II contained supplementary (additional) questions intended to further clarify and illustrate ethical recruitment practices and mechanisms in the Philippines. The following additional questions were asked.

1. Has the Philippines participated in international discussions and advanced cooperation on matters related to ethical international recruitment?
2. Are there mechanisms for internationally recruited health workers to report non-conformity to policies on ethical recruitment and labour standards?
3. What is your organization's perception of circular migration? Is it being facilitated so that skills and knowledge can be achieved for the benefit of source and destination countries?
4. How does the Philippines promote ethical recruitment?
5. Does the Philippines have a strategy to retain, sustain and distribute health workers in the country?
6. What are the measures undertaken to strengthen educational institutions to scale up training of health personnel and developing innovative curricula to address current needs?

## The participatory process

The participatory process began with an orientation of stakeholders towards a common understanding of migrant health personnel, the provisions and intentions of the Code, interpretation of the questions in the Code, and the modified tool (Philippine worksheet), and then went on to obtain the stakeholders' commitment to participate in the policy dialogue series. Using the collated responses from stakeholders, the DoH led the series of policy dialogues to clarify and validate responses, and to seek further inputs and recommendations. The series had 73 participants representing stakeholders from 55 organizations.

## The stakeholders' perspectives on monitoring the Code

A common understanding among different stakeholders was that the Philippines is a source country of health practitioners, whereas the NRI was written for a recipient (destination) country, and thus most of the NRI questions are not applicable to the Philippines. Furthermore, the Philippines has not had a full opportunity to practice ethical recruitment of health professionals from other countries and, therefore, does not have a policy structure that pays special attention to the labour rights of employed foreign-trained health professionals.

Constraints in implementing the Code were seen at different levels. National government and hospitals looked to state policies and local government devolution as setbacks, whereas recruitment agencies and professional associations felt that insufficient dissemination of the principles of the Code was a disadvantage. Trade unions looked beyond ethical recruitment and discussed the country's labour challenges and lack of involvement in the monitoring of the recruitment process.

Each stakeholder group listed below presented their perspectives on the Code and its application and implementation, the NRI, and recommendations for the improvement of ethical recruitment.

### National government

The national government's interest focused on state policies, such as the 1987 Philippine Constitution, which are seen as restrictive and do not freely allow the entry of foreign nationals to seek employment in the Philippines. In more recent years, the Philippines has been committed to pursuing a mutual recognition arrangement of three health professions among Association of Southeast Asian Nations (ASEAN) member states. These were observable contradictions. With this development, national agencies are exploring ways to amend state policies and accommodate government commitments.

The protection of social welfare and legal rights of overseas Filipino workers abroad was a common concern among stakeholders. There are no feedback mechanisms for overseas workers on the recruitment processes. However, the government has in place a regulatory mechanism for recruitment through the accreditation of recruitment agencies to ensure compliance with national policies.

### Trade unions

The concerns of trade unions centred on the individual rights and privileges of health professionals abroad as an indirect effect of national policies. The lack of a mutual recognition framework for health professions between the Philippines and recipient countries hinders promotion and equality in national treatment for salary and wages for Filipino health-care professionals. Thus, policies intended to ensure the protection of workers' labour rights are limited to those professions whose licensing, certification and competency standards are recognized by other countries. However, there has been some anecdotal evidence of preferential treatment for foreign-trained health professionals over Filipino health professionals in some hospitals in the Philippines.

## Hospitals

Hospitals are the main source of trained health professionals seeking employment in other countries, and are not recipients of foreign-educated health professionals. Their health service delivery systems are most affected by active recruitment by the international community or private recruitment agencies. This makes questions from the NRI inapplicable, except in cases of receiving foreign trainees wherein the employer-employee relationship does not exist. Hospitals have employed the use of twinning arrangements with recipient countries for the exchange of trainees. This form of exchange has benefited the country by creating an informal network of alumni in different countries who can be utilized for the expanded monitoring of ethical recruitment practices outside the Philippines.

## Recruitment agencies

Recruitment agencies likewise agree that the Code, with all its intentions to provide a guide for ethical recruitment practices, is not entirely represented by its NRI. In terms of enforcing fair labour practices, the agencies believe that the recipient countries' labour policies are more mature compared with source countries such as the Philippines. The agencies see strict implementation of existing policies as a means of monitoring the Code.

The Code as a voluntary guide for Member States is seen in itself as a constraint, and should be further institutionalized through larger dissemination activities, high-level state dialogues and incorporation of its provisions in higher education and government civil service policies.

## Professional associations

Professional associations feel that the Code's provisions have yet to be fully implemented in the light of receiving transient/temporary foreign practitioners for medical missions and training. Their engagement with national government in providing pre-employment orientations is one step towards a more comprehensive approach of the country to provide potential migrants the information for their social and labour protection needs.

The stakeholders concluded that a separate monitoring instrument should be used for source and recipient countries to capture the practices and evidence of policy implementation. The intentions of the Code will benefit health professionals from source countries and act as a tool to advocate for fair labour practices, and therefore wide dissemination of the Code and its comprehensive translation into national programmes, policies and frameworks should be ensured. To maximize the use of the tool, feedback mechanisms should be in place to help engage overseas health professionals as stakeholders in monitoring the Code.

## References

DoH (2012). Monitoring of the WHO Global Code of Practice on the International Recruitment of Health Personnel: The Philippine Multistakeholder Approach. Manila: Department of Health.

WHO (2013). WHO policy dialogue on international health workforce mobility and recruitment challenges technical report. Amsterdam: World Health Organization. http://www.euro.who.int/en/health-topics/Health-systems/health-workforce/publications2/2013/who-policy-dialogue-on-international-health-workforce-mobility-and-recruitment-challenges-technical-report

CHAPTER 5

# Health personnel challenges in Norway

OTTO CHRISTIAN RØ

©GHWA | Laboratory scientist.

In reporting on the Code implementation, Norway presented a number of strategic directives aimed first at putting into place sufficient domestic educational capacity to meet nationwide health provision needs. Secondly, regulations are being adapted to improve the utilization of health personnel in the workforce, such as transferring of part-time contracts to full-time and improving working conditions.

Today, Norway enjoys a unique workforce situation with approximately one in five of the total employed in the health-care sector, and an overall low unemployment rate (3.6% in 2013). In 2008, the Parliament decided on a health workforce capacity and competency-building programme for 2008–2015 (The national competency plan 2015). This was part of the follow up to the White Paper No. 25 (2005–2006) on care policies. The Norwegian Directorate of Health and the Ministry of Foreign Affairs published three reports in the period 2008–2010 to adopt a multisectoral approach to the Norwegian health workforce challenges and in connection with the WHO Code to be adopted in 2010. (WHO, 2010)

## The Norwegian context

Norway has five million inhabitants and is not a member of the EU. Some key OECD (2013) statistics about Norway are presented in Table 6.

**NORWAY STATISTICS (OECD, 2013)**

TABLE 6

| | | |
|---|---|---|
| Expenditures per capita | US$ 61 870 | 2011 |
| Real GDP growth (annual) | 1.4% | 2011 |
| Household disposable income (annual growth) | 4.2% | 2011 |
| Public expenditure on health (% of GDP) | 7.9% | 2011 |
| Private expenditure on health (% of GDP) | 1.3% | 2011 |
| Inflation rate, all items (annual growth) | 1.3% | 2011 |
| Unemployment rate | 3.3% | 2011 |
| Foreign-born population | 10% | 2010 |
| Life expectancy at birth | 81.2 yrs. (79/83.3) | 2010 |
| Infant mortality rate | 2.8% | 2010 |

Source: OECD (2012a).

The support ratio, i.e. the number of people in the labour force per person in need of health care services in Norway, was four in 1994 and it is estimated to fall to 2.4 in 2054. This poses a challenge to sustainable economic development in the country.

## The health system

Health care in Norway is mainly publicly funded, with total expenditure in 2012 equal to 34.6 billion Euro in 2012, a 25% increase since 2008. Statistics Norway (2013a) calculates that the share of expenditure on health has been relatively stable over many years, and was 9.4% of GDP, in 2012.

According to the OECD (2012a), Norway is spending more on health per person than most OECD countries. If, however, the share of the country income to invest in any sector is calculated, Norway has spent 10–11% of GDP since 2000, about at the same level as Finland, Italy, Sweden, and the United Kingdom (Scheel, 2013).

Hospitals are government-owned and organized in four regional health authorities under Health Authorities and Health Trusts Act (2001). Hospital care is free of charge, although outpatient care includes some out-of-pocket payments (OPPs). Patients can choose a hospital for elective hospital care, but are in acute cases referred to their local hospital. In 2012, the total expenditure of specialized health care was equal to 14.7 billion Euros. Nine percent of the total costs refer to private institutions. A total of 5% of the workforce is employed in hospitals or the specialized health-care sector (Statistics Norway, 2013b).

Primary health care is run by the 428 municipalities that are independent political entities. General physicians are responsible for an average of 1160 patients, leaving the choice of physician to each individual. On average the population has 2.6 consultations with the general physician per year (2011) (Statistics Norway, 2013c).

There are close to 40 000 nursing home beds in the municipalities in addition to home-based nursing care and care services for people with reduced functional capacity or health-care needs living at home.

There are some OPPs for primary health care, medication and transportation costs to health-care providers. There are two ceilings of OPPs per year achievable for 1.2 million inhabitants every year, the lower ceiling being US$465 as a maximum amount of spending per year. The other ceiling is by application and includes some other health services such as physiotherapy, partial dental care, stay in public rehabilitation units, etc.

## The labour market

Among the population of about five million, approximately 2.6 million people are in the labour market. The rate of registered unemployed was 3.6% in February 2014, in addition to those partly unemployed and on labour market measures.

Among the employed, 361 000 have a health or social science education, 79% of whom work in health-care services or the social sector. One in four of the labour force was on a part-time contract in 2012. Part-time work is especially frequent among female health-care workers.

## Migration patterns

Norway has an increasing net immigration. Traditionally, most immigrants have come from other Nordic countries, but immigration from the new EU-countries has increased. The health sector and the construction and farming industry are typical areas (figures 1 and 2).

FIGURE 1

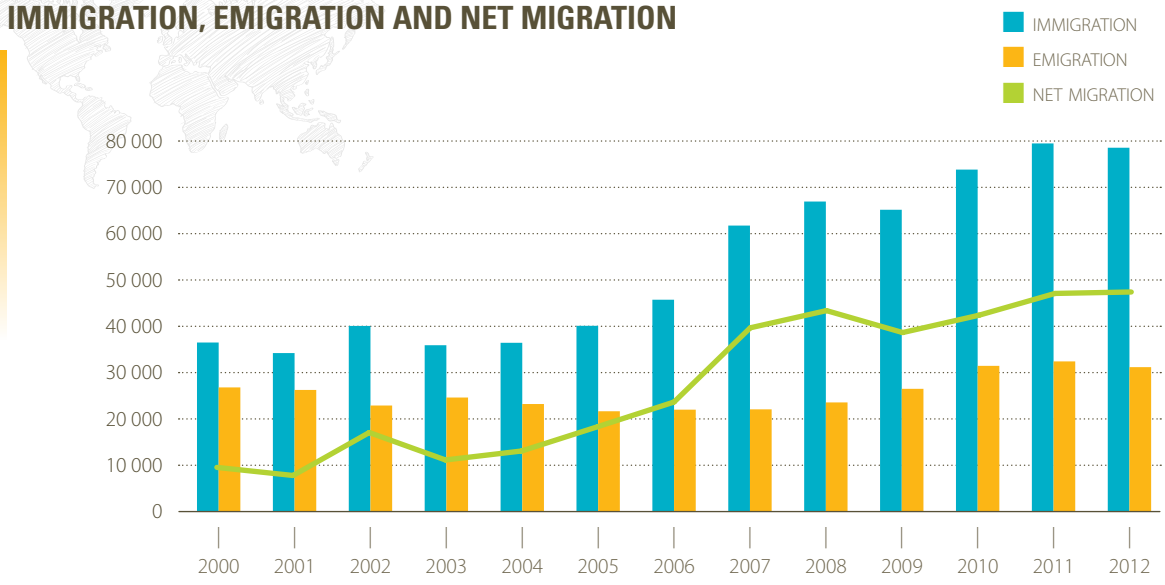
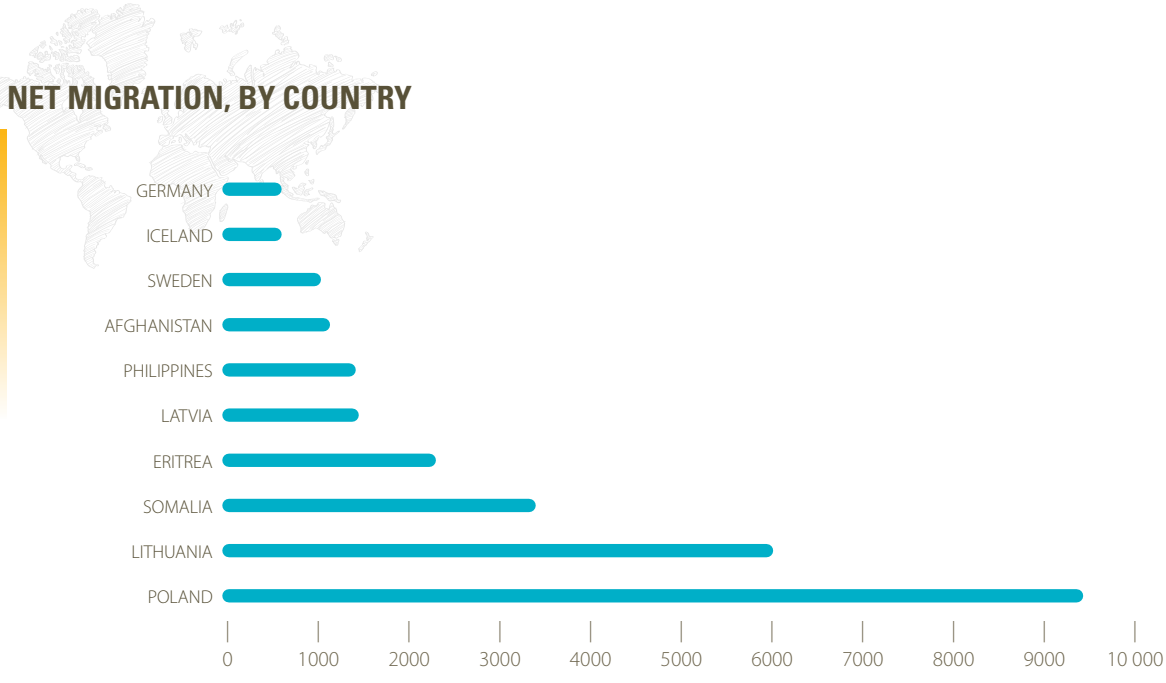



FIGURE 2



Workforce migration has long been on the political agenda in Norway (White Paper Report 18, 2007–2008, Ministry of Labour). Immigration can be considered as a condition for economic growth because the current domestic workforce supply is insufficient to cover national needs. Priority has not been given to establishing bilateral agreements on workforce immigration. A low-scale pilot project was being initiated in India and Russia in 2013 to improve the information given at Norwegian embassies about work possibilities in Norway to potential immigrants.

By laws and regulations, immigrants to Norway enjoy full rights in the labour market. A few examples of social dumping, however, have been disclosed and investigated.

In the Norwegian municipalities, 12% of all nurses and care service workers are immigrants; in Oslo as much as 49%. Of all doctors certified in Norway, 70% are qualified abroad, most of them Norwegian citizens. All together 13% of doctors in Norway have foreign citizenship.

According to the Norwegian Labour and Welfare Administration (NAV), the demand for unskilled workers in Norway is not expected to rise in the near future, but health and care professionals are among the groups that are expected to experience a continuing demand for highly skilled workers.

## Educational level

Based on current patterns of graduation, it is estimated that an average of 46% of today's women and 31% of today's men in OECD countries will complete theory-based tertiary education over their lifetime. Only 39% of women and 25% of men will do so before the age of 30.

Norway is tenth among the listed OECD countries with a high percentage of people educated with a theory-based tertiary education (OECD, 2012b). Among the population, 30% have primary school education, 42% have secondary school education and 26% have tertiary or higher education (2012) (Statistics Norway, 2013d). Immigrants have a bigger percentage with higher education than the rest of the population. At the same time, the proportion of unskilled persons is highest among immigrants.

## Health personnel

Altogether, 424 000 people aged 15–66 years are trained within health and social services in Norway, 84% of them women. In 2012, a total of 85% were employed in the health and care sector (Statistics Norway, 2013e).

In 2012, 30 700 skilled persons from abroad worked within the health and social sector, 38% of whom were from Africa, Asia or South America. The largest immigrant group is nurses (9600) and the second largest is physicians (4800). Norway has 29 authorized health personnel groups, and authorization is granted by The Norwegian Registration Authority for Health Personnel (SAK, 2013).

A total of 28% of the youth cohort starts a health and social science care-related education. Up to 20% of people employed are in the health and care sector, including kindergartens. From 2011 to 2012, the number of skilled workers in the health and social sector increased three times as much as in the general labour market.

# Policies to cope with health personnel challenges

## Domestic health workforce capacity building

The Norwegian health personnel policy approach is primarily to cope with future needs in health care by having in place information and planning systems for future imbalances in the health workforce market and mechanisms for capacity building. This will be the most powerful part of the implementation of the WHO Global Code by reducing the "pull" effect on health workers from other countries. Governmental health workforce capacity-building programmes have been running for many years.

Among the more recent political initiatives, the national care services plan 2015 (Ministry of Health and Care Services, 2006) includes a long-term investment plan for capacity building of health personnel within municipality care services and nursing homes. Compared with the 2004 level, from 2005 to 2009, the government increased annual funding to municipalities to provide an extra 10 000 more work years of employment for skilled health workers in the care services. From the 2008 level, a further increase of 12 000 work years is planned for 2015. For the most part, the government has succeeded in achieving these goals, despite a substantial deficit in the annual increase in the number of health-care workers compared to the plan's ambitions.

Evaluation of The National Competency Plan 2015 shows success in obtaining more new health personnel than planned for the period 2005–2009. The result was 18 000 more health-care service workers in the municipalities, an increase of 18% work years in the period. The new workforce led to a growth in the proportion of skilled personnel with higher education. Part-time contracts dropped from 32% to 28%. The success was, according to the evaluator, due to a combination of extra funding incentives from the government through the regional to the municipal level, an annual local plan to be reported for increased health personnel capacity, and systematic monitoring of the results with annual feed-back to the local level (Tjerbo et al., 2012).

The government has followed up by extending the implementation period until 2020 (Ministry of Health and Care Services, 2013). This includes an innovation programme for the care services to follow up a public commission report on new technology in the health-care services, not only in high technology hospital care (Ministry of Health and Care Services, 2011).

A comprehensive National Mental Health Plan (1998–2009) was conducted to modernize and build capacity, and decentralize and build more competencies (Ministry of Health and Care Services, 2007). Most of the programme targets were achieved, not least in mental care for children and adolescents. A specific treatment guarantee was introduced for these patient groups to strengthen their health-care rights, and the target of 5% of the child and adolescent population given specialized health-care services was reached.

The Ministry of Education presented a report to Parliament on education in the welfare sector (Ministry of Education and Research, 2012). One objective is to bridge the gap between the education system and labour market needs.

### Public health strategies against rising health-care costs and needs

Health-care system reform has been introduced to strengthen integrated cooperation between primary and secondary health care (White paper Report 47 (2008–2009) The Coordination Reform). The main idea is to shift from hospital care to more primary care, together with public-health initiatives to increase healthy lifestyle-related early intervention programmes and active rehabilitation. The Coordination Reform is being gradually implemented from 2012 to 2016. Mandatory agreements are in place between every hospital and surrounding municipalities. A municipal co-financing mechanism for hospital care for residents from each municipality is covered by the local authority. This is an incentive to look for possible alternative solutions to hospital care (20% of the DRG-production). Blocked beds in hospitals are paid for from the patient's home municipality, and consequently the numbers of such hospital beds has been substantially reduced since 2011. The numbers of days in blocked hospital beds from July to September 2011 was reduced from 43 145 to 16 099 during the same period in 2012 (Norwegian Directorate of Health, 2012).

Public health initiatives are reinforced by a policy that underlines the importance of early intervention and prevention (White paper Report 34 (2012–2013) Public health initiatives) and A Public Health Act (2011). Norway aims to regain a top three position on the global longevity list. Despite these new public health initiatives, Norway according to OECD figures is spending less than about 2.4% of total health expenditures on prevention and public health service. Ten OECD countries are higher on the list.

## A partner in preparing for the Code

Norwegian health authorities, together with international development authorities, have been raising the health personnel crises higher on the domestic political agenda in recent years.

The Norwegian Directorate of Health has hosted international meetings with WHO, the Global Health Workforce Alliance (GHWA) and other international partners. Between 2009 and 2013 Norway has been on the Executive Board of WHO, and has advocated for the WHO Code to be developed and adopted. Norway has also been active in GHWA steering activities. Since the Code's adoption in 2010, there is a plan for a more long-term approach for the domestic Code follow-up.

Special reports on human resources in health were published while the WHO Global Code was under development. One such report is on global health workforce solidarity (Norwegian Directorate of Health, 2007), another is on educating and utilizing health personnel (Norwegian Directorate of Health, 2009). The Ministry of Foreign Affairs published another report in 2009 on Norwegian development aid and global health workforce challenges.

### Follow-up of the Code

In 2011, the Norwegian government decided that the Code should be implemented in Norway. The Directorate of Health has translated the Code into Norwegian and published it on its website (Norwegian Directorate of Health, 2010). Norway has appointed a national reporting authority to WHO (Directorate of Health), and it duly reported in June 2012, with input from relevant stakeholders. No legal amendments have been introduced in Norway as a consequence of the implementation of the Code.

The Directorate of Health has arranged two national conferences for relevant stakeholders, including private recruitment agencies, as part of the follow-up of the Code. The Code is a challenge to these agencies, and compliance with the its principles could be a competitive advantage within the recruitment industry. One recruitment agency has reportedly included the Code on its website as part of the ethical recruitment strategy and basic values of the enterprise.

Norway has participated on several occasions where the Code has been on the agenda, including a technical briefing on the WHO European Regional Committee meeting in Malta in September 2012, a WHO policy dialogue in Amsterdam in May 2013, and a conference in Moldova in June 2013, initiated jointly by WHO and the Ministry of Health.

As part of this international challenge, Norway hosted a conference in September 2013 where GHWA together with WHO invited high-income countries to examine their specific roles and commitments in global health workforce challenges[1]. This was part of the preparations for the Third Global Forum on Human Resources for Health in Brazil in November 2013.

## National health workforce forecast models

A national health workforce forecast publication is made every three years by Statistics Norway. The last edition in 2012 has a scope until 2035. The model looks into need and supply and the balance of the two for 20 authorized health personnel groups on a national level. It takes into account different suppositions of anticipated GNP growth per inhabitant and demographic changes. Current stock and flow of health personnel, education, drop-outs from school, participation in the labour force and time for pensioning are elements on the supply side. On the needs side, rates of use of health care are added to the calculations, related to future population growth (Statistics Norway, 2012).

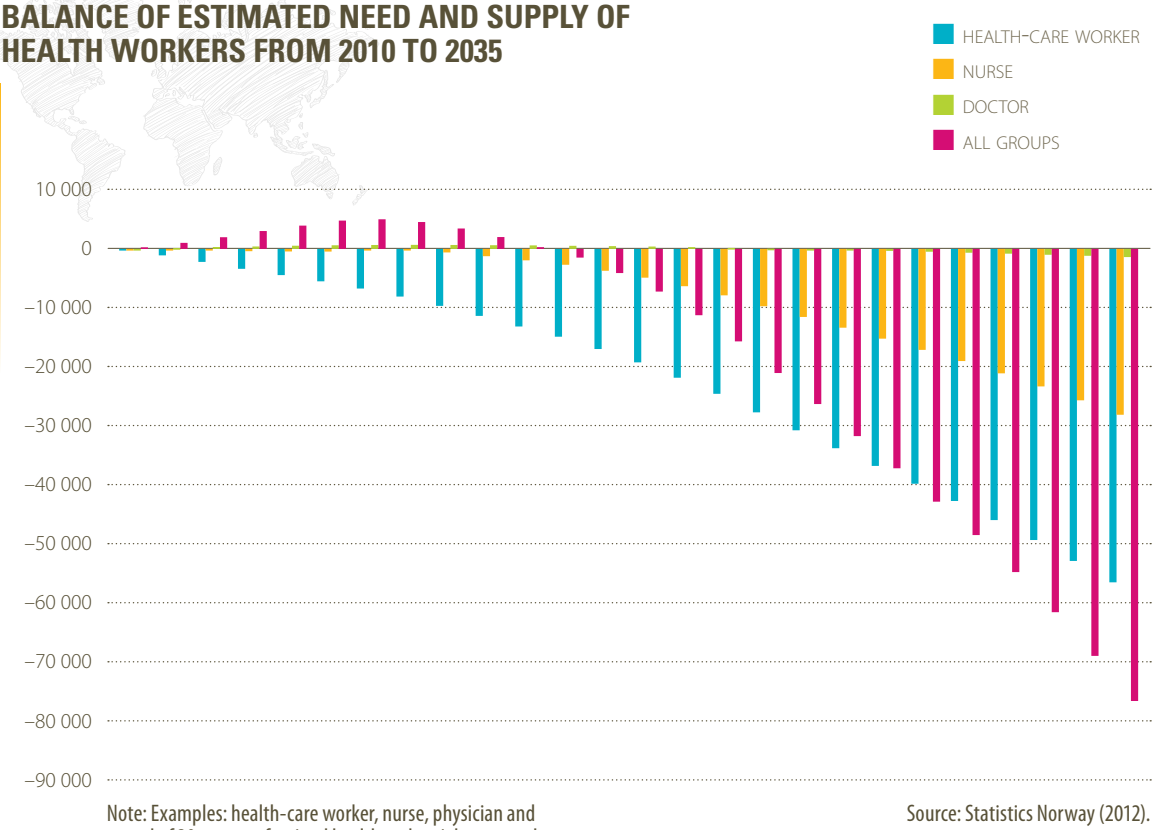
The findings suggest that there could be a lack of health personnel in years to come, in total and for identified personnel groups. The pattern shows that the number of long-term educational programme groups, such as physicians, will probably be in good balance for many years. However, the number of persons with a short-term educational programme, such as health-care workers and nurse assistants will remain increasingly insufficient.

These are valuable calculations because they allow for political interventions to cope with future imbalances in the health workforce. This is an information and planning system as one part of the responsibility taken by Norwegian society to follow up the Code's intentions and to contribute to a fair global distribution of the health workforce (Figure 3). The financial crises in Europe will obviously alter the migration pattern, which may lead to a worsening of the situation in Europe as well as elsewhere.

1 http://www.who.int/workforcealliance/media/news/2013/HRH_consultation_Oslo_provisionalagenda_22August2013.pdf

FIGURE 3

## BALANCE OF ESTIMATED NEED AND SUPPLY OF HEALTH WORKERS FROM 2010 TO 2035




Note: Examples: health-care worker, nurse, physician and a total of 20 groups of trained health and social personnel. Model: The medium GNP/person growth alternative.

Source: Statistics Norway (2012).

These estimates of future health workforce apply a calculation with a moderate GNP per person increase of on average 0.5% per year from 2010 to 2035. Some personnel groups come out with a surplus, others with a small under-balance and some with big shortages in years to come. The most affected group is health-care workers with an estimated shortage of nearly 57 000 in 2035. For nurses, the calculation reveals a shortage of more than 28 000, whereas there will be a surplus of physicians until 2027.

## Conclusion

Norway as a non-EU country has successfully invested in health personnel capacity-building programmes since the late 1990s. The government's ambition in 2005 was to achieve 10 000 more work years in the health sector during a five-year period. It funded the municipalities' plans to achieve this goal. This was a success. This initiative has come on top of a 12-year programme to strengthen mental health care in Norway through increased transparency, more decentralizing and professionalization of the field.

A substantial proportion of health workers in Norway are of foreign origin. Immigrants enjoy full rights in the labour market in Norway. Some training programmes for unskilled personnel have taken place.

An important Norwegian policy approach for reducing the "pull" effect on health work force migration is comprehensive and long-term domestic programmes on capacity building of health-care personnel in mental health and primary care services. In addition, a larger workforce can be made available by reducing part-time contracts in the field. Innovation not only in high-technology hospital medicine but also in care services will contribute to more efficient use of the health workforce in the long run.

To cope with rising health costs and needs, better coordination is required between the different players in the health sector. The Coordination Reform aims to put powerful new instruments in place. More focus on public health initiatives, prevention, health promotion and life style interventions can contribute to a more sustainable development.

The WHO Code is considered as an important, but not sufficient, instrument to increase the awareness of the global health workforce crises. The Norwegian government has decided to implement the Code, even though no legal amendments are proposed and bilateral agreements are not part of the Norwegian labour migration policy.

National health workforce forecasts, based on valid statistics, are published every three years and enable Norway to plan for future needs and imbalances in the health workforce market. There will be substantial shortages of short-term educational health personnel groups such as health-care workers during the next 20–25 years, but there will be sufficient numbers of long-term educational groups such as physicians. Such planning instruments will not be sufficiently robust when influenced by unpredictable changes such as financial crises in Europe. For Norway, international cooperation is urgent in order to share experiences, including as a health workforce recipient country.

**References**

Norway. Ministry of Education and Research (2012), White paper Report 13 (2011–2012). Oslo. http://www.regjeringen.no/en/dep/kd/documents/bills-and-white-papers/reports-to-the-storting/2011-2012/meld-st-13-20112012.html?id=672836

Norway. Ministry of Health and Care Services (2006). White paper Report 25 (2005–2006). Oslo. http://www.regjeringen.no/en/dep/hod/documents/regpubl/stmeld/20052006/stmeld-nr-25-2005-2006-/3.html?id=200892

Norway. Ministry of Health and Care Services (2007). Opptrappingsplanen for psykisk helse 1999–2008. Oslo. http://www.regjeringen.no/nb/dep/hod/tema/psykisk_helse/opptrappingsplanen-for-psykisk-helse-199.html?id=274864

Norway. Ministry of Health and Care Services (2011). NOU 2011:11. Oslo. http://www.regjeringen.no/en/dep/hod/documents/nouer/2011/nou-2011-11.html?id=646812

Norway. Ministry of Health and Care Services (2013). White Paper Report 29 (2012-2013). Oslo. http://www.regjeringen.no/en/dep/hod/documents/regpubl/stmeld/2012-2013/meld-st-29-20122013.html?id=723252

Norwegian Directorate of Health (2007). Recruitment of health workers: towards global solidarity. Oslo.

Norwegian Directorate of Health (2009). Educate enough, utilise well: domestic activities to deal with domestic and global HRH challenges. Oslo.

Norwegian Directorate of Health (2010). Brukerveiledning til WHOs globale kode for internasjonal rekruttering avhelsepersonell. Oslo: Helsedirektoratet. http://www.helsedirektoratet.no/publikasjoner/brukerveiledning-tilwhos-globale-kode-for-internasjonal-rekruttering-av-helsepersonell/Sider/default.aspx

Norwegian Directorate of Health (2012). Styringsdata for kommuner. Oslo. http://helsedirektoratet.no/finansiering/okonomiske-virkemidler-i-samhandlingsreformen/styringsdata-for-kommuner/_layouts/xlviewer.aspx?id=/finansiering/okonomiske-virkemidler-i-samhandlingsreformen/styringsdata-for-kommuner/Excelservices%20dokumenter/ukp.xlsb#

OECD (2012a). Health at a Glance: Europe 2012. Paris. http://www.oecd.org/health/healthataglanceeurope.htm

OECD (2012b). Education at a glance: OECD indicators 2012. Paris. http://www.oecd.org/education/EAG2012%20-%20Country%20note%20-%20European%20Union.pdf

OECD (2013). Country statistical profile: Norway 2013. Paris, Organisation for Economic Co-operation and Development. http://www.oecd-ilibrary.org/economics/country-statistical-profile-norway_20752288-table-nor

SAK (2013). About SAK. http://english.sak.no/sites/SAK-english/about-sak/Sider/default.aspx

Scheel HH (2013). Høye helseutgifter? [High health-care costs?]. Statistics Norway, 29 January. http://www.ssb.no/nasjonalregnskap-og-konjunkturer/artikler-og-publikasjoner/hoye-helseutgifter

Statistics Norway (2012). Arbeidsmarkedet for helse- og sosialpersonell fram mot år 2035. [website]. Oslo: Norwegian Registration Authority for Health Personnel. http://www.ssb.no/arbeid-og-lonn/artikler-og-publikasjoner/arbeidsmarkedet-for-helse-og-sosialpersonell-fram-mot-aar-2035?fane=om

Statistics Norway (2013a). Helseutgiftene utgjør en stabil andel av BNP [Health expenditure a stable share of GDP]. Oslo. http://www.ssb.no/nasjonalregnskap-og-konjunkturer/statistikker/helsesat)

Statistics Norway (2013b). Specialist health service, 2012. Oslo. http://www.ssb.no/helse/statistikker/speshelse

Statistics Norway (2013c). General practitioners services, 2011. Oslo. http://www.ssb.no/helse/statistikker/fastlegetj

Statistics Norway (2013d). Population´s level of education, 2012. Oslo. http://www.ssb.no/utdanning/statistikker/utniv

Statistics Norway (2013e). Health care personnel, 2012, 4th quarter. Oslo. http://www.ssb.no/arbeid-og-lonn/statistikker/hesospers

Tjerbo T et al. (2012). Bemanning av pleie-og omsorgsektoren: handlingsplan og iverksetting. Oslo: NIBR-rapport No. 3. http://www.nibr.no/filer/2012-3.pdf

WHO (2010). The WHO Global Code of Practice of International Recruitment of Health Personnel. Geneva: World Health Organization.

CHAPTER 6

# Swiss commitment to implementing the Code

DELPHINE SORDAT FORNEROD



Medical students.

The adoption of WHO's Global Code of Practice is a major step in the recognition of a specific migration phenomenon, whose magnitude weakens especially health systems in developing countries. Switzerland, due to its geographical location, its high level of economic development and a health-care system that ranks among the best in the OECD countries is in a privileged position and attracts numerous foreign health professionals, mainly from neighbouring countries.

Aware of this situation, Switzerland was already taking steps prior to the adoption of the Code and continues to be actively engaged since then. It is notably one of the first countries to have defined an inter-ministerial strategy for global health at government level, which lists health personnel as one of its priorities. At the national level, the "Health2020" strategy adopted in January 2013 by the Swiss government also emphasizes the need for better-trained health staff (Switzerland. FOPH, 2013a).

## The Swiss context

### The Swiss health system and its health personnel from an OECD and WHO perspective

According to experts of the OECD and WHO (2011), the Swiss health system is highly efficient and has achieved a number of important objectives, including the establishment of UHC allowing access to a wide range of health-care services. Life expectancy is one of the highest in the world, and, according to a 2010 Commonwealth Fund survey, the Swiss population is generally satisfied with its health-care system (Commonwealth Fund, 2010).

However, this excellence comes at a price. Switzerland spent 11% of its GDP on health in 2011 and will have to face challenges to maintain and improve the level of its system. Switzerland has an aging population and declining birth rates. In the coming decades this will result in a significant increase in the number of older people with chronic and multi-morbid diseases which in turn will increase the demand for health services.

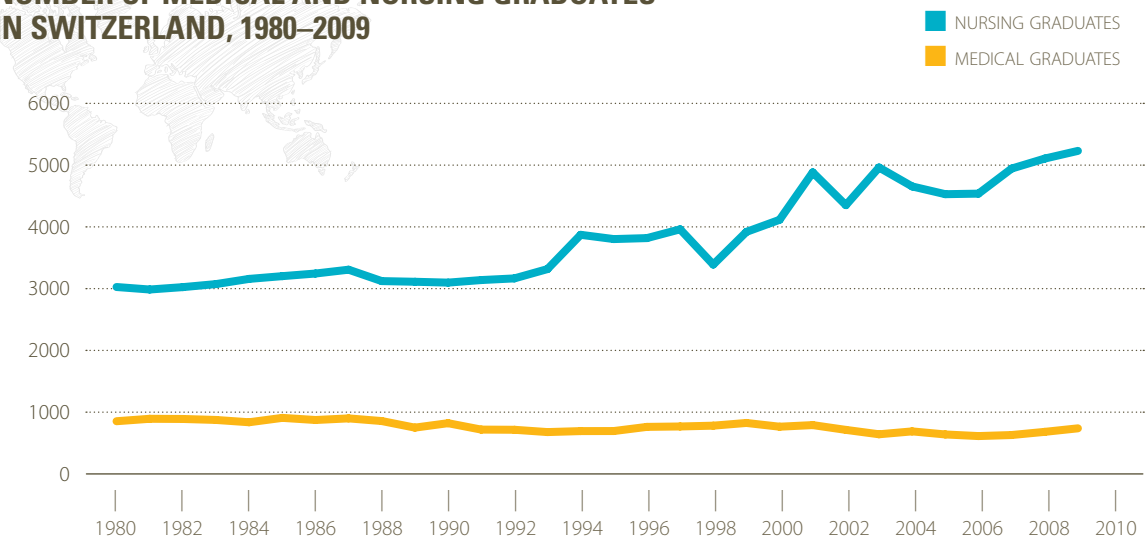
Although Switzerland enjoys an above average number of health professionals compared to other OECD countries, disparities exist across occupations and regions. The density of general practitioners in Switzerland is below the OECD average, with a ratio of 0.6 GPs per 1000

inhabitants, against 0.73 for the OECD average. The geographical distribution of health personnel between urban and rural areas also shows large variations and can be challenging, especially in remote regions. Another layer of complexity adds itself in the form of the recent trends in the medical staff also present in other OECD countries: the aging of health professionals, the feminization of the medical profession, as well as changes in work organization, including the development of part-time and group practices.

In terms of educating health staff, the numbers of graduates in medicine and nursing have followed opposite trends: the average number of new medical graduates declined over time, while the number of nursing professionals (across all skill levels) increased. The result is that Switzerland currently ranks below the OECD average regarding medical graduates per 100 000 inhabitants (figures 4 and 5).

FIGURE 4

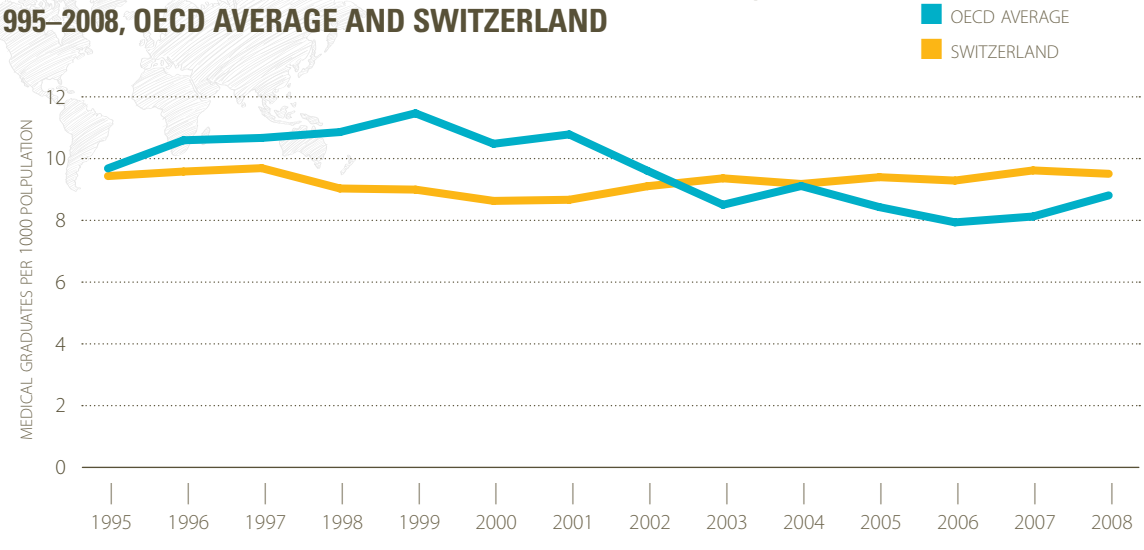
**NUMBER OF MEDICAL AND NURSING GRADUATES IN SWITZERLAND, 1980–2009**




Source: OECD (2011).

FIGURE 5

**NUMBER OF MEDICAL GRADUATES PER 1000 POPULATION, 1995–2008, OECD AVERAGE AND SWITZERLAND**




Source: OECD (2011).

## Switzerland in the context of international migration

Located in the centre of Europe, Switzerland has been an immigration country for a long time and the proportion of migrants is particularly high. While it has seen an influx especially of unskilled labour in the past, Switzerland currently attracts mostly highly skilled professionals from neighbouring countries, mainly France, Germany and Italy. In 2010, the number of foreign residents accounted for about 23% of the total population and, according to a report by the Swiss Health Observatory (Ruedin & Widmer, 2010), the share of foreign health professionals represented about 5% of total immigration to Switzerland. Switzerland is one of the net beneficiaries (more inflow than outflow) of the international migration of health personnel and the proportion of foreign health workers, especially nurses, is among the highest in OECD countries (Table 7).

TABLE 7

### PERCENTAGE OF PRACTICING MIGRANT DOCTORS AND NURSES IN OECD COUNTRIES (FOREIGN-BORN)

| OECD country | Nurses (%) | Doctors (%) |
|---|---|---|
| New Zealand | 23.2 | 46.9 |
| Australia | 24.8 | 42.9 |
| Ireland | 14.3 | 35.3 |
| Canada | 17.2 | 35.1 |
| United Kingdom | 15.2 | 33.7 |
| Luxembourg | 25.8 | 30.2 |
| Switzerland | 28.6 | 28.1 |
| United States | 11.9 | 24.4 |
| Sweden | 8.9 | 22.9 |
| Portugal | 13.9 | 19.7 |
| France | 5.5 | 16.9 |
| Netherlands | 6.9 | 16.7 |
| Norway | 6.1 | 16.6 |
| Austria | 14.5 | 14.6 |
| Belgium | 6.6 | 11.8 |
| Germany | 10.4 | 11.1 |
| Hungary | 3.1 | 11.0 |
| Denmark | 4.1 | 10.9 |
| Greece | 9.7 | 8.6 |
| Spain | 3.4 | 7.5 |
| Turkey | ND | 6.2 |
| Finland | 0.8 | 4.0 |
| Poland | 0.4 | 3.2 |
| Mexico | 0.2 | 1.5 |
| **OECD average** | **10.7** | **18.2** |

Source: OECD (2011).

The share of foreign-born health professionals is particularly high in the hospital sector, where 39% of auxiliary health staff, 38% of care personnel at the tertiary level, and 35% of medical doctors and other postgraduate health professionals are immigrants. The importance of migration is also reflected in the fact that recent years have shown an annual flow of foreign doctors to Switzerland, which has almost equalled the annual number of Swiss medical school graduates. In 2008, the inflow of foreign doctors even exceeded the number of new Swiss graduates (Ruedin & Widmer, 2010).

This means that, currently, the Swiss health system could not run properly without the contribution of foreign labour. This situation raises questions about the desirability and sustainability of such a dependence on foreign personnel and is an important issue of equity regarding the countries of origin. Indeed, by employing staff from neighbouring countries, Switzerland contributes to a cascade phenomenon and hence to the reduction of skilled health personnel in the poorest countries, located at the other end of the migration chain (Ruedin & Widmer, 2010).

## EU agreement on the free movement of persons

Switzerland has concluded an agreement with the EU on the free movement of persons (ALCP), which entered into force in 2002. With it, the fundamental principles of freedom of movement of persons, as applicable in the EU, have been introduced. This agreement has established the principle of mutual recognition of qualification in a number of professions, including doctors, pharmacists, dentists, nurses and midwives. Since its entry into force, about 16 000 medical diplomas have been recognized, of which more than half are from Germany.

At the same time, to prevent an increase in health-care costs related to an influx of doctors from the EU, the Swiss Parliament introduced a moratorium on the opening of new private practices, subjecting new practices to the proof of need when providing services covered by the compulsory health insurance. The suspension of the measure in late 2011 led to a surge of applications, especially of specialists and foreign doctors. It was, therefore, reintroduced in July 2013 as a temporary measure, pending a more comprehensive solution to avoid both a surplus and a shortage of care offered in different regions of the country. This tool is available to the Swiss cantons, which apply it when necessary and only towards specialists. In addition, physicians who have worked for at least three years in a recognized Swiss training institution are exempt.

On 9 February 2014, the Swiss people voted in favour of a popular initiative "against mass immigration". It is, however, too early at this stage to assess the possible effects of this popular vote on the migration of health personnel.

## Switzerland's international commitment

### Swiss foreign health policy

As part of its first strategy for global health, concluded in 2006, Switzerland has established an inter-ministerial working group to discuss and coordinate issues of health personnel at national and international levels. This group has been actively involved in the preparatory work of WHO's Code of Practice and reported in 2010 the first inventory of the Swiss situation. It

published three studies on recruitment and migration of health personnel (Switzerland. FOPH, 2010a). These studies have provided additional information on the statistics of immigration to Switzerland, hiring practices and cooperation practices implemented in the context of development assistance.

Switzerland has strengthened the cooperation between WHO and OECD on this issue in order to establish a dialogue between industrialized countries – the main beneficiaries of migration - and developing countries, which suffer most from the adverse consequences. Thus, Switzerland assigned a WHO expert to the OECD for a period of two years, which enabled the publication in 2007 of a specific chapter on the migration of health professionals in the OECD report on international migration perspectives (OECD, 2007). This chapter is scheduled to be updated in 2014. In addition, another study was published in 2008 on the relationship between international migration and labour policies on health personnel (OECD, 2008).

The new inter-ministerial strategy for global health ("Swiss Foreign Health Policy"), adopted in March 2012 by the Swiss government, made health personnel one of its priorities, focusing on a partnership approach to ensure sustained recruitment of sufficient numbers of health staff. International migration of health personnel is a complex and dynamic phenomenon, which requires agreed solutions among all stakeholders, both public and private. Foreign health policy is a very valuable tool that should increase the coherence and effectiveness of the Swiss position in the health arena. Ultimately, it should achieve better coordination of domestic policies and foreign policy cooperation, particularly with regard to health personnel.

In this context, Switzerland concluded in May 2013 a country cooperation strategy with WHO (WHO, 2013). It aims to improve the collaboration between WHO and Switzerland in the priority areas identified by mutual agreement, such as health personnel and the implementation of the Code.

### Swiss cooperation practices

A study by the Swiss Tropical and Public Health Institute inventoried the various international cooperation practices of Switzerland in favour of health personnel in low- and middle-income countries (Wyss, Weiss & Stuck, 2010). It shows that Switzerland supports, through development aid, a large number of important initiatives and projects aimed at improving on-site working conditions for health personnel, particularly in Romania and the United Republic of Tanzania. This requires better organization and more rigorous management of health systems in these countries, as well as the investment of resources to encourage the staff to stay in the health system of the country of origin and to take preventive action against the "brain drain". These initiatives are part of the overall goal to strengthen health systems in the countries of origin of migrant staff and are not primarily focused on the fight against the migration of health personnel.

## Monitoring and implementing the Code in Switzerland

While the Code does not constitute a legally binding instrument, Switzerland agreed with its general principles and is committed to putting it into practice. It has designated a national authority to coordinate the monitoring of the Code, and submitted its first report of implementation in June 2012. Extensive education and communication efforts were also conducted to bring the

Code to the attention of the different actors in the health system concerned with this problem. Thus, a website dedicated to the Code (Switzerland. FOPH, 2012a) was created and the Code is also available in German thanks to the combined efforts of Austria, Germany and Switzerland. Other government actions have helped increase the debate nationally. Several consultations were held with CSOs, whose positions were transmitted to WHO along with the submission of the first report of implementation of the Code by Switzerland. This report outlines a number of steps already taken by the country, and identifies challenges for the future.

## Measures taken by Switzerland

In order to move towards greater self-sufficiency, measures have already been taken in recent years in the field of education. Between 2000 and 2010, the student capacity of medical schools was increased by 15%. In late 2011, the Swiss government proposed various measures to fight the shortage of doctors and encourage primary care medicine (Switzerland. FOPH, 2011). Its report stated that 1200 to 1300 physicians should be trained annually to sustain the current volume of health services, which constitutes an increase of approximately 50% compared to the current number of graduates. The Swiss Confederation and the cantons thus agreed to train 300 additional doctors per year starting 2018/2019, increasing the number of medical graduates from 800 to 1100. Launched in 2011, the "Masterplan Family Medicine and Basic Medicine" aims to upgrade and promote the profession of family doctors in universities and strengthen, in general, basic care in Switzerland (Switzerland. FOPH, 2012b). In parallel, the revision of the law on university medical professions (LPMed) aims to improve the position of primary care medicine in university and postgraduate education so that these professions receive higher recognition. Pilot projects have been developed to allow future family physicians to become familiar with their work through internships in private practices.

Developed in 2010, the "Masterplan Training Health Care Professionals" aims to increase training capacity in nursing, and strengthen training for all skill levels, so that staff have qualifications adapted to needs. The State Secretariat for Education, Research and Innovation (SERI), the Federal Office of Public Health, the cantons and health-related organizations are working together to implement the required measures by 2015 (Switzerland. SERI, 2010).

Meanwhile, working groups are seeking, both at cantonal and federal level, new forms of collaboration and division of roles within the health workforce. Thus, the FOPH and the Swiss Conference of Cantonal Directors of Public Health (CDS) (Switzerland. FOPH & SCCDPH, 2012) jointly published a report on new models of care in primary care medicine. These models can improve collaboration between occupational groups, particularly in the division of labour, and thereby maximize the use of skills. A platform called "The Future of Medical Education" was established in 2010, in collaboration with various partner organizations to address issues such as inter-professionalism (Switzerland. FOPH, 2010b). A national concept, "Palliative Care and Training", was also approved in 2013 (Switzerland. FOPH, 2013b).

These initiatives are in line with the overall strategy "Health2020", which the Swiss government approved in January 2013 (Switzerland. FOPH, 2013a). Covering the entire health system, "Health2020" includes 36 measures aimed at ensuring quality of life, strengthening equal opportunities, improving quality of care and transparency. These measures will be gradually implemented over the next few years, in collaboration with the main stakeholders. The goals are to get the Swiss health system in good shape to meet future challenges, to ensure that

costs remain financially sustainable, and also to ensure that, in future, Switzerland has the necessary health staff with the appropriate education to meet the needs of the population.

### Challenges in implementing the Code

Given the above explanations and to meet the challenge of an aging population, Switzerland will have to continue its efforts in education while making certain professions more attractive, for instance, in the field of family medicine.

Moreover, it is still difficult to get an overview of the situation despite the improved state of knowledge on health personnel with the existence of many public and private databases. The information collected is often partial and specific to one health sector or profession. Data on the level of qualification and education of the country are also fragmented. Statistics and records are being developed to improve the integration of information on the migration of health personnel. Thus, the "Masterplan Training Health Care Professionals" aims to identify the number of health workers who hold a foreign degree. For its part, the Federal Statistical Office plans, in the context of the revision and development of statistics on health-care providers (inpatient and outpatient), to integrate more accurate and comparative variables of occupation, nationality and the origin of diplomas. In the longer term, the establishment of systematic and transparent nationwide monitoring is one of the first conditions in shaping future options for the health system. This is also in line with the recommendations of OECD and WHO (OECD, 2011).

Due to its economic standard of living and given the agreement on the free movement of persons concluded with the EU, Switzerland will presumably continue to attract health workers from abroad in the coming years without necessarily recruiting actively. Therefore, to reflect the principle of "mutuality of benefits" as established by the WHO Code, it is important that Switzerland explore new forms of international cooperation with countries whose health systems are already weakened by staff shortages.

It might also consider supporting training institutions in certain developing countries. In addition, exchanges of health personnel could be organized by means of agreements on the exchange of young professionals, which Switzerland has already reached with several countries. These agreements encompass all sectors of the economy and are aimed at people who have completed the training in their country of origin and wish to acquire knowledge abroad. While young foreign doctors and nurses already benefit from this framework and come to work temporarily in Switzerland, these agreements could also be beneficial for young Swiss graduates who wish to gain international experience.

## Conclusion

Switzerland has made health personnel a priority of its foreign health policy as well as its "Health2020" strategy, and plans to implement the Code in collaboration with all relevant partners. Having taken measures in the field of domestic training for several years, Switzerland strives to reduce the demand for foreign health professionals and hence to decrease one of the main pull factors.

The objective is to reduce Switzerland's current foreign dependence and gradually move towards greater self-sufficiency. This is generally regarded as an important measure in fighting the global

crisis of health human resources. Meanwhile, the Swiss development cooperation will continue its commitment to strengthen health systems in the countries of origin of migrants and thus act on the push factors. The migration of health professionals is in fact a consequence of a larger issue arising from the insufficient number of trained people, the difficulty of retaining professionals at work, and unequal geographical distribution. Therefore, Switzerland hopes to contribute to the solution by addressing the issue at the source of the migration phenomenon. In the longer term, these measures should strengthen strategic and coordinated planning of the health workforce, as recommended by OECD and WHO in their above-mentioned report.

Finally, in general, it is important to continue the current initiatives while assuring a dialogue and a spirit of cooperation among all key partners, both nationally and internationally, in order to meet these challenges together.

**References**

Commonwealth Fund (2010). General population 2010 survey. New York, NY. http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx

OECD (2007). International migration outlook, Part III. Paris: Organisation for Economic Co-operation and Development.

OECD (2008). The looming crisis in the health workforce: how can OECD countries respond? Health Policy Studies, Paris.

OECD (2011). OECD reviews of health systems: Switzerland, 2011. Paris.

Ruedin HJ, Widmer M (2010). L'immigration du personnel de santé vers la Suisse (Obsan Rapport 39), Neuchâtel: Observatoire suisse de la santé.

Switzerland. FOPH (2010a). Journée de travail de la politique nationale de la santé consacrée au recrutement et à la migration du personnel dans le domaine de la santé. Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/internationales/11287/11326/11330/index.html?lang=fr

Switzerland. FOPH (2010b). Plate-forme: avenir de la formation médicale. Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/berufe/11724/index.html?lang=fr

Switzerland. FOPH (2011). Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours. Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/berufe/13932/13933/14201/index.html?lang=fr

Switzerland. FOPH (2012a). Migration of Health Personnel, WHO Global Code of Practice on the International Recruitment of Health Personnel. Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/internationales/11103/11513/11607/index.html?lang=en

Switzerland. FOPH, (2012b). Masterplan « médecine de famille et médecine de base». Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/berufe/13932/13933/14198/index.html?lang=fr

Switzerland. FOPH (2013a). "Health2020". A comprehensive health care strategy. Berne: Federal Office of Public Health. http://www.bag.admin.ch/gesundheit2020/index.html?lang=en

Switzerland. FOPH, (2013b). Projet Formation de la Stratégie nationale en matière de soins palliatifs 2013–2015. Bern: Federal Office of Public Health. http://www.bag.admin.ch/themen/gesundheitspolitik/13764/13772/index.html?lang=fr

Switzerland. FOPH, SCCDPH (2012). Nouveaux modèles de soins pour la médecine de premier recours. Bern: Federal Office of Public Health and Swiss Conference of Cantonal Directors of Public Health. http://www.gdk-cds.ch/fileadmin/docs/public/gdk/Aktuelles/MMtlg/BT_Versmod_pub_20120402_f.pdf

Switzerland. SERI (2010), Masterplan "Formation aux professions de soins". Bern: State Secretariat for Education, Research and Innovation. http://www.sbfi.admin.ch/berufsbildung/01539/01541/index.html?lang=fr

WHO (2013). Signature d'une stratégie de coopération entre l'OMS et la Suisse. Geneva: World Health Organization. http://www.euro.who.int/fr/who-we-are/regional-director/news/news/2013/05/who-and-switzerland-sign-country-cooperation-strategy

Wyss K, Weiss S, Stuck C (2010). Swiss contributions to human resources for health development in low- and middle-income countries. Bern: Federal Office of Public Health and Swiss Agency for Development and Cooperation. https://team.swisstph.ch/share/s/UGkr98JYQQOCgRQo8BFh9g

CHAPTER 7

# Monitoring trends in international migration of health personnel: A critical review of existing data sources

JEAN-CHRISTOPHE DUMONT

GAETAN LAFORTUNE

PASCAL ZURN

©WHO/Gulio de Struco

Medical records register, Nepal.

The international migration of doctors, nurses and other health workers is not a new phenomenon but has drawn increasing attention in recent years following the adoption of the WHO Global Code (WHO, 2010). Both developed and developing countries face big challenges in responding to the growing demand for health professionals.

Previous work undertaken by the OECD and WHO has shed new light on the causes and consequences of the international mobility of doctors and nurses (OECD, 2007; OECD, 2008; OECD/WHO, 2010). In general, countries that have more migration, and notably more migration of highly skilled workers, tend to have more migrant health workers.

Part of the increases in migration of health workers occurring in certain OECD countries before the economic crisis can also be explained by the fact that migration was used as a "quick fix" to address unanticipated health workforce needs in the receiving countries, because training extra doctors and nurses takes many years to have an effect. How these migration flows develop in the future will largely depend on the combination of human resource development and management policies, and the migration policies adopted by receiving countries.

Improving information on health workforce migration should be viewed as only one component of a broader effort to improve information on health workforce development and management more generally. Collecting more and better information on migrant health workers would be of little use if it were not complemented by other efforts to improve information on domestic workers, the distribution of health personnel across specialties and regions, their employment status, and the capacity of the education system to train more health workers[1].

This chapter aims to contribute to efforts to guide discussions between countries, international organizations and other stakeholders towards the development and collection of a minimum dataset to monitor the international migration of health personnel.

It first introduces basic principles for the monitoring of international migration of health personnel, bearing in mind the key criteria of relevancy to both countries of origin and receiving countries, and the feasibility of regular data collection. It then reviews the available data sources in OECD countries (including work permits, recognition of foreign credentials and licensing,

1 See for example Dal Poz, et al. (2009).

professional registers, specific surveys of health personnel, labour force surveys and population censuses) that can be used for monitoring health workforce migration, providing an overview of their main strengths and limitations. Lastly, the chapter summarizes the results of the evaluation process and identifies possible options for the regular monitoring of health workforce migration, taking into account feasibility and cost constraints.

## Monitoring international migration of health personnel

Improving the availability and comparability of statistics on international migration of health workers is needed to inform policy debates at both the national and international levels and to evaluate the impact of any policies and programmes put in place to affect migration patterns. The main destination countries have the capacity to provide origin countries with useful and updated information in this regard.

### Addressing the information needs for both origin and destination countries

While health workforce migration is a particular concern to countries that are losing some of their skilled workforce to other countries, *emigration* statistics are scarce in most countries and usually not reliable. Statistics on exits are in fact available only in a limited number of countries and generally not by occupation. More specifically, information on de-registration in health professional registries is usually not available by main motivation and in any case, most emigrants choose not to de-register in their country of origin, so as to keep their return migration option fully open.

All people who plan to leave their country of origin in order to work as doctors or nurses in another country have to produce a certificate of good standing and proof of registration in their own country. This information is sometimes used to estimate the emigration *potential* (the number of people who plan to leave their country), but available evidence shows that there is a large gap between the intention to emigrate and actually doing so. This gap can be explained, for example, by difficulties in finding a job or in getting one's qualification recognized in the destination country.

Working to improve emigration data availability and quality may be one option to monitor migration patterns, but it is unlikely that it would be easy or cheap, not only because many technical problems would have to be addressed, but also because data would have to be collected in *all* origin countries, worldwide.

The approach that seems most promising and feasible in the short term to track health workforce migration on a regular basis, is to use sources from destination countries. Through collecting data from destination countries by country of origin and aggregating these data across destination countries, it should be possible to produce estimates on the total movements of health personnel by country of origin[2]. However, the aggregation process requires that data are available and comparable across receiving countries. The work recently carried out by the OECD and WHO has shown that data available on doctors and nurses migrating in OECD countries

2 Information from destination countries by country of origin will, however, in most cases not cover persons who were trained as health workers in their country of origin but failed to enter the health workforce in the destination country. For many reasons, including a lack of proficiency in the language of the host country, non-equivalence of competencies and skills or because of barriers to entering the health workforce, this situation is not uncommon in most OECD countries. Evidence is unfortunately not widely available across OECD countries but it tends to point to a large mismatch between initial qualifications of migrant health workers and their labour force status in the receiving country.

are currently limited in terms of availability and comparability due to differences in definition, type of source, coverage and periods of reference. Hence, there is a crucial need to develop and harmonize the data sources.

The immigration flows of health workers tend to be concentrated in a limited number of OECD and non-OECD destination countries. Consequently, improving the data collection in these countries is particularly important as this can go a long way towards meeting the ultimate goal of monitoring health workforce migration.

## Defining migration

According to the UN Recommendations on Statistics of International Migration (revised in 1998), *long-term* international immigration is recorded after an individual enters a country and establishes his/her usual place of residence there for one year or more. The UN definition of *short-term* immigration is when the period of residence is limited to between three months and one year[3].

Applied to health workforce migration, these definitions raise the issue of whether a minimum duration of stay in the receiving country should be considered. Following UN definitions, persons with stays shorter than three months are not supposed to be included in international migration statistics. Obviously, this excludes commuting and cross-border migration, important components in some countries. Depending on the type of data source considered for producing the minimum dataset proposed below, a more precise time threshold may have to be discussed in order to ensure international comparability.

Migration patterns can be measured based on *nationality, place of birth, or place of education/training*. The first approach, based on nationality, faces a number of shortcomings. Firstly, foreigners disappear from the statistics when they are naturalized. The take-up of citizenship varies greatly among immigrants in OECD countries. In countries that have largely been settled by migration (Australia, Canada and New Zealand), virtually all regular immigrants naturalize within 10 years of arrival, while on average in other OECD countries citizenship take-up is only slightly over 50% (OECD, 2010). Secondly, in several OECD countries, many people who were born and raised in the country hold a different nationality. There is, therefore, no systematic link between migration and nationality.

The second approach, based on the place of birth, is more meaningful because when the country of birth differs from the country of residence, it implies that the person did cross a border at some point in time[4]. One problem may occur, however, with persons who were nationals born abroad (e.g. repatriates from Algeria in France or from Angola and Mozambique in Portugal; or children of expatriates) that one might want to distinguish as a separate migrant category.

However, the main question that arises to evaluate the impact of highly skilled migration on origin countries is where education took place. Some foreign-born people arrived at younger ages, most probably accompanying their family or in the context of family reunification, while others came to the country to pursue tertiary education and have stayed after completion of their study. In this context, most of the cost of education will have been supported by the

3 Except in cases where the movement to that country is for purposes of recreation, holiday, visits to friends and relatives, business, medical treatment or religious pilgrimage.

4 Problems, however, arise in cases where borders changed over time, like in the case of the former Soviet Union or the former Czechoslovakia.

receiving country, and/or by the migrants themselves, but not by the country of origin. One way to overcome this problem is to consider migrants according to their place of training instead of their place of birth.

The third approach, based on the place of education/training, is probably the most relevant from a policy perspective, although it does raise a number of measurement issues. These are complicated by the fact that nursing and medical education and training can be very long and go through different stages.

In fact, the definition of the place of training varies according to the data source and across countries. For example, in Canada and the United States, IMGs and Internationally Educated Nurses (IEN) are identified based on the country where their medical school or the nursing school was located, but this does not take into account the place where postgraduate training occurred. Another approach is to consider the country where the most advanced certificate, diploma or degree was obtained. This definition is usually used in censuses and surveys when this information is collected. In this case, doctors who were fully licensed in another country, but had to redo all or part of their postgraduate training to get fully registered (a frequent situation in OECD countries) could be identified as trained in the host country. Similarly, a nurse completing her specialized qualification in the host country might not be classified as foreign-trained even if she completed her initial nursing education abroad.

Further difficulties may arise when looking at foreign-trained workers. Some countries do not have a medical school but have agreements with other countries to train their doctors. This is the case, for example, for Luxembourg with neighbouring countries, or Cape Verde with Portugal. In these cases, it would be misleading to interpret emigration from the country of qualification as a loss, because return migration is part of the initial agreement. A similar situation occurs with international medical students going abroad to get their medical education, usually paying themselves to circumvent obstacles to access medical education in their own country. This is an increasing phenomenon illustrated by the temporary migration of American students to the Caribbean, of Canadian students to Europe, of French students to Belgium and more recently to Romania, or of German students to Austria and, increasingly, to Hungary and the Czech Republic. When these individuals go back to their country of origin, they are identified as foreign-trained and the loss is attributed to the country of training. This may not measure accurately the "brain drain".

Despite these limitations, the information on foreign-trained workers still seems to be the most appropriate in the context of the international mobility of health professionals, precisely because it incorporates jointly the migration and the education history. This implies, however, the need to reach some agreement on who will be identified as "foreign-educated/foreign-trained".

In practice, to avoid losing information on too many migrant health workers (who had to redo part or all of their postgraduate training in the receiving country), it seems more appropriate to identify them based on the place where they took their initial training (medical school or nursing school). Ideally, this information should be linked to additional variables related to the place of birth or the country where the most advanced qualification was obtained, in order to take better account of some of the special cases mentioned above.

## Review of potential data sources

Migrant health workers have to go through various steps before being authorized to enter and practice in another country. The first requirement is usually to obtain residence and a work permit. Those who enter through labour migration streams will have to declare their occupation. Those who enter under family and humanitarian streams may be asked to indicate their intended occupation although this is certainly not systematic. The same applies to permanent immigrants who enter under specific highly skilled migration programmes. The information collected on work and residence permits may, therefore, be one of the data sources that can be used to monitor international migration.

One key stage in health workers' migration process is the recognition of foreign qualifications. Basic documents such as certificates of good standing or proof of registration in the country of origin need to be provided. In many cases, migrants have to take language tests, professional examinations or may need to follow bridging courses before they are fully authorized to practice. Those who were fully trained in the country of residence also need to be licensed, although the process is quite straightforward once final exams are passed. The licensing process (including the recognition of foreign qualifications for foreign-trained health workers) is, therefore, another potential source of information to monitor entries in the health workforce.

With a licence to practice, registration in the relevant professional register is usually the next step. This is one of the key data sources for analysing the health workforce, although it may not be systematically available and may face a number of shortcomings. In order to collect data that are more specific on key characteristics of health workers, several OECD countries undertake regular surveys of the health workforce. These surveys prove to be useful for collecting more information and analysing health workforce management policies.

More general labour force surveys and population censuses are carried out in all OECD countries, but with different degrees of frequency. These sources may also provide some information on the international migration of health workers.

This section reviews, one by one, the above-mentioned potential data sources. Each sub-section follows the same structure, starting first with a presentation of the advantages and limitations of the data source followed by specific country examples or cross-country overviews.

## Work permits

Except within free movement areas, migrants intending to move to another country to work or settle usually need to apply for and be granted a work permit. Data on work permits can therefore be a potential source for monitoring the international migration of health workers. The immigration authority of each receiving country collects these administrative data. Depending on the immigration policy in each country, different types of work permits can be issued (e.g. temporary or permanent permits), and different policies apply for the renewal of these permits.

### Advantages of using work permits

The main advantages of this data source are:

- The immigration authority in all countries centrally administers work permit data. Basic variables, such as sex, age and nationality, are usually collected.

- Data based on work permits can be used to monitor the annual *inflows*, although they need to be combined with some other source if one of the aims is to measure the relative proportion of new doctors and nurses who are foreign-trained versus those who are domestically trained.

## Limitations in data availability and comparability of work permits

The main limitations of this data source are:

- Not every migrant needs a work permit. Those who enter under family migration or humanitarian categories or through highly skilled migration programmes may indeed be entitled to work in the country without a specific authorization. In some countries, the intended occupation is recorded but this is not systematic and not necessarily reliable. Furthermore, the issuance of work permits is only applicable outside of a free-movement region, as work permits are not required within such areas (e.g. the EU or other regions with bilateral agreements, such as Australia and New Zealand). Finally, people who are naturalized or in most cases, those who get married to a national, do not need a residence or work permit and, therefore, disappear from migration statistics. Consequently, data on work permits imperfectly record total entries by occupation.
- In principle, it should be possible to make a distinction between the issuing of a first work permit and its renewal but, in practice, this information is not always readily available. In some cases, such migration statistics record entries in the country rather than permits granted.
- Work permits data do not give information on the stock of migrant health workers. Maintaining a database on the number of currently valid work permits would necessitate keeping track of all status changes from one category to another as well as the expiration of permits. It would, in addition, require a combination of data on actual entries (as some work permit holders may enter with some delay or not at all) and exits (some people may overstay and continue working after the expiration of their work permit). In practice, few countries are able to do this, and not for detailed occupations.
- The differentiation between temporary and permanent permits also further complicates the monitoring, as countries have different definitions regarding the duration of the permits. Adding both permit types does not necessarily give the total migration.
- Work permits also generally do not provide information on the location of education and training, so the information relates mainly to foreign-national health workers. Some migrants who have studied in the destination country may be entitled to apply for a work permit. These individuals are included as migrants although they were trained domestically. Conversely, foreign-trained nationals would not need a work permit. This applies, for example, in the case of American students studying in Caribbean countries, who do not need authorization to come back to the country.

## Country examples

In Australia, it is possible to compare annual inflow data based on work permits with those from surveys of health personnel (which is linked to the registration renewal process). Figure 6 shows the comparison for nurse migration. Data on permanent migrant nurses from the Department of Migration and Multicultural Affairs are very close to the data from the Nursing and Midwifery Labour Force Survey for one year (2007), whereas the difference is larger for other years (2004 and 2005).

In Switzerland, the permit data of the Swiss Federal Migration Office can be compared to data provided by the Swiss Red Cross, which is the authority administering the recognition of foreign qualifications. This comparison shows that the numbers of permit data are consistent with those derived from people seeking the recognition of their foreign credentials (Figure 7). As there is no central registry system in Switzerland which would provide information on the number of newly registered foreign-trained nurses, it is not possible to make this additional comparison of how many eventually obtained registrations and ended up practising.

Data for Canada, on the other hand, show quite different patterns between permit data and registry data in relation to doctors (Figure 8). This suggests that a large number of foreign doctors have not realized their intention to move to Canada and be registered as a doctor there.

Figures 6–8 show data for nurse and doctor migration in selected OECD countries, based on work permits and other sources.

FIGURE 6

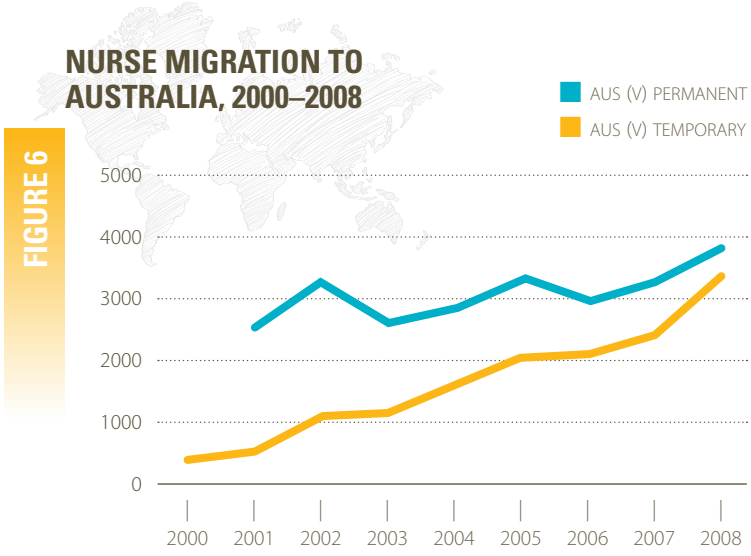



FIGURE 7

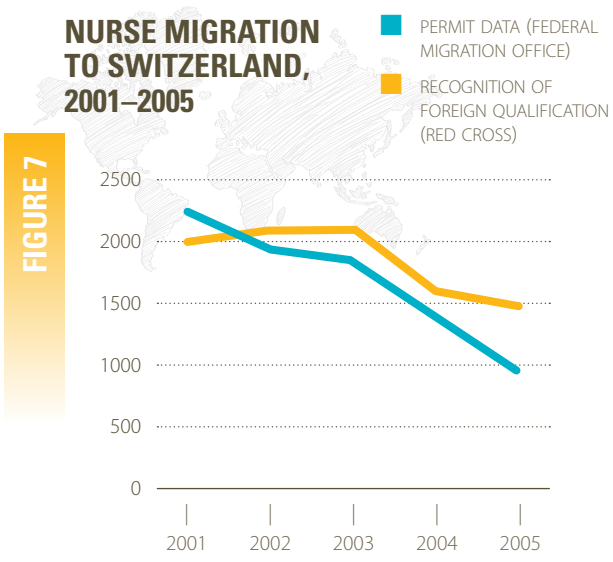
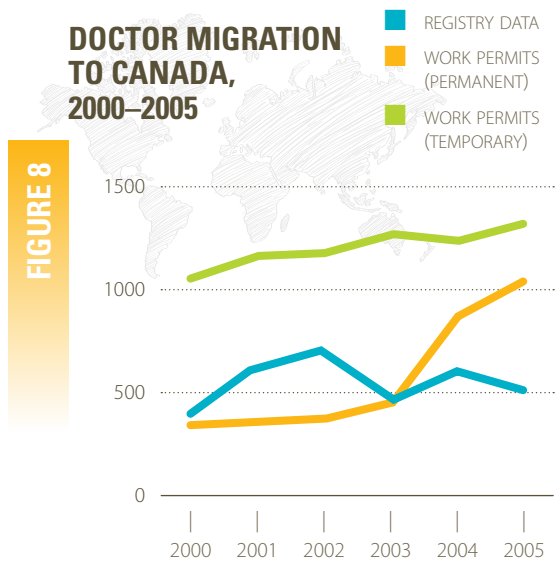



FIGURE 8



## Recognition of foreign credentials and licensing

The law always requires licensing for health professionals. The ministry of health or a commissioned licensing board most often grants the licence. It is compulsory in order to ensure patient safety and ethical standards of practice are respected. The recognition of foreign qualifications, by which a receiving country validates the credentials (education and job experience) of migrant health workers before granting them the right to practice, is part of the licensing process for foreign-trained health workers. In some countries, foreign-trained workers need to pass specific national exams. Various institutions take part in the licensing process depending on the country. Counting migrants who successfully go through the licensing process can therefore be used to derive useful information to monitor international health-worker migration.

### Advantages of using recognition of foreign qualifications and licensing

The main advantages are:

- As all health professionals have to be licensed, monitoring the number of new licences granted to domestically trained and foreign-trained people who had their qualification recognized could provide a comprehensive picture of those who are newly entitled to practice. It is, therefore, a valid instrument for monitoring the annual *flows* of migrant health workers.
- Licensing data should be easily available and comparable for a relatively large number of countries, including middle- and low-income countries.
- Information on country of education/training is systematically collected.

### Limitations in data availability and comparability of recognition of foreign credentials and licensing

The main limitations are:

- Recognition of foreign qualifications does not necessarily always imply migration. For example, health workers may submit a request for recognition of foreign qualifications, but abandon their migration project because they fail to pass the language proficiency test or for personal reasons. Conversely, in some OECD countries, it is possible to practice under supervision without the full recognition of qualifications.
- Recognition of foreign qualifications can be a lengthy process; there may be several years between when the migrant health worker leaves the country of origin and when a licence to practice is granted. The process for recognition of foreign qualifications varies across countries and, in some cases, may imply special exams and/or a need to redo part or all of postgraduate training. In other cases, notably in the EU, there are agreements for mutual recognition of foreign qualifications, which, as a result, create a relatively straightforward and quick process. The delay, therefore, varies significantly across countries, which casts doubts on the international comparability of the data and the possibility to aggregate them by countries of origin.
- Monitoring the granted recognition of foreign qualifications does not provide information on the *stocks* of health workforce migrants. Additional information on secondary migration (emigration to a third country or return migration) would be needed.

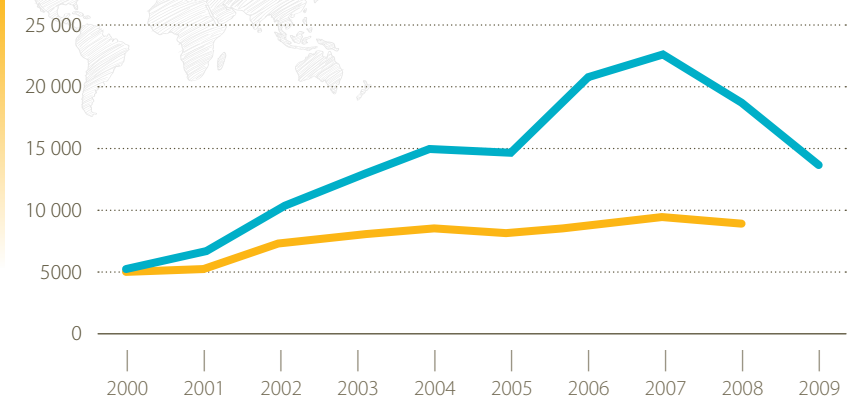
- As this source only covers selected health occupations subject to regulation, this approach might be difficult to expand to non-regulated occupations. In addition, the number of regulated occupations may vary across countries and over time within countries.
- Data accessibility and dissemination will greatly depend on the existence of a body that centralizes and harmonizes data from the requests for recognition of foreign qualifications at national level.

## Country example: United States

In the case of the United States, foreign-trained health professionals first need to get their qualifications accredited by an authorized body, such as the Educational Commission for Foreign Medical Graduates (ECFMG) before they are eligible to take the national state examination along with domestically trained candidates. Figure 9 depicts the annual number of foreign-trained nurses and doctors passing the final required exam in order to be permitted to practice nursing or medicine in the United States. Data are usually available broken down by country of education. Citizens from the United States who obtained their qualification overseas, such as in Caribbean countries, would therefore appear as part of the foreign-trained population. IMGs are here defined as those graduating from a non-American and non-Canadian medical school (given that graduates from Canadian universities do not have to take the exam for IMGs).

FIGURE 9

**FOREIGN-TRAINED NURSES AND DOCTORS PASSING EXAMS IN THE UNITED STATES, 2000–2009**




* International medical graduates of non-American and Canadian schools.

Source: National Council of State Boards of Nursing (NCSBN), United States.

## Professional registries

When there is a professional registry, registration is usually compulsory in order to practice. Medical or nursing councils often administer the registries. In some cases, medical or nursing associations maintain registries, in which case the membership is most likely voluntary. The registers are a valuable data source particularly on doctors and nurses.

### Advantages of using professional registries

The main advantages are:

- Registries are in place in a large number of countries worldwide; but registry data are less readily available for nurses compared to doctors (e.g. Germany and Switzerland do not have a registry for nurses).
- In nearly all countries where they exist, registries enable the identification of migrant health workers. Indeed, many registries provide information on the country of first qualification and sometimes of last specialization.
- Registries usually include other variables of interest such as demographic variables (age and gender), the year of registration, the registration status, and information on specialization.
- Registries permit monitoring of both *flows* (in and out of the registry) and *stocks* of health workers.

### Limitations in data availability and comparability of professional registries

The main limitations are:

- Registration data do not always reflect the actual entry of the foreign-trained health personnel in the country or actual exit out of the country. In some cases, health personnel are already in the country before being officially registered (see above for a similar argument for licensing), whereas in other cases, health personnel can be included on the register of a country while living in another country.
- Registries do not always provide the required information to distinguish between active/practising and inactive/non-practising doctors and nurses. In some cases, non-practising health workers can still be in the register.
- In some countries, registries only collect information on foreign citizens, instead of the foreign-trained (see Table 8).
- There are different types of registration status in each country (full, temporary, limited, provisional, and conditional). In addition, there are differences across countries in whether registries of doctors include interns/residents or not. Some harmonization in the definition and coverage would therefore be needed to obtain a more accurate aggregation of registry data of foreign-trained doctors by country of origin.
- Multiple registrations in countries when the registry is not centralized, or between countries, may also be a source of concern. In addition, double counting of the same doctor with multiple specializations may occur, unless there is a proper mechanism to avoid this problem.

## Cross-country examples of use of registry data to monitor health workforce migration

### FOREIGN-TRAINED (OR FOREIGN) NURSES AND DOCTORS IN SELECTED OECD COUNTRIES, BASED ON PROFESSIONAL REGISTRIES

TABLE 8

| Nurses | | | | |
|---|---|---|---|---|
| | Year | Number | Share (%) | Sources |
| **Foreign-trained** | | | | |
| Finland | 2008 | 530 | 0.5 | National Supervisory Authority for Welfare and Health (Valvira) |
| Netherlands | 2005 | 3479 | 1.4 | BIG Register (Beroepen in de Individuele Gezondheidszorg) |
| Sweden | 2007 | 2585 | 2.6 | Swedish National Board of Health and Welfare |
| United States | 2004 | 100 791 | 3.5 | National Council of State Boards of Nursing (NCSBN) |
| Denmark | 2005 | 5109 | 6.2 | National Board of Health, Nursing Adviser |
| Canada | 2007 | 20 319 | 7.9 | CIHI Workforce Trends of Regulated Nurses in Canada |
| United Kingdom | 2001 | 50 564 | 8.0 | Nursing and Midwivery Council |
| New Zealand | 2008 | 9895 | 22.1 | Ministry of Health/Nursing Council of New Zealand |
| Ireland | 2008 | 37 892 | 47.1 | An Bord Altranais |
| **Foreign** | | | | |
| Belgium | 2008 | 2271 | 1.5 | Federal Public Service Health, Food Chain Safety and Environment |
| France | 2005 | 7058 | 1.6 | DREES, ADELI |
| Portugal | 2008 | 2037 | 3.6 | Ordem dos Enfermeiros |
| Italy | 2008 | 33 364 | 9.4 | Federazione Ipasvi |
| **Doctors** | | | | |
| **Foreign-trained** | | | | |
| Poland | 2005 | 734 | 0.6 | Polish Chamber of Physicians and Dentists |
| Austria | 2008 | 1556 | 4.1 | Austrian Medical Chamber |
| France | 2005 | 12 124 | 5.8 | Ordre des Médecins |
| Denmark | 2008 | 1282 | 6.1 | National Board of Health, Labour Register for Health Personnel |
| Netherlands | 2006 | 3907 | 6.2 | BIG Register (Beroepen in de Individuele Gezondheidszorg) |
| Belgium | 2008 | 2 89 | 6.7 | Federal Public Service Health, Food Chain Safety and Environment |
| Finland | 2008 | 2713 | 11.7 | National Supervisory Authority for Welfare and Health (Valvira) |
| Canada | 2007 | 14 051 | 17.9 | CIHI, SMDB Scott's Medical Database |
| Sweden | 2007 | 6034 | 18.4 | Swedish National Board of Health and Welfare |
| Switzerland | 2008 | 6659 | 22.5 | FMH Swiss Medical Association |
| United States | 2007 | 243 457 | 25.9 | American Medical Association |
| United Kingdom | 2008 | 48 697 | 31.5 | General Medical Council |
| Ireland | 2008 | 6300 | 35.5 | Irish Medical Council |
| New Zealand | 2008 | 4106 | 38.9 | New Zealand Ministry of Health, Information Directorate |
| **Foreign** | | | | |
| Slovak Republic | 2004 | 139 | 0.8 | Ministry of Health of Slovak Republic |
| Japan | 2008 | 2483 | 0.9 | Statistic Bureau, Ministry of Internal Affairs and Communication |
| Greece | 2001 | 897 | 2.5 | General Secretariat of the National Statistical Service of Greece |
| Italy | 2008 | 14 747 | 3.7 | AMSI Associazione Medici di Origine Straniera, based on ENPAM |
| Germany | 2008 | 21 784 | 5.2 | Bundesärztekammer |
| Portugal | 2008 | 4400 | 11.1 | Immigration Observatory, ACIDI, I.P. |
| Norway | 2008 | 3172 | 15.9 | Den Norske Legeforening |

## Surveys of health personnel

In some countries, such as Australia, Canada and New Zealand, the ministry of health or other bodies regularly conduct (or commission) surveys on health personnel, usually separately for physicians and nurses. These surveys can provide a broad set of data on the education, migration and employment of physicians and nurses. However, there are variations across countries in the method used to select the sample, in the way the information is collected on migration-related issues, and in the frequency of these surveys (ranging from annual surveys in Australia and New Zealand, to once every three years for doctors in Canada).

### Advantages of using surveys of health personnel

The main advantages are:

- Surveys can collect information that is more detailed on *employment and working conditions* than most other sources, including whether doctors and nurses are active or inactive, and additional information on practice types, working hours, etc.
- Surveys also collect more information than most other sources on the *education and training* of doctors and nurses, generally seeking information on the country where they have obtained their first medical/nursing degree, thereby allowing a good measure of the number and share of foreign-trained.
- When surveys are integrated into the registration process, as in Australia where health personnel are given questionnaires at the time of their annual registration renewal, they can be easily implemented, with a high response rate, and at a relatively low cost.
- Surveys are well suited to monitor the total *stock* of foreign-trained and foreign-born doctors and nurses. Existing surveys in Australia, Canada and New Zealand also provide a measure of the annual *flows* because they seek information on the year of entry into the registry.
- In addition to providing the necessary information to respond to a minimum dataset, surveys of health personnel can also provide some useful complementary information on the employment and education history of doctors and nurses that might be used to analyse internal and international migration.

### Limitations in data availability and comparability of surveys of health personnel

The main limitations are:

- Data availability based on this source is limited because only relatively few countries are currently implementing such surveys on a regular basis. This may be due to the complexity and cost of conducting such surveys.
- As conducting and processing survey data takes more time than extracting data from other existing sources (e.g. professional registries), the results can only be provided with a time lag (usually at least one year after the survey). Another time-related issue is the frequency of surveys. As already noted, in Canada, the physician survey is only carried out once every three years. This restricts data availability.
- An important issue with surveys are *non-response rates*, and the statistical bias they may introduce if the non-respondent population does not have the same characteristics as the respondents. Surveys are generally carried out on a voluntary basis, and response rates vary across countries, depending on the method used. For example, the response rate in the Canadian National Physician Survey was only 32% in 2007, while it reached 70% in the

Australian Medical Labour Force Survey in 2007, and 87% in the Medical Council Workforce Survey in New Zealand in 2008. Some additional statistical work may be needed to assess the impact of non-response rates on how representative the survey results are and, if problems are detected, to make necessary adjustments.

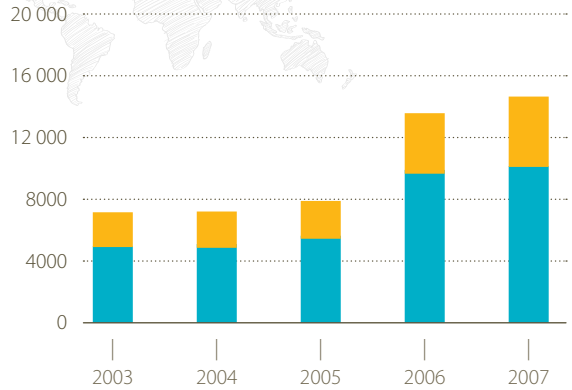
- Another possible limitation exists when occupational associations carry out surveys where membership is voluntary. The Canadian National Physician Survey, for example, is based on contact addresses from the Canadian Medical Association (CMA) Membership System as well as the College of Family Physicians Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) membership databases. As membership of such bodies is voluntary, the use of data might result in a lack of representativeness of the survey if the membership itself is not representative of the entire population of doctors.

## Country example: Australia

In Australia, the Medical Labour Force Survey and the Nursing and Midwifery Labour Force Survey are generally carried out every year under the coordination of the Australian Institute of Health and Welfare (AIHW). The surveys are sent out at the time of registration renewals by the medical and nursing boards of each state and territory. There is agreement on core questions of the survey throughout all regions, but there are some variations in non-core questions and the format of the questionnaires. Figures 10 and 11 show some of the data available from these surveys.

FIGURE 10

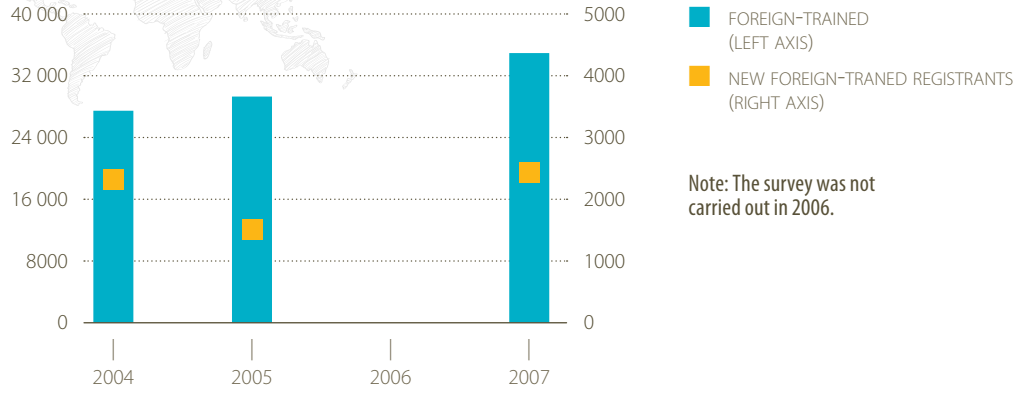
**EMPLOYED FOREIGN-TRAINED MEDICAL PRACTITIONERS IN AUSTRALIA, 2003–2007**




Note: The reason for the large increase in the number of foreign-trained doctors from 2005 to 2006 is not known.

FIGURE 11

## EMPLOYED FOREIGN-TRAINED REGISTERED NURSES IN AUSTRALIA, 2004–2007




Note: The survey was not carried out in 2006.

Source: AIHW Australian Nursing and Midwidery Labour Force Surveys, 2003–2007.

The questionnaires are designed differently for doctors and nurses. Whereas the question on the time of first registration is not asked in the Medical Labour Force Survey, the Nursing and Midwifery Labour Force Survey can provide flow data as it identifies new registrations of foreign-trained nurses. On the other hand, a detailed breakdown of foreign-trained personnel by citizenship and residence status is only possible in the Medical Survey.

## Labour force surveys

Labour force surveys (LFS) are conducted on a regular basis in OECD countries and in many low- and middle-income countries. They are designed to collect data on labour market participation, covering all sectors and all occupations in the economy.

In Europe, the European Union LFS (EU LFS) is available on a quarterly basis in all EU Member States, three countries of the European Free Trade Association (EFTA), and candidate countries to the EU. National statistical institutes are responsible for selecting the sample, preparing the questionnaires, conducting the interviews, and forwarding the results to Eurostat in accordance with a common coding scheme. Consistency in EU LFS results are achieved by using the same concepts and definitions (following ILO guidelines) and common classifications (NACE Rev. 2, ISIC, ISCO, ISCED[5]) (Eurostat, 2010).

In non-European countries, national LFS are also generally consistent with international definitions and classifications (or it is possible to map national classifications with international classifications). In three OECD countries (Chile, Japan and the Republic of Korea), LFS do not permit migrants to be distinguished.

5 NACE Rev. 2 is the statistical classification of economic activities in use in the EU. ISIC is the International Standard Industrial Classification. ISCO is the International Standard Classification of Occupations. ISCED is the International Standard Classification of Education.

### Advantages of using LFS

The main advantages are:

- Given that LFS are already carried out on a regular basis in most countries, their use may involve less cost than setting up a specific survey of health personnel.
- Compared with other potential sources such as work permits, LFS have the advantage of clearly identifying people who are *active* in the labour market in the country to which they have migrated. They also provide a lot of additional information on their employment conditions.
- LFS can provide some information on the stock and recent migration. For instance, in the EU LFS, the *stock* of immigrant workers can be measured by using the questions on nationality and place/country of birth, while information on *flows* can be obtained from the question on the place/country of residence one year before the survey.

### Limitations in data availability and comparability of LFS

The main limitations are:

- Since the LFS aim to cover *all* sectors and *all* occupations, only a limited number of observations are available for each occupation. An additional (minor) issue is that nurses are grouped with midwives at the 3-digit level in ISCO-08; a disaggregation at the 4-digit level is required to differentiate nurses from midwives.
- There is a problem of small sample size to identify migrant groups in specific occupations. For most EU countries, breaking down figures for total foreign-born employed doctors or nurses by detailed country of origin will not be possible without breaking the reliability threshold.
- Some research has found a high level of discrepancy when comparing EU LFS data on *flows* with those from censuses or population-based registers. On the other hand, there was better consistency between EU LFS data and other sources on measuring the *stocks* (Marti & Rodenas, 2007; their analysis looked at all migrant workers, not only health workers).
- To our knowledge, no LFS includes information on the place of education and training, thereby making it impossible to measure the number and share of foreign-trained doctors and nurses. Additional question(s) might be added to LFS to measure this dimension, although the addition of such question(s) would need to be perceived by managers of LFS as being relevant to all occupations, and the relative importance of adding such question(s) would have to be weighed against other competing priorities for LFS questionnaires. As LFS data are based on self-reports, this may lead to some biases in underestimating or overestimating the number of foreign health workers. The information provided may also be less reliable compared to other data sources based on regulatory registration.

## Population censuses

National population censuses are designed to produce statistical information about the total population, their homes, their socioeconomic background and other characteristics. Censuses have the potential to provide nationally representative information on health human resources. Questions on country of birth, nationality/citizenship, previous place of residence and/or place of residence at a given time in the past (e.g. five years) allows for the collection of information on the migration status among medical, nursing and other health professionals (Table 9).

An increasing number of countries worldwide are undertaking censuses at least every 10 years. For the 2000 global round of censuses (1995–2004) over 80% of countries in North America, South America, Europe and Oceania undertook censuses. Many of the African countries that did not participate in the previous round have undertaken censuses for the 2010 global round (covering the period 2005 to 2014) (United Nations Statistics Division, 2010).

## Advantages of using population censuses

The main advantages are:

- Population censuses cover the entire population and do not suffer from limitation due to sample size in surveys.
- They are usually implemented in a large number of countries at regular intervals (e.g. every 5–10 years), allowing for monitoring trends in the *stock* of migrant health workers.
- Information on "place of birth", which is commonly asked in censuses, allows to capture lifetime migration through the notion of "foreign-born".
- Censuses provide the possibility to disaggregate data on migrant health workers by a wide range of demographic, social and economic characteristics (such as sex, occupation and place of residence).
- Censuses usually apply international classification for occupations (ISCO) or sectors (ISIC), allowing for robust international comparisons.
- Accessibility to census data tends to be good and sample of census may be easily available through the IPUMS project that gathers around 130 censuses from 44 countries since 1960 to the present.

## Limitations in data availability and comparability of censuses

The main limitations are:

- Censuses are only conducted at lengthy intervals (usually once every 5–10 years) and thus are unable to provide up-to-date information on migration of health workers.
- Because of complex operations for data processing and management, there is usually a significant time lag between data collection and dissemination (sometimes two years or more).
- Most censuses do not allow distinction of *foreign-trained* health personnel, as most do not capture information on place of education.
- As with other sources, censuses are unable to capture information on emigration or out-flow because they generally only cover people who are present/resident in the country at the time of enumeration (a notable exception is the census in the Philippines, which captures through its household questionnaire information on overseas workers).
- There are variations from one country to another regarding data accessibility. Confidentiality issues surrounding micro data access, computationally cumbersome processes to compile custom data tabulations, procedures and costs for external users to request census information, are all factors influencing data accessibility. For example, in some countries it is illegal for users from foreign countries to access census micro data, while in others census micro data files can be directly downloaded from the Internet among approved researchers following written permission from the relevant authorities.

Table 9 shows cross-country examples of use of census data to monitor health workforce migration.

TABLE 9

## EMPLOYED NURSES AND DOCTORS IN OECD COUNTRIES BY PLACE OF BIRTH, BASED ON POPULATION CENSUSES AROUND 2000

| Country of residence | Nurses (ISCO 223+323) | | | Doctors (ISCO 2221) | | | Year |
|---|---|---|---|---|---|---|---|
| | Total | Foreign-born | % Total (excluding unknown place of birth) | Total | Foreign-born | % Total (excluding unknown place of birth) | |
| Australia | 191 105 | 46 750 | 24.8 | 48 211 | 20 452 | 42.9 | 2001 |
| Austria | 56 797 | 8217 | 14.5 | 30 068 | 4400 | 14.6 | 2001 |
| Canada | 284 945 | 48 880 | 17.2 | 65 110 | 22 860 | 35.1 | 2001 |
| Switzerland | 62 194 | 17 636 | 28.6 | 23 039 | 6431 | 28.1 | 2000 |
| Spain | 167 498 | 5638 | 3.4 | 126 248 | 9433 | 7.5 | 2001 |
| Finland | 56 365 | 470 | 0.8 | 14 560 | 575 | 4.0 | 2000 |
| France | 421 602 | 23 308 | 5.5 | 200 358 | 33 879 | 16.9 | 1999 |
| United Kingdom | 538 647 | 81 623 | 15.2 | 147 677 | 49 780 | 33.7 | 2001 |
| Greece | 39 952 | 3883 | 9.7 | 13 744 | 1181 | 8.6 | 2001 |
| Hungary | 49 738 | 1538 | 3.1 | 24 671 | 2724 | 11.0 | 2001 |
| Ireland | 43 320 | 6204 | 14.3 | 8208 | 2895 | 35.3 | 2002 |
| Luxembourg | 2551 | 658 | 25.8 | 882 | 266 | 30.2 | 2001 |
| Mexico | 267 537 | 550 | 0.2 | 205 571 | 3005 | 1.5 | 2000 |
| New Zealand | 33 261 | 7698 | 23.2 | 9009 | 4215 | 46.9 | 2001 |
| Poland | 243 225 | 1074 | 0.4 | 99 687 | 3144 | 3.2 | 2002 |
| Portugal | 36 595 | 5077 | 13.9 | 23 131 | 4552 | 19.7 | 2001 |
| Turkey | — | — | — | 82 221 | 5 090 | 6.2 | 2000 |
| United States | 2 818 735 | 336 183 | 11.9 | 807 844 | 196 815 | 24.4 | 2000 |

Notes: —, not determined. In Greece, Portugal and Spain, figures for doctors have been estimated based on health professionals (separately for native-born and foreign-born). For reasons of international comparison, people born in Puerto Rico are considered as foreign-born in the United States (i.e. including 3850 doctors and 6701 nurses).

## Conclusion

The six potential data sources reviewed in this chapter all offer some valuable information, but they also face some more or less severe shortcomings. Cost and administrative feasibility constraints also need to be taken into account to identify the best options to improve the available data sources. Table 10 synthesises the main advantages and limitations of the different data sources.

Based on this review, professional registries, surveys of health personnel, and requests for recognition of foreign credentials seem to be the most promising sources to monitor international migration of health professionals worldwide. Both existing registries and surveys of health personnel have the advantage of potentially offering both stock and flow data by country of education (foreign-trained health workers) and possibly also the required information on employment status. The main advantage of using requests for recognition of foreign credentials as a source is that the resource implications would be low, but the main disadvantage is that this source can only provide flow data. Depending on the sources used, the following data developmental work would be needed in order to be able to collect data that would be internationally comparable and more widely available:

1. Harmonizing the information on migration-related issues collected in *professional registries*;
2. Promoting the development of a common survey module (a common set of questions) on migration-related issues that could be used in regular national *surveys of health personnel*; and
3. Achieving greater national and international co-ordination of data that can be derived from individual requests for *recognition of their foreign credentials*.

This effort should be given high priority in the main destination countries in order to provide sound evidence on which to base policy-making.

## PRELIMINARY ASSESSMENT OF DIFFERENT POTENTIAL SOURCES TO MONITOR HEALTH WORKFORCE MIGRATION

**TABLE 10**

| Data source | Minimum data set | | | | | | Implementation considerations | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Measures of: stocks/flows | | Education and migration | | | Employment (distinction: active/ inactive) | Resource implications | Frequency | Coverage | Institutional constraints |
| | | | Foreign-trained | Foreign-born | Foreigners | | | | | |
| 1. Work permits | No | Yes | No | No | Yes | No | Low | Annual | Full | High |
| 2. Recognition of foreign credentials and licensing | No | Yes | Yes | Yes | No | No | Low | Annual (continuous) | Full | Low |
| 3. Registries | Yes | Yes | Yes | (Yes) | (Yes) | (Yes) | Low or large | Annual (continuous) | High | High |
| 4. Surveys of health personnel | Yes | Yes | Yes | (No) | (No) | Yes | Medium to large depending on methodology | Annual or periodical | (High) | Low |
| 5. Labour force surveys | (Yes) | (Yes) | (No) | Yes | Yes | Yes | Nil or large | Annual | Representativity problems | Very high |
| 6. Population censuses | Yes | (Yes) | (No) | Yes | Yes | Yes | Nil or large | Every 5–10 years | Full | Very high |

## References

Dal Poz MR, Gupta N, Quain EE, Soucat ALB (eds) (2009). Handbook on monitoring and evaluation of human resources for health, with special applications for low- and middle-income countries. Geneva: World Health Organization, 2009, v.1.

Eurostat (2010). European Union Labour Force Survey (EU LFS): Description of dataset. Brussels. http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/lfs.

Marti M, Rodenas C (2007). Migration estimation based on the labour force survey: An EU-15 perspective, Int Migr Rev. 41:101–126.

OECD (2007). Immigrant health workers in OECD countries in the broader context of highly skilled migration. International Migration Outlook: SOPEMI 2007. Paris: Organisation for Economic Co-operation and Development.

OECD (2008). The looming crisis in the health workforce: how can OECD countries respond? Paris.

OECD (2010). Naturalisation and the labour market integration of immigrants. International Migration Outlook: SOPEMI 2009. Paris.

OECD-WHO (2010). International migration of health workers: improving international co-operation to address the global health workforce crisis. Policy Brief, Feb.

United Nations Statistics Division (2010). 2010 World Population and Housing Census Programme: census dates for all countries. New York, NY. http://unstats.un.org/unsd/demographic/sources/census/censusdates.htm.

WHO (2010). Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organization.

WHO-OECD (2008). WHO-OECD hosted dialogue on migration and other health workforce issues in a global economy. Geneva. http:// www.who.int/hrh/migration/who_oecd_dialogue/en/index.html

CHAPTER 8

# Immigration and the health-care workforce since the global economic crisis: Overview

MADELEINE SUMPTION

MICHAEL FIX



Nurses in training, ReSurge International.

International migrants play an important role in the health workforce of developed nations. In recent decades, immigrant-destination countries have relied upon foreign-born and foreign-trained professionals to fill positions across the skill spectrum, from home health aides and assistants to nurses, physicians, and medical specialists.

The drivers of health workforce migration are enormously complex. Migration flows respond to a wide range of push and pull factors that affect all forms of migration (such as opportunity differentials between sending and receiving countries, and historical, political and trade relationships). In addition, they depend on developments in health workforce policies and institutions in both sending and receiving countries, changing demand for health care (including in response to population aging), policies on the licensing or registration of foreign-trained professionals in destination countries, and a host of immigration rules and regulations, most of which are not designed with the needs of the health sector in mind.

Health workforce migration has come under scrutiny in the past decade, in large part because of concerns about its potential impacts on countries of origin. These flows – and their impacts – have been the subject of substantial academic and policy research[1].

This and the following four chapters examine four major destinations: Australia, Canada, the United Kingdom, and the United States, which together account for a majority of internationally mobile doctors and nurses in OECD countries[2].

The four study countries rely on a range of different immigration policies. For example, Australia, Canada, and the United Kingdom have high shares of work-based immigration flows, while the United States does not. In Australia and the United Kingdom, free movement from the European Union and New Zealand, respectively, has enabled the migration of substantial numbers of health professionals largely beyond immediate government control.

1 For some key publications in the field, see OECD: http://www.oecd.org/els/healthpoliciesanddata/healthworkforceprojects.htm; (accessed 26 April 2014) and MoHProf: http://www.mohprof.eu/LIVE/ (accessed 26 April 2014).

2 See: http://www.who.int/workforcealliance/knowledge/resources/oecd_migration_highskilled/en/ (accessed 26 April 2014).

As a result of their immigration policies, professional registration regimes, and many other factors, all four countries have experienced substantial health workforce migration, although in the past decade only one of them – the United Kingdom – has made deliberate and targeted efforts to increase the number of health professionals coming from abroad. Three of the four countries – Australia, Canada, and the United Kingdom – are undergoing significant immigration policy changes, which have influenced the mobility of health professionals in various ways. In the United States, significant immigration reform is being debated but its outcome is highly uncertain.

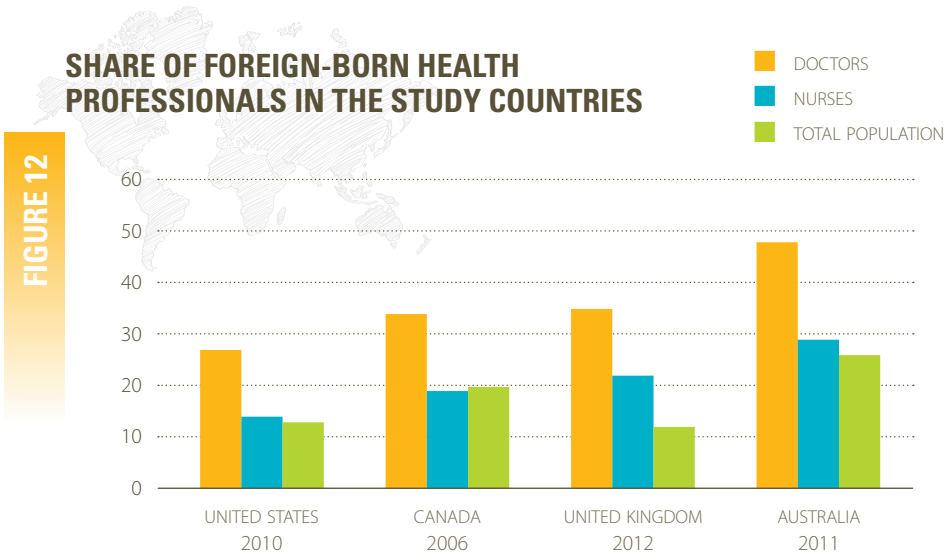
## Recent trends in health workforce migration

Immigrants make up a significant share of the health workforce in all four-study countries, although reliance on foreign personnel varies by destination and by occupation.

Approximately 37% of registered doctors are foreign trained in the United Kingdom, compared to 26% in the Australia, 26% in the US, and 22–24% in Canada[3]. In total, this means that there are approximately 243 000 foreign-trained doctors registered to practise in the United States (according to 2007 data), 91 000 in the United Kingdom (in 2011), 18 000 in Australia (in 2009), and 18 000 in Canada (in 2012).

Comparable data on the foreign trained are not available for nurses in all the study countries, but it is clear from data on *foreign-born* health-care practitioners that immigrants make up a smaller share of the nursing workforce than the medical-practitioner workforce – 14–29% (Figure 12)[4]. Immigrants comprise a significantly lower share of nurses – a proportion that is closer to the average share of immigrants in the total population. Despite the lower reliance on nurses as a share of the workforce, it is worth noting that nurses greatly outnumber physicians; as a result, the absolute number of foreign-born nurses the four countries have recruited is larger than the number of doctors.

FIGURE 12




3 Source: Country case studies.

4 From a policy perspective, the place of training is more significant than the place of birth. Some immigrant health professionals move well before they undertake their training (for example, as international students or as family members or refugees), and these individuals do not face the same barriers to practice as those who are foreign-trained. Reliable data on the size of the foreign-trained health workforce, however, are less widely available and are harder to define accurately. Many migrant health professionals have qualifications from more than one country – their home country, their ultimate destination, and perhaps even another developed country in which they have previously worked or studied.

The notable exception to this is the United Kingdom, which has a much higher share of immigrant nurses than immigrant residents overall. This relatively recent phenomenon is in large part explained by an unusual feature of the United Kingdom policy environment during the early 2000s – an active government policy to recruit large numbers of nurses from abroad, discussed in detail in the United Kingdom case study.

The number of immigrant health-care professionals has increased in each of the four study countries over the past decade, albeit to different degrees. Since the mid-2000s in particular, inflows of doctors have remained roughly steady in the United States, and have increased in Australia and Canada. In the United Kingdom, by contrast, inflows of both doctors and nurses rose rapidly in the early 2000s but plummeted from 2006 to 2008, as the government reversed its policy of active international recruitment.

Several factors shape destination countries' reliance on immigrant health professionals. The share of immigrant physicians is larger in the countries with high per-capita immigration rates – immigrants comprise about 26% of the population in Australia but only 13% in the United States – and policies that emphasize skilled migration (most notably Australia).

The demand for foreign health professionals is also likely to respond to the fluctuating supply of workers born or trained at home. Among other things, this domestic workforce is shaped by investments in the education and training pipeline; changes in the way that work is structured (increasing or reducing the demand for certain types of professionals); and demographic trends such as the retirement decisions of older health professionals and the workforce's share of women, who are more likely to work part time. The effects of these changes on demand for foreign health-care professionals can be significant. Large investments in increasing the number of qualified nurses entering the United Kingdom workforce in the first half of the 2000s, for example, allowed the government to meet nurse staffing targets while bringing to an end its policy of active international recruitment. More recently, the growing supply of USA-trained nurses is reported to have scaled back the once-thriving international recruitment industry dramatically (Squires, 2013). These trends appear to be more important than the economic crisis in shaping new inflows of foreign health professionals.

## Countries of origin

The sources of foreign-trained health professionals vary depending on the receiving country and on the occupation. India is the major source of medical doctors in the study countries. It is the top country of origin for doctors in Australia, the United Kingdom, and the United States, and has recently risen to second place in Canada. South Africa has also been a significant source of doctors in all countries except the United States, and is the largest (and a growing) origin country in Canada[5]. Similarly, the Philippines is the dominant country of origin for nurses, representing the top source for nurses in Canada, the United Kingdom and the United States, and the third largest source in Australia after nurses coming from New Zealand and the United Kingdom/Ireland.

In addition to these major global sources, each country has some specific migration corridors of note. For example, the United States hosts about 13 000 Mexican medical professionals and substantial numbers of Haitian nurses. The United Kingdom has received significant numbers

5 Note that the flows of South African doctors to the United Kingdom, which peaked at over 3000 in 2003, have slowed to less than 50 per year.

of doctors and nurses from its former colonies, although since visa and professional licensing requirements were tightened around 2006, EU Member States (whose nationals face no visa requirement and lower professional licensing hurdles) have become a more important source in relative terms. Some migration *between* the study countries also takes place, most notably from the United Kingdom to Australia and (to a lesser extent) Canada.

## Policy and routes into the health workforce for foreign professionals

Immigrants' routes into receiving countries' health-care workforces are rather diverse. While some health professionals arrive on temporary or permanent employment-based visas, many gain work and residence rights independently of their occupation through family unification, humanitarian migration, or free-movement. With some exceptions, these policies have not been tailored to the needs of the health workforce. Substantial health workforce migration has taken place even in the absence of active recruitment initiatives of the kind that the United Kingdom undertook in the early 2000s.

Instead, health professionals generally enter according to the general rules of the immigration system, which are designed to accommodate a much wider set of strategic goals than shaping the health workforce alone. However, the impacts of these general policies often differ by occupation, and some have had meaningful impacts on the migration of health professionals in both expected and unexpected ways. This section reviews the most important such policy changes that have taken place in the past five to 10 years.

Australia, Canada, and the Untied Kingdom all devote a substantial share of visas to employment-based, skilled immigration. Since both doctors and nurses are generally considered "skilled", significant numbers have been eligible to enter the country explicitly for the purpose of work. In Canada, a major immigration reform in 2002 shifted the selection criteria for economic migrants – a substantial share of total Canadian immigration – away from occupational characteristics towards more generic education and human capital ones. While health professions had generally not been among the occupations prioritized for immigration under the pre-2002 system, nurses and especially doctors have high levels of education and thus the new human capital-based model opened the door to significant migration to the sector. Much of this migration was driven by "supply" – that is, by immigrants' choices to apply to migrate. Where work-based immigration is driven by employers' decisions to sponsor immigrants – as in the case in the United Kingdom and the United States and is increasingly the case in Australia and Canada – inflows of eligible, foreign-trained professionals can often also respond directly to fluctuations in labour market demand in the destination countries.

In the United States, work visas have not been the main route into the labour market for health professionals, although the sheer scale of the United States economy means that considerable numbers still migrate in this way in absolute terms. (Between 6000 and 8000 health professionals arrived on temporary H-1B visas annually in the last few years of the decade, for example.) Employment-based immigration is more difficult for nurses than for doctors. Temporary skilled migration is possible in most occupations that require a bachelor's degree, but most nurses in the United States currently have sub-degree post-secondary education only. As a result, they are generally not eligible for temporary visas and must thus wait several years to apply for permanent ones. Interestingly, however, educational requirements are gradually increasing within the nursing profession – a shift that could potentially open the door to greater employment-based immigration.

Both Australia and Canada have shifted their immigration policies in recent years to give regional governments and employers (rather than the federal/national government) a greater role in selecting immigrants. The shift towards regional involvement in sponsoring immigrants in both countries took place in response to a high geographical concentration of immigrants in traditional destinations within the country (primarily the major urban areas), where immigrants tend to cluster if given a completely free choice of location.

This policy is particularly relevant for the health workforce, because geographical imbalances in the supply of doctors and nurses – with sufficient or even surplus numbers in the major urban areas and shortages elsewhere – have been a persistent concern. Subnational selection provides a more direct way for immigration policy to respond to these perceived needs, allowing governments to draw immigrant health practitioners to areas perceived to face shortages as a condition of their visas – at least for a certain period of time.

Employer selection (whose role, as mentioned above, has increased in Australia and Canada and is already paramount in the United Kingdom and the United States) is another mechanism that can channel immigrants to non-traditional destinations. Interestingly, the province of Ontario, the major recipient of immigrants within Canada, also requires IMGs who train in the province to practice for five years in an underserved area, usually outside of the major urban locations. USA-trained foreign physicians can also apply for a smoother route to permanent residence in the country if they find work in a medically underserved area after finishing their residency.

A handful of health-specific immigration policies have been used periodically in the study countries, although they appear to be on the wane. A "nurse visa," which existed in the United States during the 1990s and imposed special sponsorship conditions on hospitals hiring foreign nurses, is now no longer in force and nurses must enter through the (rather cumbersome and time-consuming) permanent immigration system. During the early 2000s, the United Kingdom operated special rules that allowed trainee doctors to work on student visas rather than employment ones (the latter being harder to obtain). Australia operated a "medical practitioner visa" until 2010, when it closed this route and required health professionals to enter through ordinary employment-based channels (Department of Immigration and Citizenship, 2010). These policies are the exception, rather than the norm, however. For the most part, health professionals are subject to the general rules of the immigration system as a whole.

In the immediate post-crisis period, relatively few major shifts in immigration policy have taken place in the study countries. The exception to this is the United Kingdom, which has introduced a series of measures designed to restrict immigration. These new rules primarily affect less-skilled occupations (below the level of nurses and midwives). However, among the newly introduced policies is an income threshold determining eligibility for permanent settlement through the employment-based route. While employment-based immigrants can enter the United Kingdom if they earn at least £20 000, from April 2016 they must earn £35 000 or more to apply for permanent residence (otherwise their stay will be limited to no more than six years). This could have a significant impact on the retention of nurses, the vast majority of whom do not earn enough.

### Professional registration: impacts on skills use and immigration flows

Another major factor shaping health workforce immigration is professional registration. Nurses, midwives, and especially doctors undertake substantial education and training before they are fully licensed to practice. They may be assessed both through formal examinations and clinical placements or work experience, which in the case of doctors can last for many years. Since these training and assessment systems are designed with domestically trained professionals in mind, they create a conundrum for foreign professionals who have not taken a traditional path through the training system. Becoming re-certified in the destination country can be expensive and time-consuming for immigrants and their employers, especially in countries like the United States where regulatory bodies have done little to facilitate professional registration for the foreign-trained. Investments in assessment and professional registration systems that accommodate the specific circumstances of the foreign trained have varied widely by country.

Barriers to professional registration for the foreign-trained have two major impacts: they affect the motivations for health professionals to move across borders (by controlling their access to their professions and, in some cases, eligibility for work visas); and they affect the extent to which foreign-trained professionals already in the country under a range of channels (including family unification, political asylum, and free movement) can put their skills to good use.

## The links between immigration policy and professional registration

International migration is, for obvious reasons, more attractive to health professionals who know that their skills will be recognized at destination and changes to licensing rules for overseas health professionals can affect the numbers of people choosing to migrate. Recent policy changes in some of the study countries illustrate this phenomenon.

In the United Kingdom, a tightening of professional registration pathways was part of a policy package that was used to turn off the "tap" of international health workforce recruitment after a period of very high inflows. As more domestic graduates entered the labour force and unfilled vacancies declined in the mid-2000s, stricter visa rules were introduced for doctors and nurses – rules which had been relatively liberal in the early 2000s. However, the professional associations for medicine and nursing/midwifery also contributed to the reduction by tightening rules on professional registration. Most notably, nurses were required to meet higher language proficiency standards and to complete a newly standardized induction programme, for which a limited number of places was available. For doctors, access to postgraduate clinical placements that lead to full registration became more difficult as employers were newly required to fill placements with domestic graduates where they were available.

Perhaps more directly, the potential impact of licensing rules on doctors' migration is illustrated by a 2003 surge in registrations from eight countries that were due to lose the right to automatic recognition of qualifications in 2004[6]. New registrations averaged over 1000 per year in the first three years of the decade, peaked at over 7000 in 2003, before falling to fewer than 200 per year from 2004 onwards.

6 These countries included Australia, China, Hong Kong SAR, Malaysia, New Zealand, Singapore, South Africa and the West Indies.

By contrast, Australia recently liberalized professional registration requirements for IMGs who have been licensed to practice by "trusted" authorities in certain English-speaking countries. Following this change, the Australian Medical Council has reported a large increase in applications from the United Kingdom in particular.

The availability of conditional registration for employer-sponsored doctors coming on temporary visas is also thought to have boosted medical migration to Australia. Conditional registration allows foreign-qualified doctors to work in supervised positions before they meet the conditions for full registration. It has the potential benefit of allowing beneficiaries to brush up their occupational language skills and acclimatize to the working environment rather than entering any examination process "cold". While policy-makers have pushed regulatory bodies to create conditional registration options in several countries, the success of this approach often depends on the willingness of employers to provide suitable supervised work placements (Sumption, 2013). This may be one reason that its use has been widespread in non-urban areas of Australia where there are widely perceived shortages of health professionals and thus a greater incentive to employ foreign-trained individuals even if they must be supervised.

## The links between skills use, immigrant integration and professional registration

Professional licensing in the health professions is necessary in the interest of public safety (i.e. to ensure that doctors and nurses are sufficiently qualified); but it also creates barriers to entry for the foreign trained. A significant drawback of using professional licensing hurdles – rather than visa policy – as a tool for controlling or reducing immigration inflows is that barriers to practice penalize immigrants who are already in the country for other reasons (such as refugees or family migrants) and increase the risk that their skills will be wasted. Indeed, the waste of skills among foreign-trained professionals is considered a persistent problem in immigrant destination countries.

Of the study countries, only Australia and Canada have good data on the ease with which foreign-trained health professions are able to practice at destination. In both countries, it is clear that substantial shares of IMGs are not practicing, and that there are large discrepancies in access to practice depending on the immigrant's country of origin. In Canada, middle- and low-income countries are heavily over-represented among those trained but not practicing as physicians. In Australia, the greatest barriers emerged for doctors qualified in the People's Republic of China, Viet Nam, and eastern Europe. For both doctors and nurses, passing the occupational English language tests is a major hurdle, with high rates of failure for some nationalities. Despite a lack of data in the United Kingdom and the United States, non-profit organizations that work with immigrants consistently report that language and clinical skills examinations are a major obstacle, especially for foreign-trained applicants from developing countries[7].

To address this problem, some countries have introduced pre-migration screening that requires workers to undertake at least the initial phases of the qualifications assessment process before they can qualify for employment-based immigration. In the United States, employers can only

7 In the United States, immigrants working in low- and middle-skilled occupations have higher levels of education than their US-born counterparts. While the field of their qualifications cannot be identified, this is consistent with the possibility that foreign-trained doctors or nurses are "downgrading" their occupational status because of factors including incomplete recognition of qualifications. In Australia, there is also evidence that nurses from non-English speaking countries are more likely to work in less desirable (and less well-paid) positions such as elderly care.

sponsor foreign-trained health professionals if they already have the necessary licence for the position. In Australia, most immigrants must undertake a credential assessment before qualifying for the economic migration stream. The Canadian government has announced that it will introduce a similar policy, following a long experience with an immigration system that admitted people on the basis of skills that they were not able to put to use once they arrived. Another form of pre-migration screening is performed by employers, who have a strong incentive to recruit workers whose credentials can be easily recognized. Employers are the prevailing selection mechanism in the United Kingdom and the United States, and have grown in significance for health workforce migration to Australia. This policy affects the profile of health professionals that the country receives. In Australia, for example, a greater emphasis on employer selection in the immigration process is thought to have encouraged a shift towards immigrants from English-speaking countries – immigrants who fare much better in occupational language testing and may, in many cases, have their right to practice immediately recognized.

These polices can help to reduce the risk of "skills waste" among immigrants selected for work – in large part by rejecting applications from those who will find it most difficult to become licensed. But they do not affect immigrants who arrive through other channels, notably family unification and humanitarian protection – whose skills are not screened as part of the admission process. For immigrants already in the country, both Canada and Australia have developed "bridging" programmes designed to help the foreign-trained meet regulatory requirements for their profession without having to repeat the full course of education and training. These programmes have often been successful, although their major drawback is cost. The programmes are often resource-intensive and graduate relatively small numbers of people.

Some immigrants have avoided these problems by arriving as international students and obtaining local qualifications before remaining in the country as labour migrants or moving to other countries in which their medical qualifications are recognized. This trend has been most notable in Australia, which saw enormous growth in the numbers of international students in nursing and medicine over the course of the 2000s. High shares of these students remain in the country to work after graduation.

## The economic crisis

The global economic crisis and rising unemployment levels it provoked had much smaller impacts on health workforce migration than other migration flows. Across immigrant-receiving countries as a whole, the economic crisis disrupted a number of significant, employment-driven immigration flows[8]. Lower demand for labour (and rising unemployment) reduced demand for many types of immigrant workers – especially more economically sensitive ones such as labour migration and free-movement within the EU. However, the health sector has been largely insulated from this trend. The health workforce held steady or grew in the study countries despite substantial job losses in other sectors. In the United States, for example, unemployment among health-care practitioners and technicians was a mere 2.5% in 2010, against a national unemployment rate of 9.6%; and immigrant employment in many occupations within the health-care sector has grown despite the recession. The United Kingdom also experienced a sharp increase in unemployment in the late 2000s, but rates of unemployment and inactivity remained low for both immigrants and UK-born workers with experience in the health professions.

8 One exception worth noting is a sharp increase in the migration of doctors and nurses to the United Kingdom from crisis-hit countries in the EU.

Recent immigration trends have responded more to policy developments within the health and immigration fields than to macroeconomic conditions. While many analysts predicted that the economic crisis would prompt policy changes to clamp down on immigration flows and calm public fears about immigrant competition for jobs, the immigration policy response to the recession in many developed countries was relatively moderate. Australia (which did not enter recession in the late 2000s) and Canada continued to admit growing levels of employment-based immigrants, and the United States made no major adjustments to its immigration laws. The United Kingdom did make significant changes to its immigration policies – including introducing a target for low immigration across a range of visa categories – although the recession was not the only motivation for these adjustments, which the newly elected government presented as a response to high levels of immigration during the previous 10 years.

The crisis may have a less direct impact on health workforce migration by putting pressure on public finances and thus the available public funding for health care as well as training the domestic workforce. Government budget deficits grew at the end of the 2000s in all the study countries although the structure of public financing for health and health-workforce training differs between them. In the United Kingdom, in particular, the vast majority of care is delivered through the NHS and the government exerts substantial control over staffing numbers and training places; the NHS has not borne the brunt of spending cuts from 2010 onwards, but the number of training places for nurses has fallen (Kings Fund, n.d.). In Canada, care is publicly funded but not publicly delivered; the government controls health costs primarily by restricting the number of people who can access publicly funded training places and thus enter the profession. This is also true to some extent of the United States, where despite lower public funding for health care, funding for residency programmes is determined by Congress.

Meanwhile, the demand for health care is expected to increase in all study countries as their populations age. In the United States, the newly introduced health-care law is expected to produce an additional boost in the number of people accessing health care through both private and public channels in coming years). These dynamics – pitted against constraints on public finances and the unpredictable effects of changing technologies and divisions of labour within the health workforce – will be important in determining the pressure for health workforce migration in coming decades.

## References

Department of Immigration and Citizenship (2010). Information for Australian businesses seeking to engage a medical practitioner under the Subclass 457 Visa. http://www.immi.gov.au/skilled/_pdf/faq-engage-mp-457-visa.pdf

Kings Fund (n.d.). Non-medical and nursing workforce. London: Kings Fund. http://www.kingsfund.org.uk/time-to-think-differently/trends/professional-attitudes-and-workforce/non-medical-and-nursing-workforce

Squires A, Beltran-Sanchez H (2013). Strengthening health systems In North and Central America: what role for migration? Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/research/strengthening-health-systems-north-and-central-america-what-role-migration

Sumption M (2013). Tackling brain waste: strategies to improve the recognition of immigrants' foreign qualifications. Washington, DC: Migration Policy Institute.

CHAPTER 9

# WHO four-country study: Health workforce migration in Australia

LESLEYANNE HAWTHORNE




Nurse at work.

## The scale and nature in recent years of the foreign-born and foreign-trained medical and health workforce developed in Australia

The scale of skilled migration to Australia has grown rapidly in recent years, constituting up to 68% of permanent intakes (Department of Immigration and Citizenship, 2011). Between 2004 and 2005, and 2008 and 2009, 358 151 permanent arrivals were selected through the General Skilled Migration (GSM) category, including 115 000 people in 2008–2009. Few were derived from the major English-speaking background (ESB) countries, defined as the Canada, Ireland, New Zealand, South Africa, the United Kingdom and the United States. Eight of Australia's top 10 GSM source countries at this time were in Asia – in rank order India (21%), China (18%), the United Kingdom (14%), Malaysia (6%), Indonesia (4%), China, Hong Kong SAR (3%), Republic of Korea (3%), Singapore (3%), Sri Lanka (3%) and South Africa (3%).

In 2009–2010, Australia's permanent migration target was set at 182 450 people, of which 59% of places were allocated to skilled intakes (108 100), 33% to the family category (60 300) and 8% to humanitarian entrants (13 750). Health-qualified migrants entered through all three. In 2010–2011, a further 113 850 skilled migrants were selected, out of a permanent migration programme of 196 000 people. By 2012–2013 this rose to an historic high of 219 000 places, at a time when 68% of non-humanitarian places were allocated to skilled migrants (129 250 arrivals), vastly exceeding Australia's 1998–1999 intake (Table 11).

TABLE 11

**PERMANENT IMMIGRATION INTAKES TO AUSTRALIA BY MAJOR CATEGORY (1998–1999 TO 2012–2013)**

| Programme stream | 1998–1999 | 2001–2002 | 2006–2007 | 2008–2009 | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 |
|---|---|---|---|---|---|---|---|---|
| Skilled | 35 000 | 53 520 | 97 920 | 114 777 | 107 868 | 113 725 | 125 850 | 129 250 |
| Family | 32 040 | 38 090 | 50 080 | 56 366 | 60 254 | 54 543 | 58 600 | 60 185 |
| Special eligibility | 890 | 1480 | 200 | 175 | 501 | 417 | 550 | 565 |
| Humanitarian | 11 356 | 12 349 | 13 017 | 13 507 | 13 770 | 13 799 | 11 900 | 20 000 |

Source: Department of Immigration and Citizenship (2011).

In the coming decade, skilled migration is set to remain a national priority for Australia, with strong relevance for the health professions. Long-term workforce demand will be met through dramatically expanded domestic training (most notably with 40% of the youth cohort becoming bachelor degree qualified) (Government of Australia, 2008; Rudd et al., 2007). Medium-term demand will be satisfied through the General Skilled Migration programme. Short-term demand will be addressed through employer and state territory sponsored labour migration categories – the uncapped 457 business visa which allows temporary foreign workers to work up to four years. According to the Department of Immigration and Citizenship (2010), Australia's policy is driven by the "three P's – *population* – the number of people in the economy; *participation* – the average number of hours these people work; and *productivity* – the average output produced by these people for every hour worked." Immigration is deemed to contribute to all three through, "increasing the working-age population by bringing more people into Australia aged 15–64 years; raising workforce participation by bringing in people who have a higher propensity to work and are concentrated in the prime working ages of 25 to 44 years; and improving productivity by having a strong emphasis on permanent and temporary skilled migration" (Department of Immigration and Citizenship, 2010).

## The size of Australia's health workforce

In 2009, the Australian health workforce included 82 895 registered doctors, compared to 57 553 in 1999 of whom 90% were employed in the medical workforce, virtually all as physicians (a ratio of 3 per 1000 of the population, standard for OECD nations). Overall, 25 707 doctors were employed as primary care practitioners (a rise of 25% in the past decade), with a further 24 290 specialists (+48%), 9154 specialists in training (+106%) and 7677 hospital non-specialists (+72%) (Health Workforce Australia, 2012a).

In 2011–2012, Australia's health workforce also included 326 669 registered nurses and midwives (8% growth since 2007, with 90% of all nurses and midwives being female), 26 547 registered pharmacists, 23 501 physiotherapists and 19 087 dental practitioners (Pharmacy Board of Australia, 2012; Australian Health Practitioner Regulation Agency, 2012; Physiotherapy Board of Australia, 2012; Australian Institute of Health and Welfare, 2011a).

Australian health ministers have set a goal for domestic self-sufficiency by 2025. Their policy imperative is thus to recruit migrant professionals able to contribute effectively within the next 13 years. Health Workforce Australia has been charged by the Australian Health Ministers' Conference to develop a National Training Plan. Specifically, its aim is to provide:

> *… the estimated numbers of professional entry, postgraduate and specialist trainees that will be required between 2012 and 2025 to achieve self-sufficiency. Self-sufficiency is defined as a situation in which all of Australia's requirements for medical, nursing and midwifery professionals in 2025 can be met from the supply of domestically-trained graduates without the need to import overseas trained doctors, nurses and midwives to meet a supply gap.* (Medical Deans of Australasia, 2011.)

Addressing this challenge, Australia has dramatically increased domestic supply in the past decade. Most notably:

- **Medical schools:** Enrolments in existing medical schools have expanded, with new schools established in New South Wales (Western Sydney, Wollongong, and Notre Dame Sydney), Queensland (Griffith, Bond & Cook), Victoria (Deakin), the Australian Capital Territory (ANU), and Western Australia (Notre Dame Fremantle) (Joyce et al., 2007; Joyce, McNeil & Stoelwinder, 2006).
- **Domestic medical graduations:** By 2006, 8318 Commonwealth-supported students were enrolled in medical degrees, rising to 11 873 in 2010. The number of domestic full-fee medical students also doubled (from 405 to 905), with local graduates rising from 1203 in 2001 to 1915 in 2009.
- **Domestic allied health graduations:** Rapid growth similarly occurred in nursing (graduations rising from 5084 in 2001 to around 10 000 by 2013) and in dentistry (164 graduations in 2007, compared to 416 by 2009, noting earlier data were not provided) (Mason, 2013).

Despite this level of government investment, modelling by Health Workforce Australia suggests Australia's scale of dependence on migrant health professionals will remain strong. Should immigration be reduced by 50% to 2025, a shortfall of 129 818 nurses and 9300 doctors is anticipated (rising to -148 113 nurses and -15 240 doctors should migration be cut by 95%). The problem goes far beyond numbers. Workforce maldistribution remains an entrenched challenge in Australia – one largely addressed to date by migration. Few local graduates choose rural or remote work (except nurses), or commit to less popular sectors (such as care of the aged or Aboriginal and Torres Strait Islander care). Rural incentive programmes are problematic, with few existing outside medical facilities. It is difficult to prove the effectiveness of "retention and relocation payments". Only "a very small subset of practitioners" would consider moving to a rural location of 5000 people or less, in a context where 86% of Australian doctors "would not move at all" (Scott et al., 2013). In terms of domestic training "there is debate about the effectiveness of the 25% rural origin target in influencing…distribution", few students undertake rural internships (8%), and bonded scholars are likely to buy out their regional service obligations (Mason, 2013). The risks in terms of health service provision are severe, with:

> *… less accessible services for Australians living in rural, remote and outer metropolitan regions; bottlenecks, inefficiency and incapacity in the training system, especially for doctors; and continued reliance on poorly-coordinated skilled migration to meet essential workforce requirements – with Australian having a high level of dependence on internationally-recruited health professionals relative to most other OECD countries.* (Health Workforce Australia, 2012a.)

Despite a decade of experimentation, migration remains Australia's key workforce distribution strategy. A 10-year moratorium confines medical insurance (Medicare) provider numbers to IMGs employed in "districts of workforce shortage". Under Australia's temporary foreign worker visa, employers recruit migrants to areas of need, with entry tied to location. The latest data show 22 110 health professionals were admitted through the 457 visa programme in the three years to June 2013 (compared to 9466 permanent skilled migrants), including 9115 doctors, 8410 nurses, and 330 dentists. According to Rural Health Workforce Australia, international recruitment remains "central to Australia's efforts to redress rural health inequality (and) a key policy enabler", in medical and allied health fields (2011:4–5). Indeed Australia's Productivity

Commission, in its 2005 health workforce review, expressed concern for the goal of self-sufficiency. In an age of globalization, the Commission asserted, health workforce migration provides "a valuable avenue for skills transmission and through this productivity gains" – so long as ethical protocols are complied with (Productivity Commission, 2005:39).

By 2011, according to a Parliamentary Inquiry, overseas-trained doctors constituted 36% of Australia's registered medical workforce. Analysis of 2011 Census data demonstrates 48% of doctors to be overseas-born, compared to 59% of dentists, 29% of nurses, 46% of pharmacists and 26% of physiotherapists. There are no firm data on the percentage that are overseas-qualified in these fields, but an extraordinary 25% of these health professionals had migrated from 2006 to 2011 (House of Representatives Standing Committee on Health and Ageing, 2012; Hawthorne, Hazarika & Remedios, 2014).

## Immigrants' routes into the health-care sector

### Medical migration pathways

Migrant health professionals enter Australia by seven immigration pathways – the first five involving workers who are trained overseas. As demonstrated by Table 12 (reporting health professional migration solely for the skilled categories), immigration source countries have recently become highly diverse.

**TABLE 12**

**TOP 10 RECENT SOURCE COUNTRIES FOR PERMANENT COMPARED TO TEMPORARY MIGRANT HEALTH PROFESSIONALS BETWEEN 2005–2006 AND 2009–2010**

| Top 10 permanent source countries: General skilled migration primary applicants (Total all sources = 13 880) | Top 10 temporary source countries: 457 long-stay business visa primary applicants (Total all sources = 34 870) |
|---|---|
| 1. United Kindom: 4120 | 1. United Kingdom: 9350 |
| 2. India: 1510 | 2. India: 6420 |
| 3. Malaysia: 1300 | 3. Philippines: 1850 |
| 4. China: 970 | 4. South Africa: 1770 |
| 5. Philippines: 510 | 5. Malaysia: 1570 |
| 6. South Africa: 500 | 6. Ireland: 1560 |
| 7. Republic of Korea: 480 | 7. China: 1380 |
| 8. Egypt: 420 | 8. Zimbabwe: 1180 |
| 9. Singapore: 390 | 9. Canada: 950 |
| 10. Ireland: 350 | 10. United States: 830 |

Source: Analysis of unpublished 2005–2006 to 2009–2010 arrivals data provided by the Department of Immigration and Citizenship (2011).

The following pathways currently predominate:

1. **Temporary labour migration:** Between 2005–2006 and 2009–2010, 34 870 health professionals were sponsored to Australia as temporary 457 visa migrants. The fields of nursing (15 960) and medicine (15 490) led, with 457 visa migrants recruited to pre-arranged jobs. This scale of temporary migration shows no sign of abating. As noted, a further 22 110 health professionals were sponsored by employers in the three years to June 2013 (Hawthorne, Hazarika & Remedios, 2014).
2. **Permanent skilled migration:** From 2005–2006 and 2009–2010, an additional 15 940 General Skilled Migrants with health qualifications arrived, principally qualified in the fields of nursing (8250), medicine (2330) and pharmacy (2080). From June 2010 to 2013 a further 9466 permanent health professionals migrated, including 2830 doctors, 3954 nurses and 622 pharmacists.
3. **Trans-Tasman migration:** Substantial numbers of health professionals were also admitted from New Zealand, enjoying free entry rights under the Trans-Tasman Arrangement, in a context where 12% of the New Zealand population were resident in Australia by 2006 (544 000 people). This included 1163 New Zealand doctors, 5905 nurses, 1894 allied health professionals and 196 dentists, making a total of 9158 New Zealand health professionals in all. This process is dynamic, noting there was a 41% spike in New Zealand arrivals in the 2011–2012 period.
4. **Spouse and family migration:** Thousands of additional health professionals reach Australia each year as the dependents of labour migrants, or through the family reunion category. These migrants are unscreened in advance for human capital attributes, including English language ability and credential recognition. Large numbers face occupational displacement, with significant dependence on English and pre-registration bridging programmes.
5. **Humanitarian migration:** Hundreds more health professionals are admitted annually through Australia's humanitarian category (for example, as Iraqi or Myanmar refugees). Like family migrants, they arrive unscreened in advance for human capital attributes, and facing severe risk of skills disqualification (Hawthorne, 2008).
6. **Student migration:** Australia's study-migration pathway represents an increasingly significant skilled migration resource. By 2009, 8690 international students were enrolled in Australian entry to practice nursing degrees, 2772 in medicine, 387 in dentistry, and 365 in physiotherapy. Vast numbers of international students currently stay, including 78% of all medical graduates. Since 1999, former international students have been immediately eligible to migrate, and are ideally placed to secure skilled migrant status (Hawthorne & To, 2012). Those with local health qualifications have proven highly attractive to employers. From 2009–2011, 99% of former international medical students who stayed in Australia were employed full-time within four months of course completion, compared to 96% qualified in dentistry and pharmacy, 67% qualified in physiotherapy, and 66% qualified in nursing (Hawthorne & To, 2014).
7. **Child migration:** A seventh migration-related health workforce resource exists. By definition, substantial numbers of migrants first arrived as children and qualified with local degrees (a notable success of Australia's post-war mass migration programme). By the mid-1990s, for example, 40% of domestic students in Australian medical courses were overseas-born. A striking 24% were derived from Asia – six times the Asia-born proportion in the overall population, compared to just 7% in the total derived from Europe, including the United Kingdom and Ireland, and the former Soviet Union/Baltic States. These health professionals face no labour market barriers, and are not further investigated here (Hawthorne, Minas & Singh, 2004).

The scale of health professional migration to Australia is thus dynamic – driven by workforce maldistribution and undersupply. Between June 2010 and 2013, around 32 000 migrant health professionals were admitted in the skilled categories alone. In 2012–2013, the Immigration Department established "occupational caps" for up to 29 880 health professionals, including 15 660 nurses, 4560 doctors, 1380 pharmacists and 720 dentists (Department of Immigration and Citizenship, 2012).

## Australia's level of reliance on medical migration

In the recent decade, as affirmed by the OECD, Australia has developed an extraordinary dependence on IMGs (Productivity Commission, 2005; OECD, 2007; Australian Institute of Health and Welfare, 2010). By 2006, 45% of residents with medical qualifications were overseas-born.

Between 2006 and August 2011, a further 12 696 doctors migrated across all immigration categories (triple the number accepted from 1996–2000). The United Kingdom/Ireland (1579), Other India (2625), Sri Lanka and Bangladesh (2022), North Africa/Middle East (1194), China (705), Malaysia (634), South Africa (632) and the Philippines (473) predominated (Table 13).

According to the Australian Institute of Health and Welfare, by 2009, 25% of Australia's 72 739 medically employed workforce was trained overseas, including 6% of doctors from the United Kingdom/Ireland, 3% from New Zealand, and 16% (or 11 948) from other countries (Australian Institute of Health and Welfare, 2011b). This figure rises to 36% of doctors in regional areas, based on a 2011 Parliamentary estimate (House of Representatives Standing Committee on Health and Ageing, 2012).

As demonstrated by the 2011 Census, 57% of IMGs secured medical employment in Australia in their first five years. Labour market integration occurred swiftly for doctors from ESB countries, while Commonwealth-Asian doctors from countries such as India, Malaysia, Singapore and Sri Lanka also fared well. By contrast doctors qualified in China, VietNam and Eastern Europe were at severe risk of occupational displacement. Just 8% of doctors from China gained medical employment within five years, compared to 12% from Viet Nam and 27% from Eastern Europe. Many had arrived within the family and humanitarian categories – untested in advance for English language ability or registerability (Hawthorne, 2008). Large numbers of migrant doctors were defined as "not in the labour force" (NLF) in their first five years – typically learning English and/or trying to pass pre-registration exams.

## LABOUR MARKET OUTCOMES FOR DEGREE-QUALIFIED AUSTRALIA/NEW ZEALAND-BORN MEDICAL GRADUATES, COMPARED TO MIGRANT MEDICAL GRADUATES ARRIVING 2006–2011 (2011 CENSUS)

TABLE 13

| Arrived 2006–2011 | Employment | | | | | | | Unemployment/ NLF[a] | Total | Number |
|---|---|---|---|---|---|---|---|---|---|---|
| | Professional in own field | Other professional field | Admin/ manager | Associate professional | Technology | All other occupations | Sub-total | | | |
| United Kingdom/Eire (Ireland) | 73.7 | 9.7 | 2.0 | 3.2 | 0 | 4.1 | 92.7 | 7.3 | 100.0 | 1579 |
| Northern Europe and Western Europe | 58.7 | 10.5 | 2.7 | 4.6 | 0 | 6.6 | 83.1 | 16.9 | 100.0 | 409 |
| South Eastern Europe | 60.8 | 4.1 | 0 | 8.1 | 0 | 8.1 | 81.1 | 18.9 | 100.0 | 74 |
| Eastern Europe | 27.2 | 9.5 | 4.1 | 3.6 | 1.8 | 24.9 | 71.1 | 29.0 | 100.1 | 169 |
| Viet Nam | 11.8 | 0 | 0 | 5.9 | 0 | 17.6 | 35.3 | 64.7 | 100.0 | 51 |
| Indonesia | 3.8 | 3.8 | 0 | 0 | 0 | 27.8 | 35.4 | 64.6 | 100.0 | 79 |
| Malaysia | 75.1 | 4.7 | 0 | 0.5 | 0 | 1.9 | 82.2 | 17.8 | 100.0 | 634 |
| Philippines | 46.5 | 7.0 | 0 | 1.3 | 0 | 26.6 | 81.4 | 18.6 | 100.0 | 473 |
| Singapore | 55.9 | 6.5 | 0 | 9.7 | 0 | 0 | 72.1 | 28.0 | 100.1 | 93 |
| China (not Hong Kong SAR/ Taiwan) | 7.9 | 12.2 | 2.0 | 6.5 | 0 | 28.1 | 56.7 | 43.3 | 100.0 | 705 |
| China Hong Kong SAR/ Macau SAR | 60.3 | 4.4 | 0 | 13.2 | 0 | 4.4 | 82.3 | 17.6 | 99.9 | 68 |
| Japan/South Korea | 28.1 | 11.5 | 0 | 0 | 0 | 16.5 | 56.1 | 43.9 | 100.0 | 139 |
| India | 60.8 | 5.4 | 0.9 | 2.2 | 0.1 | 11.8 | 81.2 | 18.8 | 100.0 | 2625 |
| Sri Lanka/Bangladesh | 57.6 | 2.7 | 0.3 | 0.7 | 0 | 9.0 | 70.3 | 29.7 | 100.0 | 2022 |
| Remainder of Southern and Central Asia | 0 | 0 | 0 | 0 | 0 | 12 | 12.0 | 88.0 | 100.0 | 25 |
| Canada | 63.7 | 2.7 | 0 | 2.1 | 0 | 6.8 | 75.3 | 24.7 | 100.0 | 146 |
| United States | 49.3 | 7.9 | 2.0 | 5.9 | 2.0 | 13.2 | 80.3 | 19.7 | 100.0 | 152 |
| South/Central America | 42.1 | 5.9 | 1.4 | 1.4 | 0 | 18.6 | 69.4 | 30.8 | 100.2 | 221 |
| South Africa | 83.2 | 2.7 | 1.1 | 2.4 | 0.5 | 4.1 | 94.0 | 6.0 | 100.0 | 632 |
| Remainder of Africa (Sub-Sahara) | 63 | 7.7 | 1.5 | 2.3 | 0.6 | 9.0 | 84.1 | 15.9 | 100.0 | 479 |
| North Africa/Middle East | 51.8 | 3.1 | 0.3 | 2.5 | 0 | 6.9 | 64.6 | 35.5 | 100.1 | 1194 |
| Other | 53.8 | 5.0 | 1.1 | 0.4 | 0 | 11.4 | 71.7 | 28.3 | 100.0 | 727 |
| **Total** | **57.0** | **5.8** | **0.9** | **2.4** | **0.1** | **10.4** | **76.9** | **23.0** | 100.0 | **12 696** |

[a] Not in the labour force. Source: Analysis of Australian 2011 Census data-based on survey responses from 1 Jan 2006 to the Census date of 9 Aug 2011.

## Barriers to IMGs' labour market integration

A recent report, commissioned by Health Workforce Australia, detailed the impact of English language testing on migrant health professionals in Australia, based on an analysis of 2004–2011 Occupational English Test data (Hawthorne, Health Workforce Australia, 2011). A total of 43% of medical candidates passed the test in 2010, compared to 47% of migrant dentists, 34% of physiotherapists, 28% of pharmacists, and just 19% of nurses. The highest OET failure rates for 2010 were experienced by health professionals trained in Egypt (87%) and the Philippines (91%), averaged across all fields, with an average failure rate of 82%. Chinese candidates were the sole non-English speaking background group to have improved their Occupational English Test outcomes in 2010 compared to 2005 – reflecting the markedly greater exposure to English now characteristic of China. Overall pass rates improved after re-sitting the test as required, but results for Filipino (16%) and Egyptian (19%) candidates remained very poor. By 2011, pass rates had risen to 62% for dentists and 52% for doctors, compared to 38% for pharmacists, 32% for physiotherapists, and just 17% for nurses (Hawthorne & To, 2013).

In addition to a pass in the English language test (with a minimum Band B grade in the International English Language Testing System also an option), the majority of IMGs are required to pass a Multiple Choice Question (MCQ) Examination of medical knowledge and a Structured Clinical Examination to assess the clinical knowledge including capacity for effective interaction with patients. Recent IMG outcomes data can be found in the Australian Medical Council's (AMC) 2011 submission to the House of Representatives' Inquiry into Registration Processes and Support for Overseas Trained Doctors (Australian Medical Council, 2011). From 1978–1979 to December 2010, 33 725 IMGs sat for the MCQ exam, including 20 728 new candidates

TABLE 14

### AUSTRALIAN MEDICAL COUNCIL MCQ AND CLINICAL EXAMINATION OUTCOMES BY SELECTED COUNTRY OF TRAINING (1 JANUARY 1978 TO 31 DECEMBER 2010)

| Selected country of training | Total MCQ candidates | Total MCQ passes | Total clinical candidates | Total clinical passes | Candidates total |
|---|---|---|---|---|---|
| India | 6241 | 3183 | 2870 | 1600 | 9111 |
| Sri Lanka | 2169 | 1517 | 1220 | 708 | 3389 |
| Egypt | 1990 | 825 | 1230 | 541 | 3220 |
| Pakistan | 2316 | 1103 | 742 | 414 | 3058 |
| Philippines | 2056 | 639 | 689 | 260 | 2745 |
| Bangladesh | 1614 | 862 | 941 | 470 | 2555 |
| China | 1587 | 781 | 843 | 547 | 2430 |
| Iran | 1204 | 726 | 484 | 314 | 1688 |
| United Kingdom/ Ireland | 992 | 791 | 650 | 368 | 1642 |
| Iraq | 895 | 586 | 623 | 371 | 1518 |
| South Africa | 924 | 683 | 564 | 444 | 1488 |
| Myanmar | 998 | 602 | 446 | 231 | 1444 |
| Germany | 531 | 325 | 296 | 186 | 827 |
| Nigeria | 504 | 214 | 117 | 70 | 621 |

Note: MCQ, multiple choice question.

Source: Derived from examination data provided in selected tables in Australian Medical Council (2011) and data provided to the author to inform research on health workforce migration in 2011.

(Table 14). The pass rate was 50%. A total of 15 963 candidates attempted the Clinical exam (10 462 new candidates), with a pass rate of 55%. Pass rates rose with subsequent attempts. By 2010, 85% of MCQ candidates passed overall (most within two attempts), and 94% of those who proceeded passed the Clinical examination (a comparable pattern). As with English testing, however, pass rates by source country were highly variable – reported here for primary countries of training, and with multiple attempts counted (Table 14).

Indian doctors' MCQ pass rate was 51%, compared to 79% for doctors trained in the United Kingdom/Ireland, 74% in South Africa, 65% in Iraq, and 60% in Myanmar. In marked contrast, just 31% of doctors trained in the Philippines passed the MCQ. Comparable variations were evident in relation to Clinical exam outcomes (for example a Chinese pass rate of 58% compared to 52% for India, Iraq and Egypt, but 38% for Filipino candidates).

Reflecting the scale of medical migration, demand for AMC examinations is increasing. In 2009–2010, 4466 candidates attempted the MCQ, compared to 1509 in 2005–2006. Clinical attempts rose from 887 to 1258. Age was a critical variable in relation to AMC pass rates. From 2004–2010, 57% of IMG's aged 21–30 years passed the MCQ on their first attempt, compared to 46% aged 41–50 years, and just 31% aged over 50. Similar trends were evident in relation to the Clinical exam. Gender was less important to the MCQ (55% of female candidates passing the MCQ compared to 52% of males) but differences for the second exam were stark (59% of females passing the Clinical on their first attempt compared to 48% of males). Outcomes were significantly better for IMGs selected through the General Skilled Migration programme, or via the 457 visa temporary sponsored pathways as defined below (Birrell, Hawthorne & Richardson, 2006; Hawthorne, 2011). In terms of the scale of recent demand, in 2012, the Australian Medical Council handled 7412 initial document verifications, and tested 2881 MCQ and 1941 clinical examination candidates (Australian Medical Council, 2013). In comparison, in 2013, 4747 applications were handled by the Australian Nursing and Midwifery Assessment Council (double the scale of the previous year), while the Australian Dental Council conducted 700 initial assessments, 320 written examinations and 200 practical assessments.

## The scale of specialist migration

The scale of recent migrant arrivals holding medical specialist qualifications is also very significant. From 2004–2010, 11 612 IMG specialist assessment applications were received by the AMC. The majority were from males (69% of the total), with the top 10 specialist countries of training as follows: the United Kingdom (3009), India (2712), South Africa (1084), the United States (647), Germany (468), Sri Lanka (372), Ireland (226), Iran (205), Canada (202) and the Philippines (152). Unsurprisingly, IMGs seeking specialist AMC assessment proved to be significantly older than the norm (a trend with productivity implications). A total of 443 candidates were aged 21–30 years, 6093 aged 31–40 years, 3876 aged 41–50 years, 968 aged 51–60 years, and 232 aged 61 years or older. Doctors older than 40 years at this time were ineligible to apply for the General Skilled Migration programme; most therefore sought to enter Australia through the temporary 457 visa. Key fields of specialist qualification were as follows: anaesthesia (13%), psychiatry (11%), obstetrics and gynaecology (8%), diagnostic radiology (8%) and general surgery (6%).

Recognition outcomes varied markedly by country of training, with 80% of South African qualifications deemed "substantially" or "partially comparable" to Australian standards, compared to 76% of the United Kingdom qualifications, 49% from Canada, 43% from Iran and

just 39% from the Philippines. In terms of speciality, just 15% of migrant general surgeons were deemed "substantially comparable" to Australian qualifications from 2004–2010, compared to 20% of psychiatrists and 29% of anaesthetists. Again, barriers confronting overseas trained medical specialists were repeatedly raised in submissions to the 2011 House of Representatives Inquiry, including from major ESB countries (such as South Africa). Far less information is available on allied health fields.

## Changes in policies and regulation, and the flows of immigrant medical professionals

Four trends are worth noting in relation to Australian health migration policies and regulations, focused primarily on medicine. (This reflects the availability of data.)

### The privatization of skilled migration

First, the privatization of Australia's skilled migration programme has become marked (Cully, 2009; Hawthorne, 2012). By 2009, 70% of temporary and permanent labour migrants were sponsored – in terms of medicine typically to work in areas of need for up to four years (Cully, 2009). From 2010, sponsored migrants were guaranteed priority processing: ranked first when employer-sponsored, second and third when sponsored by States, and fourth when applying to migrate on the traditional points-tested independent basis. Since July 2012, Australia has required prospective skilled migrants to apply online – submitting an "Expression of Interest" supported by personal information, proof of English ability, a recognized skills assessment (by the relevant regulatory body), and affirmation that their field features on Australia's Skilled Occupation List (where health occupations are prominent). Following ranking, a stage two "Invitation" to migrate is issued to successful applicants, with numerical caps imposed on fields at risk of oversupply. Applicants lacking sufficient points can stay in the pool for up to two years – upgrading their skills if desired, while screened for potential sponsorship by labour-hungry states and employers. Migrant health professionals without doubt will be prioritized in this process.

### The preference for temporary rather than permanent migrant flows

Second, in a marked departure from Australia's classic migration paradigm, the majority of health migrants are currently admitted on a temporary rather than a permanent basis (Table 15). From 2005–2006 to 2010–2011, 17 910 IMGs were sponsored on 457 visas, compared to just 2790 selected in the General Skilled Migration category. From 2005–2006 to 2009–2010, 15 960 nurses were also admitted, along with 660 dentists, 420 physiotherapists and 160 pharmacists. This trend shows no sign of abating. In the three years to June 2013, as we have seen, a further 22 110 migrants were sponsored through the 457 visa, including 9115 doctors, 8410 nurses, and 330 dentists. This constituted two-thirds of the 31 576 health skilled migration total at this time. Two powerful drivers underpinned this trend – access to priority processing (despite recent "red tape") and the government's capacity to constrain location as a condition of visa entry.

TABLE 15

**HEALTH PROFESSIONAL MIGRATION – PERMANENT (GSM) AND TEMPORARY (457 VISA) CATEGORY ARRIVALS BY SELECT FIELD (JULY 1 2010 TO JUNE 30 2013 TOTAL)**

| Select field – permanent GSM visa | 2010–2011 | 2011–2012 | 2012–2013 | Total |
|---|---|---|---|---|
| Nursing | 1374 | 1174 | 1406 | 3954 |
| Medicine | 505 | 1036 | 1289 | 2830 |
| Pharmacy | 157 | 223 | 242 | 622 |
| Dentistry | 113 | 170 | 206 | 489 |
| Physiotherapy | 95 | 80 | 80 | 255 |
| GSM total (all fields) | 2244 | 2683 | 3223 | 8150 |
| **Select field – temporary 457 visa** | **2010–2011** | **2011–2012** | **2012–2013** | **Total** |
| Nursing | 2275 | 3195 | 2940 | 8410 |
| Medicine | 2930 | 3320 | 2865 | 9115 |
| Pharmacy | 25 | 15 | 20 | 60 |
| Dentistry | 160 | 170 | 160 | 490 |
| Physiotherapy | 100 | 110 | 120 | 330 |
| 457 visa total (all fields) | 5460 | 6810 | 6105 | 18 405 |
| Grand total (all fields) | 7704 | 9493 | 9328 | 26 555 |

Note: GSM, general skilled migration.

Source: Analysis of unpublished immigration arrivals data, by select field and labour migration category, provided to L Hawthorne by the Department of Immigration and Border Protection, Canberra. Please note some 457 visa numbers may have been re-counted.

## Development of innovative pathways to registration and practice

Migrant doctors accepting area-of-need positions work under supervision for up to four years (typically with various forms of conditional registration) (Department of Immigration and Multicultural Affairs 2005; Birrell, 2011). Following these years of service, they can apply for permanent resident status. This practice has become widespread in the past decade, despite mounting concern for the risk of developing what is termed two-tier medical care (Hawthorne & Birrell, 2002). Australia secures essential workforce supply by this means. At the same time, significant debate has emerged on the conditional registration scheme, which allows thousands of IMGs to practise on a supervised practice basis. Many require substantial occupational bridging – the challenge of delivering this is exacerbated by remote location.

Third, within this dynamic policy context innovative pathways to practice and registration have been developed, led by the federal government with cross-national State and Territory support. As noted, the Australian health ministers have set a goal for domestic self-sufficiency. Their imperative to 2025 is to recruit migrants able to make an immediate contribution. By 2010, according to the Rural Workforce Agency, Victoria, 36% of the 1209 general practitioners (GP's) working in rural and remote Victoria had obtained their basic medical qualification outside Australia, primarily in South Asia (11%), the United Kingdom/Ireland (7%), Africa (5%), Eastern Europe (4%) and the Middle East (3%). As early as 2007, IMG's constituted 52% of rural and remote GPs in Western Australia, derived from 33 countries of training – most notably the United Kingdom (24%), South Africa (20%), India (14%), Nigeria and the Netherlands. By 2010, this had risen marginally to 53% – double the level of reliance in 2002. According to Health Workforce Queensland, by 2010, 46% of doctors in rural and remote practice in Queensland were trained overseas – primarily qualified in the United Kingdom (20%), India (15%), South

Africa (12%), the Philippines, New Zealand, Pakistan and Sri Lanka. While many had permanent resident status or were citizens (as in other states), 13% were temporary resident arrivals (207), typically employed to practise with limited registration (Rural Workforce Agency, Victoria, 2010; Health Workforce Queensland, 2010; Rural Health West, 2010; DoH Western Australia, 2007; Rural Health West, 2010). The quality of their skills thus mattered.

## The competent authority pathway

Significant new Australian entry-to-practice pathways have evolved in recent years, in line with Commonwealth of Australian Government reforms. The Competent Authority (CA) pathway (introduced in 2007) is a fast-track option developed by the Australian Medical Council in association with the Queensland DoH. It caters to what might be termed the "elite" of Australia's recent medical migration programme (McLean & Bennett, 2008). Based on the research evidence, the CA model recognizes that there are "a number of established international screening examinations for the purposes of medical licensure that represent a "competent" assessment of applied medical knowledge and basic clinical skills" to a standard consistent with AMC requirements. Four examination and two accreditation systems have been reviewed and approved by the AMC for the CA model of assessment, namely:

- The Professional and Linguistic Assessments Board Examination of the United Kingdom
- The Medical Council of Canada Licensing Examination
- The United States Medical Licensing Exam
- The New Zealand Registration Exam for Overseas Doctors
- General Medical Council accredited medical schools in the United Kingdom
- Medical schools in Ireland accredited by the Medical Council of Ireland.

Within the Competent Authority model, IMGs' country of original qualification is deemed less important than their place of vocational accreditation. To address ethical issues, for countries wishing to curb out-migration, nations can opt in or opt out of the CA pathway – South Africa and Singapore choosing to opt out in the preliminary period, despite the level of Australian demand for such qualifications. Doctors fully accredited in one of the six systems, supported by a minimum of a year's "Foundation Year/residency/rotations or not less than 12 months post-examination practice in a designated CA country" are eligible to undertake the CA path without further assessment of medical knowledge or clinical skills (Australian Medical Council, 2011; McLean & Bennet, 2008). Following 12 months of Australian experience supported by "light touch" clinical supervision they can achieve full Australian Medical Council certification – a designated English language pass being the sole examination requirement. Global response to the CA pathway has been immediate and positive, associated with what might be termed transformational recruitment outcomes.

In terms of IMGs, the AMC CA process has proven extraordinarily cost-effective to date. From July 2007 to 2010, 4955 CA applications were received, with 3327 Certificates of Advanced Standing issued, 1990 applicants from 56 countries of training successfully completed the process by December 2010, a year in which 1281 applications for assessment were received. The CA pathway has also greatly enhanced Australia's global competitiveness (Frank, 2011). From 2007–2010, it attracted relatively young applicants, with 54% of those issued Advanced Standing Certificates aged 21–30 years compared to 38% aged 31–40. Applicants trained in the United Kingdom were the major beneficiaries (1019), followed by IMG's qualified in India

(422) and Ireland (176). Lifestyle is a major reported motive. There is also anecdotal evidence to suggest health-sector funding cuts have influenced applications, for example, recent cuts to the UK National Health Service budgets (Buchan, 2011).

## Workplace-based assessment

For IMGs requiring greater periods of adjustment, additional pathways are being designed to provide enhanced supervision, address differential levels of training need, and increase readiness for specific locations of practice (e.g. remote practice and/or solo sites). The Workplace-Based Assessment pathway, for example, is being trialled by sites including the Hunter New England Area Health Services (NSW), the Rural and Outer Metropolitan United Alliance (Victoria), the Launceston General Hospital (Tasmania), Western Australia Health, Bunbury Hospital, Hollywood Private Hospital and the Joondalup Health Campus as part of the Council of Australian Governments' IMG initiative. According to the Australian Medical Council, the Workplace-Based Assessment model has significant potential value, with MCQ and English passes first required:

- The assessments are undertaken over time, providing a much more reliable and accurate evaluation of the clinical skills of the IMG.
- The IMG is assessed in terms of his or her performance rather than competence alone. In other words they are assessed in relation to how they perform in a clinical setting rather than measuring their capabilities in an artificial examination setting.
- The assessment includes feedback on performance which assists in addressing performance problems and issues, a function that is not available in the AMC clinical examination, unless these can be linked to bridging programmes.
- The IMG's are employed and are better able to offset the cost of their assessments (Australian Medical Council, 2011).

Like CA and standard AMC candidates, IMGs undertaking the Workplace-Based Assessment pathway require 12 months of supervised clinical practice to complete – a problem given the scale of IMG demand and limited supervisory infrastructure (House of Representatives Standing Committee on Health and Ageing, 2012). Large numbers of internationally qualified nurses also undertake bridging programmes. Fee-for-service courses were offered for nurses in 2012 by over 30 university, hospital and registered training organization sectors, noting fewer options existed in the smaller allied health professions.

## International students as a medical workforce resource

Finally, as noted, Australia has an additional health workforce resource – former international students who have self-funded to meet domestic requirements. By definition former students are characterized by:

- youth (on average aged 24 years);
- exemption from English language testing (when an International English Language Testing System (IELTS) score of Band 7 has been required for course commencement);
- full medical or allied health vocational registration;
- significant acculturation;
- training to Australian professional norms (including completion of regional as well as urban rotations).

In 1999, following Australia's removal of a three-year eligibility bar, international students became immediately able to migrate. Within a year of this policy change, around 50% of GSM applicants held local degrees, dropping to 35% in the recent period. From 2002, former international students were permitted to apply onshore – ideally placed to secure the requisite points if they possessed a vocation-related degree, were aged between 18 and 29 years, had advanced English language ability (with testing exempted), and an Australian qualification of two years in a high-priority field (covering virtually all health professions) (Hawthorne, 2010). By 2010, according to a recent study, 242 711 international students were enrolled in Australian university courses – including 139 902 in bachelor degrees, 80 935 in masters degrees, and 13 355 in doctoral courses (around 8% completing health courses). Commencements in medical and allied health programmes have continued to rise, from 6255 in 2008 to 6993 in 2010, yielding 18 487 total enrolments (Deloitte Access Economics, 2011).

As shown in Table 16, these international students constitute a key health workforce resource. In December 2009, 2772 international students were enrolled in entry-to-practice medical degrees (pre-vocational courses based on school-leaver or graduate entry) compared to 963 in 1996. By semester 1, 2011, enrolments had grown to around 3000. By 2009, Malaysia (1134 enrolments), Singapore (577) and Canada (437) were Australia's primary source of international medical students (noting Canadian enrolments have risen sharply since). As demonstrated by a recent study, 78% of former international students secure Australian internship training on completion of their degrees, with interest strongest from those born in North America, South East Asia (mainly Malaysia and Singapore), the Middle East and Africa (Hawthorne & To, 2012). By 2011, according to the Australian Nursing and Midwifery Accreditation Council, eight-ninths of skilled migration applications were from nurses onshore in Australia (the great majority former international students).

**TABLE 16**

**GROWTH IN UNDERGRADUATE INTERNATIONAL STUDENT ENROLMENTS IN AUSTRALIAN UNIVERSITIES IN THE MEDICAL/HEALTH SCIENCES: 1996–2009**

| Field | 1996 | 2000 | 2004 | 2007 | 2009 | % change 2007–2009 | % change 1996–2009 |
|---|---|---|---|---|---|---|---|
| Dental science | 98 | 124 | 227 | 331 | 387 | 17 | 295 |
| EP Medicine | 963 | 1117 | 1505 | 2304 | 2772 | 20 | 188 |
| Medical science | 41 | 171 | 1072 | 966 | 1003 | 4 | 2346 |
| Public health | ND | ND | 77 | 79 | 139 | 76 | ND |
| Nursing (basic) | 762 | 839 | 1623 | 4546 | 6124 | 35 | 704 |
| Nursing (post-basic) | 545 | 2336 | 3109 | 2090 | 2566 | 23 | 371 |
| Physiotherapy | 79 | 173 | 239 | 370 | 365 | -1 | 362 |
| Psychology | 136 | 335 | 1258 | 1354 | 1757 | 30 | 424 |
| Social work | — | — | — | 220 | 192 | -13 | — |

Note: —, not determined.

Source: Analysis by L Hawthorne, A Langley, A To & A Song of Department of Education Employment and Workplace Relations international student enrolment data, medical and allied health courses (February 2011).

Based on analysis of Australia's Graduate Destination Survey from 2007–2011, the study-migration pathway is associated with stellar employment outcomes. In 2011, as noted, 99% of international medical students had full-time work within four months (virtually identical to the rates of domestic students). This compared to 96% of international dental and pharmacy students, and 66% of those qualified in nursing (with an additional 20% employed in nursing part-time). By contrast 57% of IMGs were employed in their field within five years (derived from all immigration categories), 66% of nurses, 40% of dentists, and just 32% of pharmacists. Students' outcomes were also far superior to those of health professionals admitted through the General Skilled Migration pathway.

## Recent economic and policy developments, and the labour market for international health-care workers

### Overview

As demonstrated above, demand for medical and allied health migrants has greatly intensified in Australia in recent years. This favours their labour market integration. However, the six immigration options are associated with highly variable outcomes. New Zealand sponsored 457 visa and international students face minimal labour market integration barriers. Permanent skilled migrants also fare well. By contrast health professionals unfiltered in advance for human capital attributes take years (if ever) to secure professional registration – English language ability representing a particular barrier. In 2011, as noted, just 17% of migrant nurses passed the mandatory pre-registration English exam. Few secured immediate professional recognition (unless skilled migrants or qualified onshore), with large numbers required to complete competency-based bridging courses ranging from three months to a full year.

### Migrant nurses' employment outcomes

As demonstrated in Table 17, from 2006–2011, 19 746 degree-qualified nurses migrated to Australia, compared to 3100 during 1996–2000, across all immigration categories. Thousands of additional registered nurses migrated with diploma qualifications.

The top five sources for nurses at this time were the Philippines (3704), India (3697), the United Kingdom/Ireland (2885), China (1266), North Africa/Middle East (946), and South Africa (721). Overall, 66% of these migrants secured nursing employment within five years, supported by bridging programmes and sustained workforce demand. In line with medical migrants' outcomes, however, birth country/region of origin and English language ability represented major issues. Nurses from China, Hong Kong SAR, the United Kingdom/Ireland and South Africa swiftly integrated into the Australian workforce (80–82% employed in their profession within five years), followed by those from Singapore (77%), Central/South America (76%), India and other Southern/Central Asian countries (74% each).

Nurses from China (61%), Eastern Europe (59%), Viet Nam (58%), the Philippines (56%), North Africa/Middle East (56%), and South Eastern Europe (54%) fared well, with results poor for those from sub-Saharan Africa (excluding South Africa, 30%). Large numbers of migrant nurses were categorized as "Unemployed" or "Not in the labour force" in their first five

## EMPLOYMENT STATUS OF AUSTRALIA/NEW ZEALAND DEGREE-QUALIFIED NURSES, COMPARED TO OVERSEAS-BORN NURSE ARRIVALS, 2006–2011 (2011 CENSUS)

TABLE 17

| Arrived 2006–2011 | Employment | | | | | | | Unemployment/ NLF | Total | Number |
|---|---|---|---|---|---|---|---|---|---|---|
| | Professional in own field | Other professional field | Admin/ Manager | Associate professional | Technology | All other occupations | Sub-total | | | |
| United Kingdom/Eire (Ireland) | 81.5 | 1.1 | 1.9 | 0.7 | 0 | 5.9 | 91.1 | 9.0 | 100.1 | 2885 |
| Northern Europe and Western Europe | 59.3 | 3.8 | 0 | 0.9 | 0 | 13.6 | 77.6 | 22.4 | 100.0 | 317 |
| South Eastern Europe | 53.8 | 0 | 0 | 0 | 0 | 23.1 | 76.9 | 23.1 | 100.0 | 52 |
| Eastern Europe | 59.0 | 0 | 3.6 | 0 | 0 | 15.7 | 78.3 | 21.7 | 100.0 | 83 |
| Viet Nam | 57.9 | 0 | 0 | 0 | 0 | 23.7 | 81.6 | 18.4 | 100.0 | 38 |
| Indonesia | 46.1 | 0 | 0 | 0 | 0 | 24.2 | 70.3 | 29.7 | 100.0 | 128 |
| Malaysia | 62.9 | 5.1 | 0 | 0 | 0 | 7.9 | 75.9 | 24.2 | 100.1 | 178 |
| Philippines | 55.8 | 0.3 | 0.5 | 0.2 | 0.1 | 27.8 | 84.7 | 15.4 | 100.1 | 3704 |
| Singapore | 77.2 | 3.3 | 0 | 0 | 0 | 2.4 | 82.9 | 17.1 | 100.0 | 123 |
| China (not Hong Kong SAR/ Taiwan) | 60.6 | 0 | 0.2 | 0 | 0 | 20.7 | 81.5 | 18.5 | 100.0 | 1266 |
| China, Hong Kong SAR/ Macau SAR | 81.6 | 0 | 0 | 0 | 0 | 5.8 | 87.4 | 12.6 | 100.0 | 103 |
| Japan/South Korea | 37.8 | 0.5 | 1.0 | 1.0 | 0 | 23.1 | 63.4 | 36.6 | 100.0 | 601 |
| India | 74.2 | 0 | 0.1 | 0.2 | 0 | 12.0 | 86.5 | 13.5 | 100.0 | 3697 |
| Sri Lanka/Bangladesh | 46.0 | 0 | 0 | 0 | 2.9 | 20.1 | 69.0 | 30.9 | 99.9 | 139 |
| Remainder of Southern and Central Asia | 74.1 | 0 | 3.5 | 0 | 0 | 8.8 | 86.4 | 13.5 | 99.9 | 170 |
| Canada | 54.7 | 3.7 | 3.2 | 0 | 0 | 6.8 | 68.4 | 31.6 | 100.0 | 190 |
| United States | 25.5 | 0 | 0 | 0 | 0 | 44.0 | 69.5 | 30.5 | 100.0 | 141 |
| South/Central America | 75.8 | 2.3 | 1.6 | 0 | 0 | 4.2 | 83.9 | 16.1 | 100.0 | 384 |
| South Africa | 79.8 | 0.4 | 0 | 0 | 0 | 10.1 | 90.3 | 9.7 | 100.0 | 721 |
| Remainder of Africa (Sub-Sahara) | 29.5 | 1.0 | 0 | 0 | 1.0 | 14.9 | 46.4 | 53.5 | 99.9 | 288 |
| North Africa/Middle East | 55.2 | 0.3 | 0.8 | 0 | 0 | 24.9 | 81.2 | 18.7 | 99.9 | 946 |
| Other | 69.3 | 0.9 | 1.6 | 0.1 | 0 | 14.0 | 85.9 | 14.1 | 100.0 | 3592 |
| **Total** | **66.3** | **0.6** | **0.9** | **0.2** | **0.1** | **16.0** | **84.1** | **15.9** | **100.0** | **19 746** |

Note: NLF, not in the labour force.

Source: Analysis of Australian 2011 Census data based on survey responses from 1 Jan 2006 to the Census date of 9 Aug 2011.

years, most notably 53% from sub-Saharan Africa (again excluding South Africa). Severe skills discounting was evident for some groups (for example, with 28% of Filipino nurses engaged in sub-professional employment).

The major Australian study of migrant nurses to date shows that while nurses of English-speaking background passed seamlessly into employment, nurses from non-English speaking backgrounds (NESB) were obliged to surmount three major hurdles. First, mandatory English testing represented a significant bar, including access to pre-registration courses. Second, pre-migration qualification screening resulted in immediate recognition for 97% of ESB nurses compared to a mere 29% of NESB nurses. Third, while the introduction of competency-based assessment courses represented a significant Australian qualification recognition reform from 1989 (producing 90–95% pass rates in Victoria and 55–71% in NSW), funding for these courses was unstable and inadequate, with loans restricted to migrant nurses resident in Australia. Finally, while both ESB and NESB nurses secured professional work once registration had been gained, significant and persistent labour market segmentation was evident for many NESB nurses, with eastern European and non-Commonwealth Asian nurses disproportionately concentrated in the geriatric care sector (in the 1990s found to be at 840% greater risk of this than ESB nurses) (Hawthorne, 2002).

Nurse arrivals have grown rapidly since, in the context of sustained national shortages. From 2004–2005 to 2008–2009 (as we have seen), 6400 nurses reached Australia as GSM principal applicants, rising to 7676 once partners were counted. Substantial additional numbers arrived in the family and refugee categories. These permanent flows were dwarfed, however, by the scale of 457 visa temporary employer-sponsored arrivals, in a context where health and community services has emerged as the top sponsored industry sector. Overall 14 950 registered nurses were sponsored to Australia from 2004–2005 to 2008–2009, in addition to registered mental health nurses and midwives. Many such nurses went to highly dispersed sites: the primary states of sponsorship in 2008–2009 being Victoria (1010), Queensland (780) and Western Australia (750). In the three years to June 2013, a further 8410 temporary and 3954 permanent nurses were admitted through Australia's skilled migration programme (making an additional 12 364 total). As with medicine, these nurses secured variable employment outcomes in the first five years, with significant levels of over-qualification. A comparable pattern exists across all health professions.

To assess registered nurse qualifications, State and Territory Boards collectively formed and control the Australian Nursing and Midwifery Accreditation Council (ANMAC), which assesses pre-migration principal applicants on a fee for service basis. Between 2007 and 2011, ANMAC received 11 051 applications from nurse primary applicants seeking a skilled migration assessment. The principal source countries at this time were India (2437), the United Kingdom (2358), China (1316), the Philippines (957) and Zimbabwe (471). As in Australia, migrant nurses were a highly feminized group (85% of applicants). Substantial numbers from 2007–2011 were deemed suitable for migration purposes (10 029). While just 16% secured full recognition, 75% were immediately given modified approval (including many who had qualified in Australia). The remainder (9%) were deemed unsuitable or pending (unpublished data provided by the Australian Nursing and Midwifery Assessment Council, 2013). In 2011, India, the United Kingdom, Nepal, China and the Philippines were the primary applicant source countries. Labour market displacement and skills disqualification remain serious issues.

*To what extent have immigrants with medical qualifications been able to find work at their skill level, overcome barriers to credential recognition, and earn family-sustaining wages?*

In 2011, Health Workforce Australia established "Australia's first major, long-term, national projections for doctors, nurses and midwives", designed to "present the best available planning information on our future health workforce" (Health Workforce Australia, 2012b). In terms of migration, the focus was the scale of Australian dependence. The global financial crisis had clearly been irrelevant to medical migrants, beyond spurring the scale of their arrival. From 2005–2006 to 2010–2011, four-fifths had been sponsored to pre-arranged work. Fully registered migrants secured equitable wages. Comparable trends were evident in terms of the study-migration pathway. By 2011, international students qualified in medicine had starting salaries of 54 000 Australian dollars compared to 55 000 Australian dollars for domestic graduates. Salary rates were higher than for domestic graduates in dentistry, while somewhat lower for international nursing students. Outcomes for recent health professional graduates (in medicine, nursing, dentistry, pharmacy and physiotherapy) were compared with those for former international students in six over-supplied fields (accounting, business and commerce, information technology, engineering, education, and the law). Health professionals fared exceptionally well, with employment trends clearly favouring them (Hawthorne & To, 2014).

*How have the trends described varied with health-care workers' countries of origin, with a specific focus on HRH countries that have been documented as suffering severe health workforce shortages, unbalanced skill mixes and regional gaps in health-care coverage?*

In terms of the ethics of health workforce migration, Australia has endorsed the principles of the Commonwealth Code of Practice for the International Recruitment of Health Workers (2003); is a signatory to the Pacific Code of Practice for the Recruitment of Health Workers (2007); and a signatory to the WHO Code of Practice on the International Recruitment of Health Personnel (2010). Despite this, migration is strong from regions such as sub-Saharan Africa, which is threatened by out-migration. As demonstrated in Table 12, between 2005–2006 and 2009–2010, South Africa was Australia's fourth top source of temporary 457 visa health professionals (1770 arrivals) and sixth for permanent skilled migrants (500). Zimbabwe was the eighth top temporary source (1180). Sub-Saharan migrants represent a skilled migration elite who are eagerly sought across all fields. South African migrants, for instance, are very attractive to prospective employers. By 2011, 83 secured medical employment within five years, compared to 74% of doctors from the United Kingdom/Ireland, 61% from south-eastern Europe, and 56% from Singapore (Table 13). Substantial numbers of migrant health professionals are also derived from Asia. This is the case with China, India, and the Philippines (whose governments do not deem this as problematic), but also Malaysia and Singapore (whose governments do). In terms of nursing, 80% of South Africans and 77% of Singaporeans are employed in their field within five years in Australia, exceeding outcomes for nurses from India (72%), and Malaysia (63%) and the Philippines (56%) (Table 17). They will thus continue to be highly sought after, with ethical issues of minimal concern to many employers.

Humanitarian flows are also significant. As demonstrated in Table 14, from 1978 to 2010, the Australian Medical Council examined 1688 applicants qualified in Iran, along with 1518 from Iraq and 1444 from Myanmar. These doctors would have been desperately needed in their home countries. Individual agencies, however, ensured their right to migrate, and to be admitted to Australia as refugees, family applicants or skilled migrants.

The ethics of health workforce migration remain complex. Australia recruits on the international market to address labour market shortfalls. There is clear tension between its stated ethical goals, and push-pull migration dynamics. Further, the privatization of skilled migration is leading to a reduced government oversight role.

At the same time, Australia has improved its performance on a second ethical dimension. It has maximised skill utilization and minimized wastage. In global terms, Australia performs relatively well on this score, having developed multiple pathways to achieve full registration.

### *What aspects of health workforce migration in Australia should be researched in the future?*

Based on Australian health workforce migration trends to date, it is clear that in-depth research is required on the following priority topics.

1. *The growing scale of allied health workforce migration to Australia* – defining the characteristics of migrant intakes, pathways to professional registration, employment distribution and outcomes.
2. *A definitive analysis of nurse migration and outcomes given the numerical dominance of this field* – assessing recruitment strategies, barriers to labour market participation by cohort, factors influencing employment and retention outcomes.
3. *The impact of English language assessment* – a critical review of the instruments used, their fitness for purpose, and the rationale for requiring all four sub-tests to be passed at a single sitting, given the negative effect of this requirement on registration and employment to date (for selected fields such as medicine, and for selected country-of-origin groups).
4. *The role of bridging programmes in facilitating access to employment* – a detailed audit of the range of interventions available for migrant health professionals, their mode of operation, costing model, level of uptake (by field and across Australia), and degree of effectiveness in enhancing labour market integration outcomes.
5. *The impact of new medical registration pathways on access to practice* – comparison of the Competent Authority, Workplace-Based Assessment and Australian Medical Council pathways, including their impact on global recruitment, and potential application to the allied health professions.
6. *Factors influencing international student recruitment and transition to practice in Australia* – in medicine and allied health fields, within an increasingly competitive global and national environment.
7. *Policy levers to maximize migrants' distribution and retention* – assessment of the determinants of public sector and/or regional employment by key field, including strategies likely to maximize employment satisfaction/retention (noting minimal examination of this in relation to allied health fields to date).
8. *Health workforce emigration* – including definition of the push/pull factors influencing domestic graduates compared to GSM migrants, 457 visa migrants, migrants selected through other immigration categories, and former international students, supported by analysis of strategies likely to enhance different cohorts' retention.
9. *Factors in immigrant source countries with a potential to impact on future workforce supply* – critical analysis of trends and immigration drivers in China, India, Ireland, Malaysia, New Zealand, the Philippines, South Africa and the United Kingdom.

10. *Strategies in key competitor countries to recruit and retain migrant health professionals* – detailed audit of policies operating in Canada, Ireland, New Zealand, the United Kingdom, and the United States, including selection priorities, permanent compared to temporary resident pathways, geographical distribution, language testing and vocational registration requirements, and quality of employment outcomes.

**References**

Australian Health Practitioner Regulation Agency (2012). Statistics – data tables, June 2012. Canberra (http://www.dentalboard.gov.au/About-the-Board/Statistics.aspx, accessed 20 September 2012).

Australian Institute of Health and Welfare (2010). Medical labour force 2008. Canberra: Australian Institute of Health Welfare.

Australian Institute of Health and Welfare (2011a). Nursing and midwifery workforce 2011. National Health Workforce Services Number 2. Canberra.

Australian Institute of Health and Welfare (2011b). Medical labour force 2009. Canberra. http://www.aihw.gov.au/publication-detail/?id=10737419680

Australian Medical Council (2011). Submission to the House of Representatives Standing Committee on Health and Ageing Inquiry into Registration Processes and Support for Overseas Trained Doctors. 4 February. Canberra.

Australian Medical Council (2013). Annual report 2012. Canberra.

Birrell B (2011). Australia's new health crisis – too many doctors. Research Report. Melbourne: Centre for Population and Urban Research, Monash University.

Birrell B, Hawthorne L, Richardson S (2006). Evaluation of the general skilled migration categories. Canberra: Commonwealth of Australia. http://www.immi.gov.au/media/publications/research/gsm-report/index.htm

Buchan J (2011). Panel Presentation, International Health Workforce Collaborative Conference, 25 October, Brisbane.

Cully M (2009). Recent trends in Australia's skilled migration program, invited Department of Immigration and Multicultural Affairs paper, United Kingdom Migration Advisory Committee International Conference, September, London.

Deloitte Access Economics (2011). Broader implications from a downturn in international students (prepared for Universities Australia), 30 June. Canberra:11.

Department of Immigration and Citizenship (2010). Reform of Australia's Skilled Migration Program and key inflows: we've checked our policy settings – now what? May-Jun. Canberra.

Department of Immigration and Citizenship (2011). Immigration update 2010–2011. Canberra http://www.immi.gov.au/media/statistics/statistical-info/visa-grants/migrant.htm, accessed 20 September 2012).

Department of Immigration and Citizenship (2012). Skill select occupation caps 2012–13. Canberra. http://www.immi.gov.au/skills/skillselect/index/report-2012-08/

Department of Immigration and Multicultural Affairs (2005). Sponsoring a temporary overseas employee to Australia. Booklet No. 11. Canberra:18.

DoH Western Australia (2007). Engaging rural doctors – final report 2007. Perth: Department of Health, Government of Western Australia.

Frank I (2011). Presentation and comment provided at the Canada-Australia Round Table on Mutual Qualifications Recognition, Canada Public Policy Forum, 12–15 April 2011, Melbourne.

Government of Australia (2008). Skilling Australia for the future – discussion paper. Canberra.

Hawthorne L (2002). Qualifications recognition reform for skilled migrants in Australia: applying competency-based assessment to overseas-qualified nurses. Int Migr Rev.40:55–92.

Hawthorne L (2008). Migration and education: quality assurance and mutual recognition of qualifications – Australia report. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO). http://unesdoc.unesco.org/images/0017/001798/179842E.pdf

Hawthorne L (2010). How valuable is "two-step migration"? Labour Market Outcomes for International Student Migrants to Australia. Special Edition, APMJ.19:5–36.

Hawthorne L (2011). Competing for skills: migration policies and trends in New Zealand and Australia. Wellington, Department of Labour, Government of New Zealand. http://www.dol.govt.nz/publications/research/competing-forskills/report/full-report.pdf

Hawthorne L (2012). International medical migration – what is the future for Australia? Med J Aust.197:18–22.

Hawthorne I, Birrell R (2002). Doctor shortages and their impact on the quality of medical care in Australia. People and Place.10:55–67.

Hawthorne L, Hazarika I, Remedios L (2014). Review of the Australian Physiotherapy Council assessment process for overseas qualified physiotherapists. Melbourne, Australian Physiotherapy Council.

Hawthorne L and Health Workforce Australia (2011). Health workforce migration to Australia – policy trends and outcomes 2004 to 2010. Adelaide. http://www.hwa.gov.au/work-programs/international-health-professionals/health-profession-migration

Hawthorne L, Minas H, Singh B (2004). A case study in the globalisation of medical education: assisting overseas born students at the University of Melbourne'. Medi Teach.26:150–159.

Hawthorne L, To A (2012). The early migration and career trajectories of international medical students qualified in Australia, report for the Medical Deans of Australasia. Sydney. (http://msod.webd3.com.au/images/TheEarlyMigrationandCareerTrajectoriesofInternationalMedicalStudies2012LHawthorneATo.pdf

Hawthorne L, To A (2013). English language skills registration standards - an Australian and glolbal comparative assessment. Melbourne: Australian Health Practitioner Regulation Agency.

Hawthorne L, To A (2014). Employer response to the study-migration pathway: the Australian evidence 2007–2011. Highly Skilled Migration: Policies, Processes and Politics, Special Issue, Int Migr.52(4) (In press: August).

Health Workforce Australia (2012a). Doctors in focus 2012. Health Workforce Series. Adelaide.

Health Workforce Australia (2012b). Health workforce 2025 – doctors, nurses and midwives. Vol 1, p. iii. Adelaide. (See also Vol. 2 for modelling detail.)

Health Workforce Queensland (2010). Medical practice in rural and remote Queensland: Queensland minimum data set report. Brisbane.

House of Representatives Standing Committee on Health and Ageing (2012). Lost in the labyrinth – report on the inquiry into registration processes and support for overseas trained doctors. Canberra: Parliament of Australia:464. http://www.mja.com.au/public/issues/188_08_210408/mcl11344_fm.html

Joyce C, McNeil J, Stoelwinder JU (2006). More doctors, but not enough: Australian medical workforce supply 2001–2012. Med J of Aust.184(8).

Joyce C et al. (2007). Riding the wave: current and emerging trends in graduates from Australian university medical schools. Med J Aust.186:309–312.

Mason J (2013). Review of Australian government health workforce programs. Canberra: Department of Health.

McLean R, Bennett J (2008). Nationally consistent assessment of international medical graduates. JA. 188:464–468.

Medical Deans of Australasia (2011). HWA Taps into data to plan Australia's future. Outcomes, Issue 5: Migration. 52:1–17.

OECD (2007). International migration outlook, SOPEMI annual report 2007. Paris: Organisation for Economic Co-operation and Development:191–192.

Pharmacy Board of Australia (2012). Statistics – data tables June 2012. http://www.pharmacyboard.gov.au/About/Statistics.aspx

Physiotherapy Board of Australia (2012). Statistics – data tables June 2012. http://www.physiotherapyboard.gov.au/News/Newsletters/July-2012.aspx

Productivity Commission (2005). Australia's health workforce: Productivity Commission Position Paper. Melbourne.

Rudd K et al. (2007). Skilling Australia for the future – Election 2007 Policy Document. Canberra: Australian Labor Party.

Rural Health West (2010). Minimum data set report and workforce analysis update, Nov. Perth.

Rural Health Workforce Australia (2011). Submission to the Health Standing Committee, Parliamentary Inquiry into Overseas Trained Doctors, 11 February. Melbourne.

Rural Workforce Agency (2010). RWAV 2010 – policy and outreach services. Victoria. http://www.rwav.comau

Scott A, Witt J, Humphreys J, Joyce C, Kalb G et al. (2013). Getting doctors into the bush: general practitioners preferences for rural location. Soc Sci & Med. 96:33–44.

CHAPTER 10

# Immigration and the health-care workforce in Canada since the global economic crisis

YAW OWUSU

ARTHUR SWEETMAN




Medical students.

Neither Canada's health-care system nor health professional migration to the country have been much affected by the recession of 2008 and 2009 as of 2013, although the ensuing public budget deficits are starting to have ramifications that are likely to have significant effects for both in the near future.

For over a decade, there have been many discussions regarding a shortage of physicians, nurses and some other health professionals in Canada (e.g. Busing, 2007; Task Force Two, 2006; CNA, 2009). Much of the discussion has focused on physicians, and in the last several years the shortage has been addressed by increasing both domestic medical school enrolment and the number of positions open to international medical graduates (IMGs)[1]. The process started before the recession and was not appreciably affected by it. Looking forward, the recession and the slow recovery are undoubtedly key factors driving ongoing government fiscal shortfalls that will almost certainly have substantial implications for cost containment in the health-care system in the medium term. Frequently, Canadian governments react slowly to recessions on the expenditure side to minimize fiscal drag on the economy during the economic recovery. But, since the health-care system is primarily publicly funded and substantial annual government deficits are accumulating, by necessity a reaction to the recession that will affect the health-care sector is commencing and it will undoubtedly affect immigrant health professionals along with the rest of the system[2].

Elements of the beginnings of a medium-term reaction can be seen in the 2012 negotiation of the collective agreement between the Ontario government and the Ontario Medical Association (OMA) in which the government is looking to keep the total physician billings constant in nominal terms despite rising physician numbers. These acrimonious negotiations followed a period of per-physician increases in gross income relative to the inflation-adjusted long-term trend as described by Henry et al. (2012), as well as cost increases from the growing number of physicians. This pattern is being played out in many public sector contract negotiations and will impact both immigrant and domestic health professionals (e.g. Ontario Ministry of Health and Long-Term Care, 2012a, 2012b; OMA 2012). A quite different, but similarly motivated,

1 Although the terminology is not standardized, in Canada graduates of US medical schools who pursue postgraduate education in the USA are frequently not considered IMGs (nor are similar Canadians considered IMGs in the USA), but Canadian citizens and permanent residents who graduate from other non-Canadian medical schools are classified as IMGs, although sometimes separately identified as Canadians Studying Abroad (CSAs).

2 In contrast to states/provinces in some countries, Canadian provinces are independent legal entities under the Constitution and hold appreciable amounts of public debt independent of that held by the federal government.

change is the reduction in per-resident funding to Ontario medical schools for clinical education announced in the 2012 budget (Ontario, Ministry of Finance, 2012). It is not yet clear if this will differentially impact IMGs versus Canadian graduates, but it will certainly reduce these programmes' flexibility.

The goal of this analysis is to establish a baseline and then to explore recent trends in the migration of internationally trained health professionals to Canada with a particular focus on physicians and nurses, and also to explore any impacts resulting from the 2008–2009 global recession. Where possible within the limits of the data available, we also consider issues relevant to the WHO's ethical code of recruitment for health professionals (WHO, 2008).

## Health care and immigration

### The health-care system

Understanding immigrant health professional occupations in Canada requires familiarity with the national health-care context (e.g. Marchildon, 2006). Provincial government medicare programmes are the dominant form of health insurance and, crucially, provincial governments are (with some exceptions, such as the military) the exclusive funders of "medically necessary" physician and hospital services (thereby including a large share of nursing and selected other health professionals). Put another way, it is a "single payer" system where payment by patients for medically necessary physician and hospital services is banned and there is no price competition. Virtually all licensed physicians bill their respective provincial government for all relevant services according to a schedule of benefits bargained collectively between each provincial government and its provincial medical association[3]. The determination of what is medically necessary and how much service should be provided is, within professional limits, entirely determined by practicing physicians. However, many medical technologies and services, ranging from pharmaceuticals outside of hospitals to chiropractic services, are neither physician nor hospital services; in these areas there are substantial policy differences across provinces.

A key result is that the affected labour markets are not competitive and what economists conceptualize as supply and demand does not operate. Moreover, the occupations are government-regulated and there is a degree of centralized planning within, although not much coordination across, provinces.

From the provinces' perspective, one way to control costs is to manage the number of physicians by managing the entry of new practitioners. Rationing ensues. On the supply side, provinces (with consultation) set the number of domestic applicants admitted to medical schools, as well as the number of IMGs admitted to residency programmes.

For the domestic population (native-born and immigrants who arrive sufficiently early in their life cycle to be educated in Canada), the rationing occurs primarily at entry to medical school. For internationally trained physicians, rationing occurs at entry to postgraduate training, which is normally required to practice, or less commonly at licensure. In determining the number of open slots, provinces balance the health-care requirements of their populations with the need

3 There are some exceptions; for example, certain physicians' services are not medically necessary and are, therefore, not covered by provincial health insurance programmes.

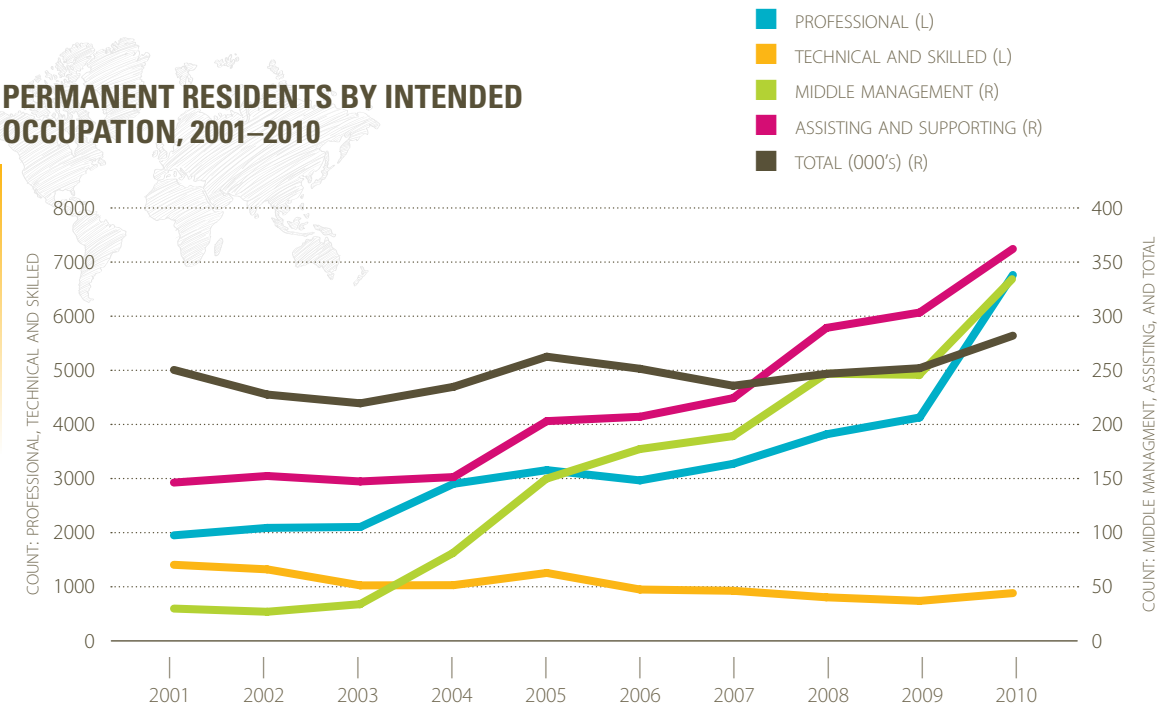
to generate tax revenue or public debt to fund those positions. The result is that Canada has far fewer physicians per capita than the OECD average, although the number of consultations per capita is more typical (OECD, 2007; 2009). Canada has also been largely unable to address the geographical maldistribution of medical service provision, so there are particular shortages in rural and remote locations.

## The immigration system

Canada's overall immigration system did not retrench during the recession. Rather, a conscious decision was made to maintain immigration targets at pre-recession levels. In fact, immigration in 2010 substantially exceeded its target and, according to Citizenship and Immigration Canada's *Facts and Figures 2011*, levels increased each year from 2007 (236 753 persons) to 2010 (280 691 persons). Picot and Sweetman (2012) provide an overview of the system and recent policy issues regarding Canadian immigration, which is in the midst of a major reform. Focusing on new immigrant arrivals whose intended occupations are in health-related occupational categories, Figure 13 presents counts by year of admission from 2001 to 2010. Clearly, although health occupations make up less than 10% of the flow, they are an increasing share across the entire period and the trends do not appear to be appreciably affected by the recession. The only health group not increasing is in the "technical and skilled" category (e.g. some laboratory technicians). Of course, intended occupation is not a perfect predictor of actual post-immigration occupation as pointed out by Goldman, Sweetman and Warman (2011), but it does suggest that the flow of new immigrants who are potential members of the health workforce is not decreasing.

FIGURE 13

**PERMANENT RESIDENTS BY INTENDED OCCUPATION, 2001–2010**




Note: Each of the four categories aggregate occupations in health and count individuals. Total represents all immigrants, in 1000's, including those in health. The "L" or "R" in the legend denotes the left or right axis.

Source: Citizenship and Immigration Canada (2010).

A distinct but relevant topic is that the flow of immigrant health professions was (probably unintentionally) affected by a change in Canada's immigration policy that was phased in starting in 2002. In that year, the federal government introduced the Immigration and Refugee Protection Act (IRPA). Prior to IRPA, the *Skilled Worker Program's* points system assessed "occupations in demand". Without at least some occupational points, or a job offer, it was virtually impossible to immigrate in this economic category, which is Canada's largest immigration stream. And, since there was a perceived surplus of physicians and many other medical personnel at that time (e.g. Barer and Stoddart, 1991), they were rarely, if ever, included on the list of occupations in demand and the relevant health professionals did not enter the country through this route unless they had a job offer in hand (McDonald. Warman & Worswick, 2011).

Some physicians might have entered the country as refugees, or in the family class category, but these numbers were not substantial. However, IRPA dramatically changed the system and eliminated points for short-term occupations in demand. Instead, this new legislation chose other measures of human capital – primarily education, language and age – as the metrics for which points were assigned. Under this new system, physicians and other highly-skilled health professionals easily met the points threshold to immigrate to Canada. Within a relatively short time, the queue of IMGs seeking licensure expanded, although the concurrent shortages in rural and remote locations remained. Thomson and Cohl (2011) discuss access to residency programmes for IMGs in Canada's largest province.

The lack of coordination between the federal government and the various provinces, with the provinces having different health human resource needs, has been problematic. A partial solution has been the expansion of the *Provincial Nominee Program* and Québec's provincial skilled worker points grid, which are subcomponents of the federal economic immigration class. It allows individual provinces to admit new immigrants in accordance with their location-specific needs. However, McDonald and Worswick (2012) using data from the early 2000s, point out that internal migration by IMGs – frequently within a few years of arrival – is from rural and remote areas, which typically have shortages, towards the largest cities. While most admissions rest with the federal government, licensure once landed is a provincial responsibility. As described by Lesky (2011) for IMGs, immigrant health professionals have to go through an expensive and time-consuming process of education, and competitive and minimum threshold medical skill/knowledge examinations, as well as language testing.

## Immigrant health professionals: Profile and recent trends

### A multi-occupational profile

A profile looking at immigration and international education status is presented in Table 18 for those employed in 10 health professions with, for comparison, the same summary statistics presented for that portion of the Canadian workforce holding a post-secondary credential, but excluding those in the heath sector, in the bottom row. This profile is based on census data from 2006 and differs slightly on some dimensions from other data sources because of, especially, differences in definitions and the age range selected. Occupations are defined broadly and, for example, medical doctors/degree holders (MDs) include those who self-report working as general practitioners, family physicians or specialists and have a medical degree with or without a Masters or PhD. Table 18 includes only registered nurses regardless of whether they have ASN, BScN, MScN or PhD. However, in Table 19, which looks at those not currently working

## IMMIGRATION STATUS AND LOCATION OF EDUCATION FOR THOSE WORKING IN SELECTED HEALTH PROFESSIONS (%)

TABLE 18

| Health profession | Number | Immigrant | Canadian born/ international education | All/ international education | Immigrant place of birth | | | | | Immigrant place of study | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | HHR crisis country | Non-OECD | Country income level | | | HHR crisis country | Canada | Country income level | | |
| | | | | | | | High | Medium | Low | | | High | Medium | Low |
| Physician | 63 455 | 33.9 | 2.9 | 17.1 | 19.9 | 63.9 | 44.5 | 50.3 | 5.2 | 6.5 | 55.2 | 76.0 | 22.9 | 1.1 |
| Registered nurse | 244 520 | 19.2 | 1.1 | 9.4 | 16.1 | 66.5 | 40.1 | 52.8 | 7.1 | 5.0 | 55.7 | 73.3 | 25.7 | 0.9 |
| Pharmacist | 23 880 | 29.2 | 4.0 | 17.1 | 22.9 | 84.6 | 31.9 | 58.6 | 9.5 | 9.0 | 51.1 | 68.1 | 30.9 | 0.9 |
| Dentist | 16 345 | 33.4 | 8.0 | 18.2 | 16.0 | 70.0 | 43.6 | 51.4 | 5.0 | 3.3 | 61.5 | 82.1 | 17.9 | * |
| Optometrist | 3485 | 15.5 | 8.3 | 12.3 | 20.4 | 71.3 | 46.3 | 46.3 | 7.4 | 0.0 | 65.7 | 90.7 | 9.3 | 0.0 |
| Psychologist | 14 900 | 17.0 | 2.9 | 8.6 | 6.3 | 31.3 | 73.9 | 24.7 | 1.4 | 1.0 | 63.6 | 93.9 | 6.1 | 0.0 |
| Physiotherapist | 14 725 | 18.6 | 1.0 | 9.8 | 15.2 | 54.5 | 55.4 | 41.3 | 3.3 | 7.7 | 51.7 | 78.6 | 21.4 | 0.0 |
| Medical radiation technologist | 14 395 | 15.5 | 0.7 | 7.7 | 16.0 | 68.8 | 43.5 | 49.6 | 7.0 | 5.2 | 54.3 | 73.9 | 26.1 | * |
| Medical laboratory technician | 16 895 | 32.1 | 13.4 | 19.1 | 17.5 | 83.2 | 21.6 | 75.0 | 3.4 | 9.5 | 40.3 | 48.7 | 50.7 | 0.6 |
| Midwife | 450 | 30.0 | 15.0 | 20.4 | 0.0 | 40.7 | 59.3 | 40.7 | 0.0 | 0.0 | 32.1 | 77.8 | 22.2 | 0.0 |
| Canadian non-health workforce | 7 324 900 | 27.9 | 2.4 | 17.3 | 19.4 | 67.8 | 40.1 | 55.3 | 4.7 | 11.2 | 44.2 | 64.8 | 33.6 | 1.6 |

Notes: * Denotes when, due to low cell counts, middle-and low-income countries are merged. 1) HHR crisis countries are the 57 countries listed by WHO (2006). 2) Income level of place of study includes those educated in Canada. 3) High-middle and low-income countries are from the World Bank (2011). 4) OECD member country list is based on OECD (2010). 5) Canadian non-health workforce aged 25–64 is restricted to those with a post-secondary education. 6) Number reflects the estimated population count derived from an underlying 20% sample. Census weights are used for this and all estimates. 7) The Canadian non-health workforce is restricted to those with a post-secondary education. 8) Internationally educated includes those educated in the United States.

Source: Canadian 2006 Census Masterfile; ages 25–64.

in their credentialed health occupation, the distinction between registered nurses and, for example, licensed practical nurses, is more difficult to determine; hence the definition is broader.

An important issue highlighted in these data is the distinction between immigrants and IEHPs. Focusing on physicians, 33.9% of physicians are immigrants; by comparison, immigrants comprise 27.9% of the Canadian non-health workforce with post-secondary degrees (23.8% including those without post-secondary). However, only 17.1% of physicians report that their highest level of education was attained outside of Canada, and a modest proportion of these follow from the 2.9% of non-immigrants who are IMGs. Fully 55.2% of immigrant physicians report being educated in Canada, although the place of education is that for the "highest" degree earned and may not reflect the degree required for the definition of IMG. This would bias down the percentage of IMGs; compared with Table 20 where the Canadian Medical Association (CMA) reports that IMGs constitute 22% of Canadian physicians, and the Canadian Post-MD Education Registry (CAPER) (2011) reports 23.6%. Country of birth, and of study, are categorized according to OECD (2010) membership status, the World Bank's (2011) country income level categorization, and being on the list of WHO (2006) countries with a health human resource crisis. Clearly, many IEHPs are educated in a higher-income country than that in which they are born.

Looking across occupations in Table 18, it is clear that there are substantial differences in the share of workers who are IEHPs, just as there are substantial differences in the share who are immigrants. Physicians, dentists, and medical laboratory technicians are among the occupations most likely comprising immigrants and/or IEHPs; and medical radiation technologists, psychologists, optometrists and registered nurses are among those occupations with the smallest share. Considering immigrant place of study, defined as the location where the individual's highest level of education was completed, a majority of immigrants in all occupations except midwifery and medical laboratory technician were educated domestically. Of course, immigrant domestic education spans the gamut from those who immigrate immediately after birth, to those who arrive after completing a post-secondary degree and then pursue an additional degree.

Table 19 has a similar format to Table 18. However, it focuses on individuals who report their highest level of education as being a credential for one of the relevant health professions, but who are not working in that occupation (this includes those who are unemployed and out of the labour force). IEHPs who return to school post-migration and obtain a subsequent degree in a different field are, therefore, not included in this table since only the field of study of the highest degree earned is reported. Of course, there is no information regarding these qualifications and whether they would be accredited by a Canadian professional college (health professional accrediting body), nor how they would be viewed by employers. Gaps between Canadian norms and those in various source countries can at times be non-trivial. For example, the Medical Council of Canada (2011) reports that, in 2011, the pass rate among first time writers of its qualifying exam (part 1) was 99% among Canadian medical graduates and 68% among IMGs. Among repeat test takers that pass rate for the Canadian educated was 67% and it was 38% for IMGs. For part II of the exam the gaps were much larger. With these caveats, the table nevertheless provides some information about individuals not working in the occupation for which they trained, and is a potential indicator of unused human capital.

## IMMIGRATION STATUS AND LOCATION OF EDUCATION FOR THOSE *NOT* WORKING IN SELECTED HEALTH PROFESSION BUT WITH RELEVANT CREDENTIALS (%)

TABLE 19

| Health profession | Number | Immigrant | Canadian born/ international education | All/ international education | Immigrant place of birth | | | | | Immigrant place of study | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | HHR crisis country | Non-OECD | Country income level | | | HHR crisis country | Canada | Country income level | | |
| | | | | | | | High | Medium | Low | | | High | Medium | Low |
| Physician | 20 300 | 74.5 | 9.4 | 68.8 | 24.3 | 87.1 | 16.0 | 77.5 | 6.5 | 19.6 | 10.9 | 25.4 | 70.3 | 4.2 |
| Registered nurse | 152 925 | 26.3 | 1.4 | 18.3 | 13.9 | 64.4 | 42.6 | 52.0 | 5.5 | 6.9 | 34.4 | 64.1 | 34.4 | 1.6 |
| Pharmacist | 10 360 | 63.3 | 5.6 | 51.1 | 26.2 | 84.7 | 23.0 | 71.5 | 5.4 | 18.3 | 22.6 | 41.3 | 56.6 | 2.1 |
| Dentist | 6140 | 69.4 | 12.2 | 64.2 | 20.9 | 87.6 | 14.0 | 83.1 | 2.9 | 16.4 | 12.8 | 25.0 | 73.5 | 1.5 |
| Optometrist | 1400 | 48.2 | 15.9 | 44.7 | 13.3 | 83.6 | 23.7 | 74.2 | 2.2 | 4.4 | 24.4 | 46.7 | 53.3 | * |
| Psychologist | 26 405 | 25.5 | 10.7 | 22.2 | 17.0 | 43.9 | 59.2 | 37.1 | 3.6 | 11.2 | 44.3 | 76.5 | 22.0 | 1.5 |
| Physiotherapist | 5000 | 42.1 | 4.7 | 36.5 | 13.3 | 72.2 | 31.6 | 65.6 | 2.9 | 8.6 | 19.7 | 42.3 | 57.7 | 0.0 |
| Medical radiation technologist | 9555 | 26.3 | 0.9 | 19.8 | 10.2 | 62.7 | 42.6 | 55.0 | 2.4 | 5.4 | 27.3 | 54.0 | 45.2 | 0.8 |
| Medical laboratory technician | 38 295 | 30.6 | 0.6 | 19.0 | 16.2 | 75.6 | 30.9 | 63.9 | 5.3 | 8.3 | 39.1 | 55.1 | 43.1 | 1.8 |
| Midwife | 5080 | 95.3 | 54.2 | 91.3 | 0.0 | 84.0 | 18.0 | 80.4 | 1.7 | 0.0 | 6.8 | 25.6 | 73.8 | 0.6 |
| Canadian non-health workforce | 7 324 900 | 27.9 | 2.4 | 17.3 | 19.4 | 67.8 | 40.1 | 55.3 | 4.7 | 11.2 | 44.2 | 64.8 | 33.6 | 1.6 |

Notes: * Denotes when, due to low cell counts, middle and low income countries are merged. 1) HHR crisis countries are the 57 countries listed by WHO (2006). 2) Income level of place of study includes those educated in Canada. 3) High, middle-and low-income countries are from the World Bank (2011). 4) OECD member country list is based on OECD (2010). 5) Canadian non-health workforce aged 25-64 is restricted to only those with a post-secondary education. 6) Number reflects the estimated population count derived from an underlying 20% sample. Census weights are used for this and all estimates. 7) The Canadian non-health workforce is restricted to those with a post-secondary education. 9) The international education column includes those educated in the United States.

Source: Canadian 2006 Census Masterfile; ages 25–64.

## PERCENT IMGs AND INGs BY PROVINCE/ TERRITORY, 2008

TABLE 20

| Provinces/territories | IMGs (%) | INGs (%) |
|---|---|---|
| Saskatchewan | 55 | 3 |
| Territories | 42 | 9 |
| Newfoundland | 40 | 1 |
| Manitoba | 29 | 7 |
| Nova Scotia | 28 | 2 |
| British Columbia | 27 | 16 |
| Ontario | 25 | 12 |
| New Brunswick | 23 | 1 |
| Alberta | 23 | 10 |
| Prince Edward Island | 19 | 2 |
| Quebec | 11 | 2 |
| Yukon | — | 8 |
| Canada | 22 | 8 |

Notes: —, not determined. The nursing data include only registered nurses.
Sources: Canadian Medical Association Master file (2008) and Nursing Canadian Institute for Health Information (2010).

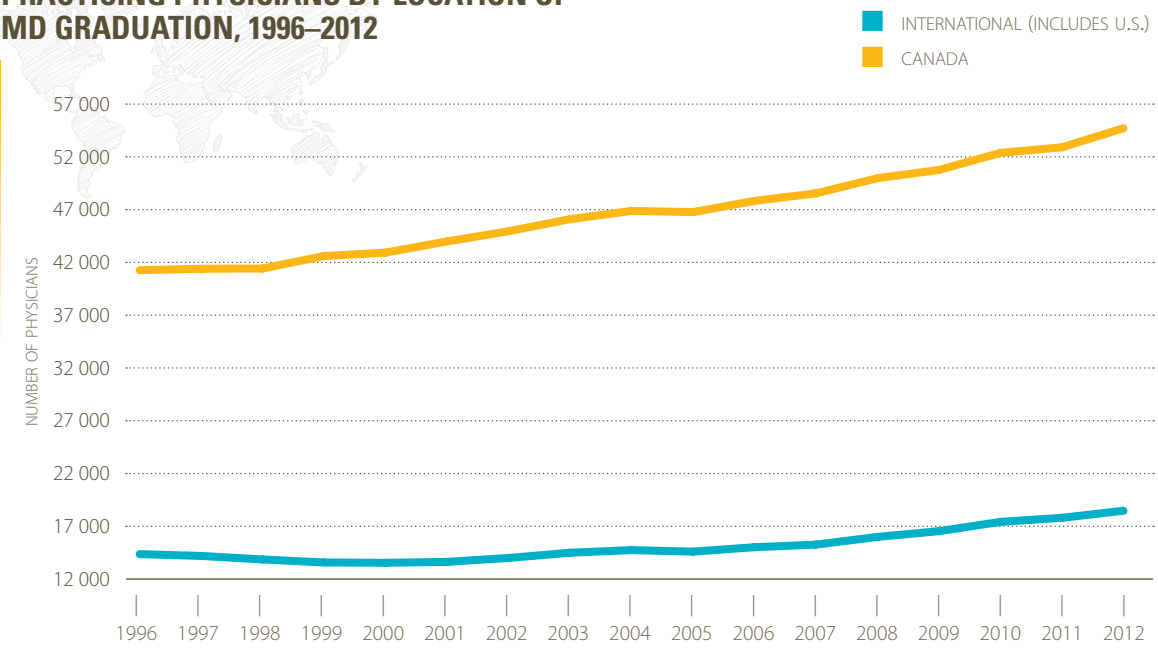
From Table 19, it is obvious that there are an appreciable number of both immigrants and non-immigrants who do not work in the profession for which they report a relevant credential. Comparing the immigrant column in Table 19 to that in Table 18, among those not working in a health occupation for which they have at least a nominal credential, the share who are immigrants is larger in Table 19 in all but one case. Among the Canadian-born, those who are internationally educated are more prevalent (as a percentage in Table 19. Those not working in their field are also more likely to have been born and/or educated in middle- or low-income, and non-OECD, countries than those working as health professionals.

An important issue relevant for IEHPs is the continuing shortages in rural and remote locations. This is reflected, as seen in Table 20, in differences in the percentage of occupations that are internationally-educated by province/territory for MDs, but, surprisingly, not for nurses. In general, IMG licensure, including provisional licensure, is more common in provinces with greater shortages. Within provinces, there are also locational differences between IMGs and domestic MDs. In part, this follows from policy since, for example, the province of Ontario requires IMGs admitted to postgraduate training to undertake five-year "return of service" agreements that normally prevent them from establishing practices in the most urbanized parts of the province (Ontario Ministry of Health and Long-Term Care, 2007)[4]. For nurses, a very different pattern is observed in the same table. There are dramatically fewer international nursing graduates (INGs) and they are much more highly concentrated in three jurisdictions that are not necessarily those with high percentages of IMGs. The concentration of INGs in Ontario and British Columbia is more reflective of immigration settlement in the country as a whole.

4 http://www.health.gov.on.ca/english/providers/program/uap/uap_hfo_ros.html (accessed September, 2012).

FIGURE 14

**PRACTICING PHYSICIANS BY LOCATION OF MD GRADUATION, 1996–2012**




Note: Includes non-clinicians licensed to practice, and excludes residents.

Source: CMA (20120.

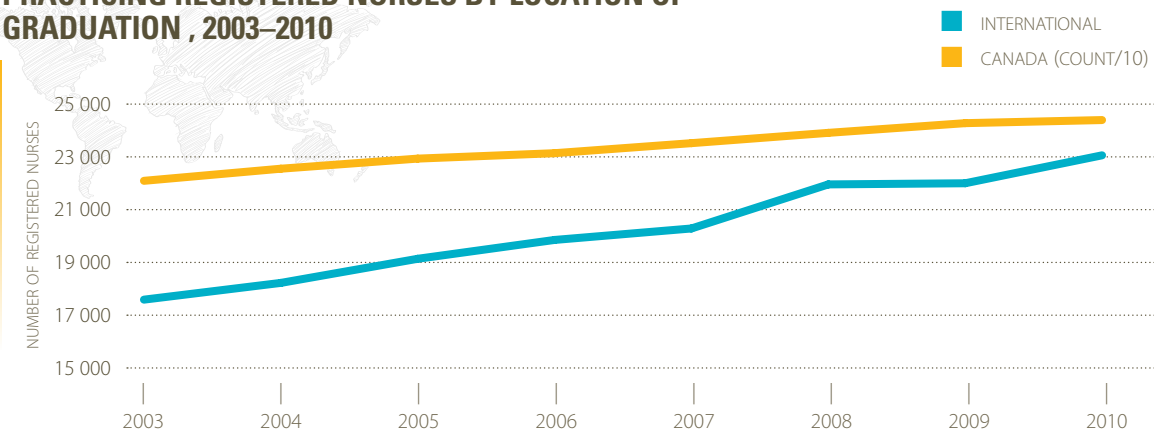
## Trends in the stock of physicians and nurses by location of education

Figure 14 depicts the number of practicing physicians in Canada according to their location of MD graduation, where for this plot United States graduates are included in the international group. As mentioned, the early- to mid-1990s was a period when the physician labour supply in Canada was held constant in an effort to reduce a perceived physician surplus (Barer & Stoddart, 1991) and as part of a broader effort to reduce or eliminate government budget deficits. This led to an interesting dynamic in Canada where there was much popular discussion about a "physician shortage", but a relatively modest response from governments regarding the licensure of new physicians until the 2000s. To put the growth in Figure 14 into perspective, the Canadian population grew by 17.7% between 1996 and 2012, whereas the number of practicing physicians who graduated from Canadian MD programmes increased by 30.5%, and those who graduated from international MD programmes increased by 23.9%. Grignon, Owusu and Sweetman (2013) suggest IEHPs may be employed in developed economies to bridge shortages in the short run given health professionals' extended training durations, and this appears to be in part consistent with the policy in this context.

Turning to registered nurses, in Figure 15, it should be noted that the period for which we have data is more limited, and to facilitate plotting both lines on a single graph the number of Canadian educated nurses is divided by 10. In this period the Canadian population grew by 7.7%, while the supply of Canadian educated nurses increased by 10%, and that of international nurses increased by almost 31%.

FIGURE 15

**PRACTICING REGISTERED NURSES BY LOCATION OF GRADUATION , 2003–2010**




Note: To facilitate plotting, the count of Canadian nursing graduates is divided by 10.

Source: CIHI (2010).

For the stock of IMGs in Table 21, and INGs in Table 22, major source countries are listed along with changes in the same between 2006 and 2010. IMGs' source countries appear to be becoming more diverse, witnessed in part by the substantial increase in "other" relative to the total increase, as well as the decline in relative importance of some traditional European source countries. For nurses, in Table 22, the picture is quite different. Notably, the Philippines dominates ING flows in a way no single country does for physicians, and its dominance only increased from 2006 to 2010. Among major source countries, only India increased at an even faster rate, but from a smaller base. Only these two increased faster than the overall rate of increase. Overall, in addition to the lower share of nurses that are internationally educated, nurses also differ from physicians in terms of the concentration and distribution of IEHP source countries.

## Trends in the flow of new physicians and nurses

Of course, changes in total supply is a result of new hires, retirements, and regular turnover, so it is important to focus on the main entry point for new practitioners to observe potential short-run changes. For IMGs this is postgraduate (residency) training, which is required even for many IMGs with clinical experience[5]. Postgraduate medical education positions in Canada are (mostly) government-funded, and the MDs are paid a modest salary while undertaking their residency. As can be seen in Figure 16, between 2002–2003 and 2011–2012 there was an appreciable increase in the intake of both IMGs and Canadian medical graduates (CMGs). There is no obvious effect of the recession (although there is a small spike in IMGs in 2009–2010); rather, there is an increasing trend throughout the entire period. The number of IMGs admitted to residency increases by about 120% and CMG's by around 70%. This is far in excess of population growth since the increase was designed to address the physician shortage.

5 The discussion ignores "visa trainees", that is, international students undertaking various levels of postgraduate medical education in Canada who are expected to return to their source country, and focuses on those expected to practice medicine in Canada. Also, internationally trained physicians who are fully licensed to practice in certain countries may not be required to take postgraduate training in Canada prior to licensure; see, for example, http://www.cpso.on.ca/registration/international/

## TABLE 21 MAJOR SOURCE COUNTRIES OF PRACTICING IMGs, 2006–2012

| Country | 2006 | 2012 | % change |
|---|---|---|---|
| South Africa | 2034 | 2547 | 25.2 |
| United Kingdom: England-Wales | 1699 | 1534 | -9.7 |
| India* | 1377 | 1682 | 22.1 |
| Ireland | 1105 | 1033 | -6.5 |
| United Kingdom: Scotland | 697 | 586 | -15.9 |
| Egypt (UAR) | 588 | 800 | 36.1 |
| United States | 508 | 663 | 30.5 |
| France | 439 | 434 | -1.1 |
| Poland | 424 | 445 | 5.0 |
| Pakistan | 411 | 680 | 65.5 |
| Philippines | 249 | 245 | -1.6 |
| Unknown grad. country | 556 | 583 | 4.9 |
| Other international | 4982 | 6695 | 34.4 |
| **Total** | **15 069** | **17 927** | **19.0** |

Note: Includes non-clinicians licensed to practice, and excludes medical residents. *India includes Goa.

Sources: CMA (2012).

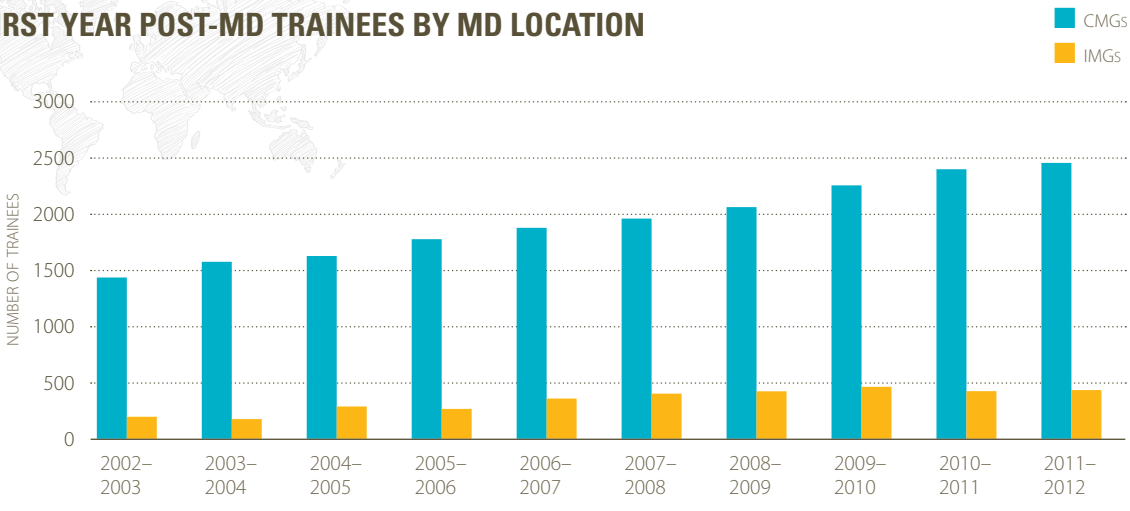
## TABLE 22 MAJOR SOURCE COUNTRIES OF PRACTICING INGs, 2006–2010

| Country | 2006 | 2010 | % change |
|---|---|---|---|
| Philippines | 6109 | 7477 | 22.4 |
| United Kingdom | 3551 | 3761 | 5.9 |
| United States | 1270 | 1454 | 14.5 |
| India | 1111 | 1500 | 35.0 |
| China, Hong Kong SAR | 932 | 946 | 1.5 |
| Poland | 674 | 646 | -4.2 |
| France | — | 531 | — |
| Australia | 357 | — | — |
| Other international | 5832 | 6761 | 15.9 |
| **Total** | **19 836** | **23 076** | **16.3** |

Note: —, country included in "other" category. The data include only registered nurses.

Source: CIHI (2010).

## FIGURE 16 FIRST YEAR POST-MD TRAINEES BY MD LOCATION

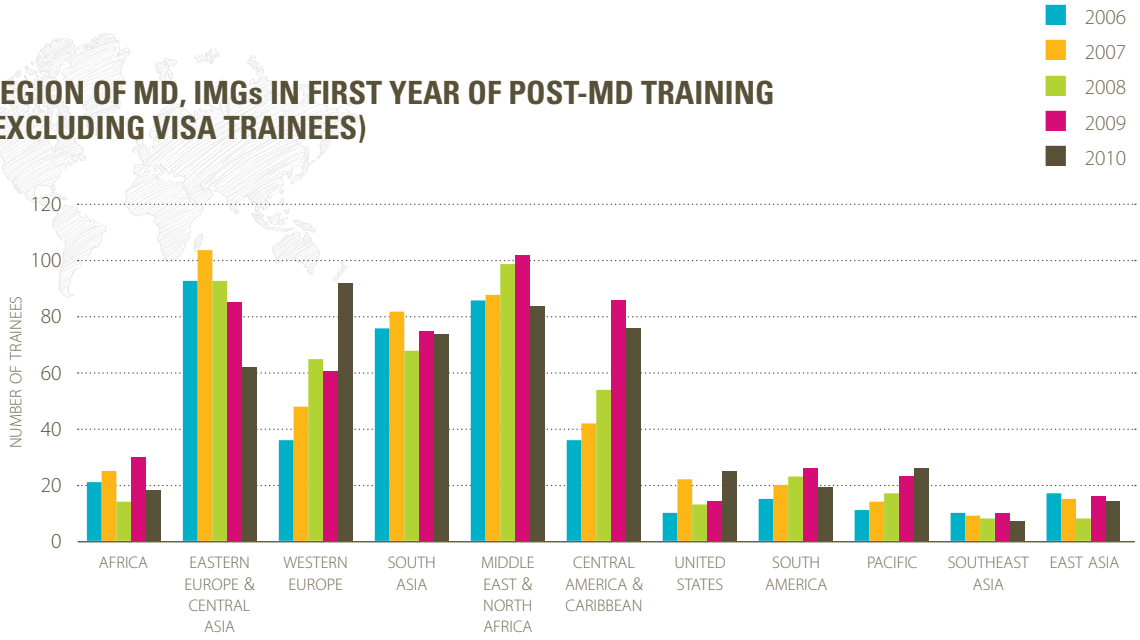



Source: CAPER (2012).

Figure 17 depicts global source regions of new IMGs from 2006 to 2010. Two noticeable trends are the increases in new residents from both western Europe, and central America and the Caribbean. There is also a small increase for the Pacific region. The only region with an appreciable decline, and only in the last year, is eastern Europe and central Asia. Although the evidence is not definitive at this stage, it is plausible that these increasing trends are driven by Canadians studying medicine abroad, which is becoming a more prevalent phenomenon. While IMGs are frequently thought of as immigrants who completed their medical degrees prior to arriving in Canada, Canadian IMGs are increasingly common. In 2006, it was estimated that there were 1500 Canadians studying medicine abroad (Banner & Comeau, 2006). By 2010, the number of Canadians enrolled in medical schools outside the country had more than doubled to 3500 (Banner et al., 2010). Although it is not clear how general this is, one leading indicator may be found in the Centre for the Evaluation of Health Professionals Educated Abroad's (CEHPEA's) 2012 annual report, which indicated that 61% of the IMGs taking its pre-residency programme were Canadian IMGs[6]. There have been notable conflicts between immigrant and Canadian IMGs – see Thomson and Cohl (2011).

FIGURE 17

**REGION OF MD, IMGs IN FIRST YEAR OF POST-MD TRAINING (EXCLUDING VISA TRAINEES)**



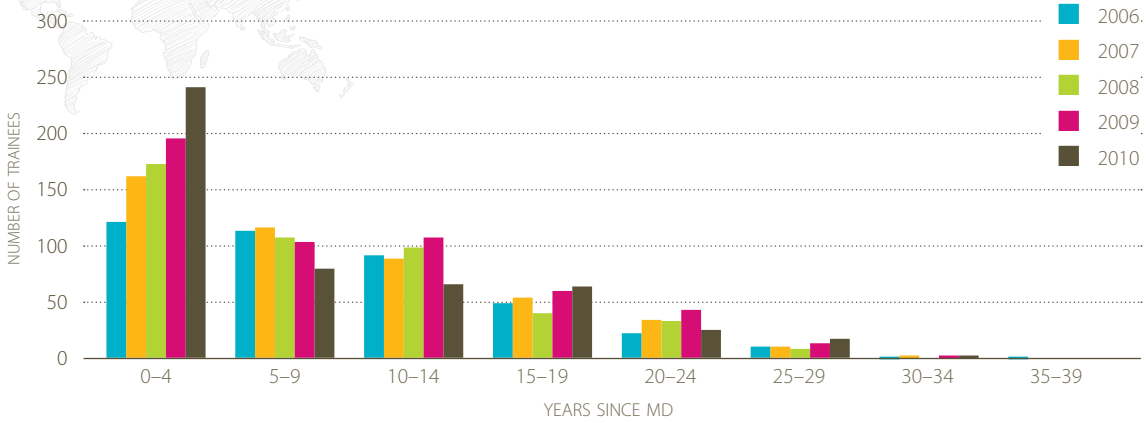

Note: Excludes visa trainees; regional destinations are based on Dussault, Fronteira and Cabral (2009).

Source: CAPER (2011).

6 Similar to the issues discussed with reference to Table 18, care is warranted in interpretation since it can be difficult to distinguish immigrant and Canadian IMGs because immigrants can gain citizenship post-MD.

FIGURE 18

## YEARS SINCE MD, IMGs IN FIRST YEAR OF POST-MD TRAINING (EXCLUDING VISA TRAINEES)



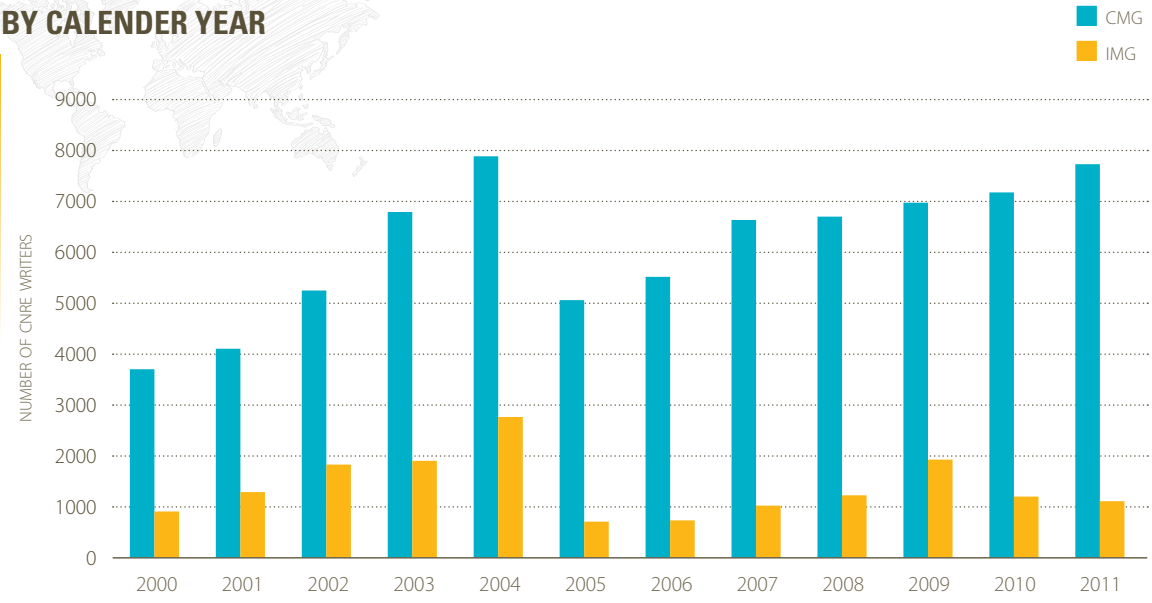

Source: CAPER (2011).

Most IMGs obtain postgraduate training positions relatively quickly following the completion of their MD, although practitioners from some countries are also required to undertake postgraduate education in Canada. This leads to an extremely broad range entering into the residency programme as illustrated in Figure 18. However, since we have no information regarding the number of potential applicants in each group, this does not address the probability of successful entry into postgraduate education as a function of years since MD graduation.

Turning to registered nurses, the normal entry point is the Canadian Registered Nurse Examination (CRNE), or its equivalent in French, *l'Examen d'autorisation infirmière au Canada (EAIC)*. Figure 19 presents trends in the number of successful CRNE exam writers between 2000 and 2011. It shows a substantial discontinuity between 2004 and 2005 for both Canadian and international nursing graduates. Part of the explanation for this may include the switch in Canada's largest province, Ontario, to requiring a university degree, as opposed to also allowing community college diplomas, for new registered nurses. Some may have made an effort to sit the exam prior to the policy change, and this would then have caused a reduction in the number sitting it immediately following. In data not shown, no such discontinuity for registered practical nurses is observed in Ontario, adding credence to this interpretation. A small spike in INGs is also observed in 2009 in Figure 19. While we can only speculate, as discussed in Baumann, Hunsberger and Crea-Arsenio (2012), the Ontario provincial government introduced a "nursing guarantee" subsidy for graduates from that province's nursing schools in 2007 and 2008 and this may have had an indirect influence on INGs. Overall, neither discontinuity is obviously associated with the recession, and a substantial and relatively consistent increase in new registered nurses is observed.

FIGURE 19

## SUCCESSFUL REGISTERED NURSING EXAM WRITERS BY CALENDER YEAR




Notes: If taken in English, Canadian Registered Nurse Examination (CRNE). If taken in French, l'Examen d'autorisation infirmière au Canada (EAIC). Quebec licensure examination writers are not included in the data. We calculate 2010 and 2011 from the CRNE bulletins, 2011 and 2012.

Source: CNA (2009, and various years).

Major source countries for the flow of new ING CRNE exam writers are shown in Table 23. Akin to the stock of INGs, the flow is extremely concentrated, however the percentage in "other" countries is larger than that for the total suggesting a small reduction in the concentration across source countries with the largest, the Philippines, declining slightly as a share of the flow (but increasing in terms of the number of individuals). In contrast, there is a marked increase in nurses from India. Note that these numbers differ somewhat from those seen in Figure 19, as these include all those who sat the exam as opposed to those who were successful. The exam pass rates are appreciably lower for INGs than Canadian nursing graduates. Between 2005 and 2011, the success rate of INGs was 50–71%, whereas that for Canadian-educated nurses was 87–95% (CNA, various years).

TABLE 23

## LEADING SOURCE COUNTRIES OF INTERNATIONALLY EDUCATED FIRST-TIME CRNE WRITERS

| Country | 2006 | 2010 | % change |
|---|---|---|---|
| Country | 313 | 464 | 48.4 |
| Philippines | 93 | 292 | 214.3 |
| India | 113 | 188 | 66.7 |
| United States | 26 | — | — |
| Iran | 68 | 83 | 22.1 |
| UK: England-Wales | 40 | 13 | -66.2 |
| Australia | 19 | — | — |
| China | — | 44 | — |
| Jamaica | 189 | 375 | 98.6 |
| Other countries | 6 | 0.0 | — |
| Unknown country | 249 | 245 | -1.6 |
| **Total** | **867** | **1461** | **68.6** |

Note: —, country included in "other" category. We calculate 2010 from CNA (2011). Quebec licensure examination writers are not included in the data.

Sources: CNA (various years).

## Paths to practice

In Canada many health professions are regulated through professional colleges that are independent (arms' length) organizations commonly subject to provincial legislation. However, the list of regulated professions and the nature of the legislation varies appreciably from province to province; particularly, Québec tends to differ[7]. In addition to the colleges, there are professional associations with a range of missions, and a sometimes confusing array of councils, specialist colleges, and other organizations. Frequently, both the colleges and associations have national umbrella organizations. Many immigrants have found the path to licensure both opaque and difficult. In response to this problem, the last several years, including those of the recession, have seen a significant effort to improve credential recognition processes. Much of this has taken the form of improved communication/transparency and procedures, and some have involved the introduction of bridge programmes. Important markers include the establishment of three federal government bodies whose joint mandates encompass health professions as well as others: the Foreign Credential Recognition Program in 2003, Health Canada's Internationally Educated Health Professionals Initiative in 2005, and the Foreign Credential Referral Office in 2007.

These federal bodies funded many, sometimes quite small, initiatives in the country to assist IEHPs with bridge training and/or guidance through the regulatory process, but much of the funding was short term and/or start-up funding. While some have continued, if ongoing funding sources were not located the programmes ceased operations. For example, the piloted Multi-jurisdictional Midwifery Bridging Program for foreign-educated midwives who intend to practice in Manitoba, Saskatchewan, Alberta, British Columbia, Northwest Territories, Nunavut and Nova Scotia has been suspended due to lack of funds. It was developed and piloted from 2006 to 2012. The first phase of the pilot project, which was between 2007 and 2010, involved nine internationally educated midwives and the second phase involved 18. The government of Canada's foreign Credential Recognition Program funded the programme initially, but it was maintained by Canadian Midwifery Regulators Consortium (CMRC) together with a consortium of university partners (CMRC, 2012). It seems possible that the range of bridging/upgrading required across individuals is quite diverse and delivering anything close to person-specific programmes may be prohibitively expensive.

On the provincial side there have been a number of initiatives inside government ministries representing health and/or immigration. Interesting new provincial government statutes have created offices or commissioners mandated to address fair access and registration practices for regulated professions, including regulated health professions. Canada's largest province, Ontario, has established the Office of the Fairness Commissioner, and similar legislation exists in the provinces of Manitoba, Nova Scotia and Québec promoting "transparent, objective, impartial and fair" practices[8]. Simultaneously, offices (frequently at arm's length from government) have been established to assist in the evaluation and occupational integration of immigrant health professionals[9].

7 Provisional licensure is a frequent route employed in some provinces (especially Newfoundland and Labrador, and Saskatchewan) that face difficulty providing physician services in rural and remote areas. See Audas Ryan and Vardy (2009), Basky et al. (2007), and Lesky (2011).

8 From the Ontario Office of the Fairness Commissioner. http://www.fairnesscommissioner.ca

9 For example, Ontario, which has among the highest immigrant concentrations, has funded organizations such as: HealthForceOntario (http://www.healthforceontario.ca/) to assist immigrant health professionals and support the province's health workforce needs; and the Centre for the Evaluation of Health Professionals Educated Abroad (http://www.cehpea.ca/), which, despite its title, focuses primarily on physicians and is only starting to implement evaluations for nurses. In their best incarnations, the "assisting" and "evaluating" roles are separate.

These initiatives have made substantial headway in communicating information about the pathways by which health professionals attain licensure, bridging or other programmes that lead to licensure, and pathways to alternative occupations. It is important to note that some of these pathways have steps that are competitive and that making the pathway fairer and more transparent to applicants does not imply increasing the number of jobs available. Most of these initiatives began prior to the recession and appear to have expanded despite it; therefore, during the recession pathways to licensures have become more transparent and fair even if the hurdles themselves have not changed all that much in many cases.

## Comparing labour market outcomes for physicians and nurses according to immigration status and location of education

Descriptive statistics are presented regarding the labour-market outcomes for those reporting relevant qualifications to practice in tables 24 and 25 for physicians, and tables 26 and 27 for nurses. They distinguish between immigration status, location of study, and employment in the relevant health profession. The statistics presented are counterparts to those presented in tables 18 and 19, and are from the 2006 census with earnings representing the 2005 calendar year. An effort, not presented to save space, was made to track some of these variables over time using Statistics Canada's Labour Force Survey. There was no evidence of any major trends between 2007 and 2011, although any such trend would have had to be substantial in order to be observed given that the estimates were not particularly precise.

Labour market outcomes for physicians are presented in Table 24, with those working as physicians in the upper panel and those not so working presented in the lower one. Each sample is presented twice: once segregated based on immigrant status, and a second time segregated based on location of highest study. A few key patterns present are obvious. First, it is clear that those employed as physicians have substantially higher annual earnings, and work substantially more weeks in 2005 and hours in the census week in 2006, compared to those not employed as physicians. For some of the groups, most clearly the non-immigrants, the ratio in earnings across those working and not working as physicians is broadly comparable to the ratio in weeks and hours of work, but it cannot be determined if the reduced labour supply decision is voluntary or involuntary. Second, for both those working and not working as physicians, immigrants earn less than non-immigrants, and the internationally educated earn less than the domestically educated. However, the gap is much greater for those not working as physicians than those working as physicians.

Table 25 focuses on those working as physicians, comparing earnings for non-immigrants and immigrants as a function of years since migration. There is a very clear profile with years since migration. On average, immigrants in Canada for more than 20 years had earnings in excess of non-immigrants, whereas those who arrived less than four years prior to the census had earnings approximately half of that of non-immigrants. Of course, in a simple cross-section of data such as that presented it is impossible to identify to what extent the profile reflects integration over time versus changing arrival cohort effects. Moreover, there are no statistical controls for demographic characteristics.

Table 26 presents summary statistics for nurses comparable to those in Table 24 for physicians. While there are some similarities to the patterns observed for physicians, there are also notable differences. For both health professions there is clearly a substantial relationship between outcomes and working in the area for which they report having a credential. In contrast to

TABLE 24

## LABOUR MARKET OUTCOMES FOR THOSE WORKING AND NOT WORKING AS PHYSICIANS

| Panel 1 | Self report working as physicians | | | |
|---|---|---|---|---|
| | Immigration status | | Location of highest study | |
| | Non-immigrants | Immigrants | Domestically educated | Foreign educated |
| Mean earned income (2005) | Can$165 645 | Can$150 470 | Can$165 740 | Can$135 095 |
| Mean hours worked in ref week | 49 | 48 | 49 | 47 |
| Mean weeks worked in 2005 | 47 | 47 | 48 | 47 |
| Mean age | 44 | 47 | 44 | 48 |
| Female (%) | 40.4 | 35.4 | 39.7 | 33.8 |
| Employed (%) | 98.1 | 95.7 | 98.2 | 92.9 |
| Immigrant (%) | — | — | 22.6 | 88.7 |
| N | 41 960 (66.1%) | 21 495 (33.9%) | 52 610 (82.9%) | 10 850 (17.1%) |
| **Panel 2** | **Self report not working as physicians** | | | |
| | Immigration status | | Location of highest study | |
| | Non-immigrants | Immigrants | Domestically educated | Foreign educated |
| Mean earned income (2005) | Can$76 050 | Can$29 230 | Can$77 305 | Can$24 785 |
| Mean hours worked in ref week | 27 | 22 | 28 | 21 |
| Mean weeks worked in 2005 | 32 | 28 | 32 | 28 |
| Mean age | 42 | 43 | 43 | 43 |
| Female (%) | 46.0 | 57.8 | 47.3 | 58.1 |
| Employed (%) | 64.6 | 59.4 | 65.9 | 58.5 |
| Immigrant (%) | — | — | 25.9 | 96.5 |
| N | 5180 (25.5%) | 15115 (74.5%) | 6340 (31.2%) | 13 960 (68.8%) |

Notes: —, not determined; N, count. Physicians include general practitioners, family physicians and specialists. Earned income is the sum of positive self-employment income, and wages and salaries. It is gross of taxes, but net of any business/professional expenses; see Statistics Canada (2006). Those not working as physicians have at least MD credentials and may have additional degrees. Earnings and weeks of work are for the calendar year 2005. Panel 1, by definition, comprises only workers, whereas panel 2 includes workers, the unemployed and those out of the labour force.

Source: Canadian 2006 Census Masterfile; ages 25–64.

## EARNINGS AND YEARS SINCE MIGRATION FOR THOSE WORKING AS PHYSICIANS

TABLE 25

| Duration of stay in Canada | Frequency | % | Mean earned income (Can$) |
|---|---|---|---|
| Non-immigrant | 41 960 | 66.1 | 165 645 |
| Immigrants: 20+ years | 12 175 | 19.2 | 176 085 |
| Immigrants: 10–19 years | 4600 | 7.2 | 144 620 |
| Immigrants: 5–9 years | 2055 | 3.2 | 105 260 |
| Immigrants: Less than 4 years | 2660 | 4.2 | 78 325 |

Note: Frequency is the estimated count in the population.

Source: Canadian 2006 Census Masterfile; see Table 24.

## LABOUR MARKET OUTCOMES FOR THOSE WORKING AND NOT WORKING AS REGISTERED NURSES (RNs)

TABLE 26

| | Self report working as RNs | | | |
|---|---|---|---|---|
| | Immigration status | | Location of highest study | |
| Panel 1 | Non-immigrants | Immigrants | Domestically educated | Foreign educated |
| Mean earned income | Can$50 230 | Can$51 200 | Can$50 335 | Can$51 195 |
| Mean hours | 31 | 33 | 31 | 33 |
| Mean weeks worked in 2005 | 47 | 46 | 47 | 45 |
| Mean age | 44 | 45 | 44 | 46 |
| Female (%) | 94.3 | 92.0 | 94.1 | 91.5 |
| Employed (%) | 93.1 | 92.1 | 93.2 | 90.9 |
| Immigrants (%) | — | — | 11.8 | 90.9 |
| N | 197 520 (80.8%) | 47 000 (19.2%) | 22 1650 (90.6%) | 22 870 (9.4%) |
| | Self report not working as RNs | | | |
| | Immigration status | | Location of highest study | |
| Panel 2 | Non-immigrants | Immigrants | Domestically educated | Foreign educated |
| Mean earned income | Can$28 130 | Can$21 745 | Can$27 840 | Can$20 260 |
| Mean hours | 20 | 21 | 20 | 21 |
| Mean weeks worked in 2005 | 30 | 30 | 30 | 30 |
| Mean age | 50 | 48 | 50 | 48 |
| Female (%) | 94.6 | 93.9 | 94.5 | 94.0 |
| Employed (%) | 59.5 | 60.8 | 59.6 | 60.6 |
| Immigrants (%) | — | — | 11.1 | 94.3 |
| N | 112 630 (73.7%) | 40 290 (26.3%) | 124 880 (81.7%) | 28 045 (18.3%) |

Notes: —, not determined; N, count. Earned income is the sum of positive self-employment income, and wages and salaries. It is gross of taxes, but net of any business/professional expenses; see Statistics Canada (2006). Those not working as registered nurses have nursing credentials and may have additional degrees. Panel 1, by definition, comprises only workers, whereas panel 2 includes workers, the unemployed and those out of the labour force.

Source: Canadian 2006 Census Masterfile; ages 25–64.

TABLE 27

### EARNINGS AND YEARS SINCE MIGRATION FOR THOSE WORKING AS REGISTERED NURSES

| Duration of stay in Canada | Frequency | % | Mean earned income (Can$) |
|---|---|---|---|
| Non-immigrant | 197 520 | 80.8 | 50 230 |
| Immigrants: 20+ years | 24 715 | 10.1 | 55 050 |
| Immigrants: 10–19 years | 12 055 | 4.9 | 51 785 |
| Immigrants: 5–9 years | 5495 | 2.2 | 45 180 |
| Immigrants: Less than 4 years | 4685 | 1.9 | 36 700 |

Note: Frequency is the estimated count in the population.
Source: Canadian 2006 Census Masterfile; see Table 26.

physicians, immigrant and internationally educated individuals working as nurses have earnings that are remarkably similar to, although slightly higher than, those of non-immigrants and the domestically educated respectively. For those not working as nurses, immigrants earn slightly less despite working comparable hours and weeks, however, the gap is not nearly as large as that for physicians. Earnings as a function of years since migration are presented in Table 25. Although the means differ, the profile is broadly similar to that for physicians. Immigrants who arrived more than 20 years ago, on average, have higher annual earnings than non-immigrants while more recent arrivals earn less.

## Discussion

Since the mid-2000s there have been, for the most part, increasing numbers of health professionals gaining access to practice in Canada, although the patterns can differ dramatically as witnessed by the accumulated stock of, and current trends among the flow of new, physicians and nurses. As of 2013, the recession appears to have had no appreciable effect on the admission of new immigrants and the integration of health professionals into Canadian practice. Although not related to the recession but concurrent with it, if anything the changes in recent years have involved steps towards the improved integration of IEHPs into the Canadian workforce.

Looking forward, financial constraints will affect the mostly publicly funded and/or subsidized health workforce in the near future as government debt and deficits are addressed. The large and increasing number of IEHPs practicing (and not practicing) in Canada suggests that shortages in some less well-off countries may be exacerbated, although there appear to be substantial increases in international health professional and medical schools preparing graduates for export that may offset some of this effect in the future. Reflecting this, an issue of concern at the moment among the Canadian medical community is the competition for postgraduate training spaces between immigrant and Canadian IMGs. More generally, care needs to be taken to differentiate between place of birth and place of education since a large percentage of immigrant health professionals receive at least some of their education in Canada. Unfortunately, we do not have adequate data to explore this issue in detail.

In light of the World Health Organization's (2008) Code of ethical recruitment for health professionals, and the problems in many countries around the world motivating this Code, the topic has been the subject of policy discussion in Canada. IEHPs have been vital to Canada's physician resource planning, especially in addressing the issue of underserved communities (e.g., the 2004 report of the Canadian Task Force on Licensure of International Medical Graduates[10]), and they allow health human resource shortages more generally to be addressed rapidly. However, one long-term response has been discussions regarding a move to increased self-sufficiency as outlined in a report of the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR, 2009). Whether this target will be achieved is a matter of conjecture, but the CMA does not anticipate the cessation of the flow of international graduates, but rather views IMGs as a significant "planning component for sustainable Canadian physician workforce" (CMA & CCCPR, 2008).

All results using the Canadian census were produced using data in Statistics Canada's Research Data Centre (RDC) at McMaster University and we thank the RDC staff for their assistance. Disclosure of the results is in accord with the regulations and guidelines of Statistics Canada. All opinions are those of the authors and do not necessarily reflect those of Statistics Canada or the Ontario government.

**References**

ACHDHR (2009). How many are enough? Redefining self-sufficiency for the health workforce, A Discussion Paper. Canadian Federal/Provincial/Territorial, Advisory Committee on Health Delivery and Human Resources, Ottawa, ON: Health Canada (http://www.hcsc. gc.ca/hcs-sss/pubs/hhrhs/2009-self-sufficiency-autosuffisance/index-eng.php, accessed 24 July 2010).

Audas R, Ryan A, Vardy D (2009). Where did the doctors go? A study of retention and migration of provisionally licensed international medical graduates practicing in Newfoundland and Labrador between 1995 and 2006. Can J Rur Med.14:21–24.

Banner S, Comeau M (2006). Analysis of the 2006 survey of Canadians studying medicine and the medical schools training Canadians outside of Canada and the U.S. Final report to Health Canada:1–20.

Banner S, McKiver A, Rattanasithy S, Cassie J, Woodward C, Ford R (2010). Canadian students studying medicine abroad. Canadian Resident Matching Service (CaRMS) report:5–6.

Barer M, Stoddart G (1991). Toward integrated medical resource policies for Canada: background document. HPRU 91:06D.

Basky G, Mathews M, Edwards AC, Rourke JTB (2007). Do they stay or do they go? Retention of provisionally licensed international medical graduates in Newfoundland and Labrador. Summary report. St. John's: Division of Community Health and Humanities, Memorial University of Newfoundland.

Baumann A, Hunsberger M, Crea-Arsenio M (2012). Impact of public policy on nursing employment: providing the evidence. Canadian Public Policy.38:167–179.

Busing N (2007). Managing physician shortages: we are not doing enough. Can Med Assoc J.176:1057.

10 http://rcpsc.medical.org/publicpolicy/imwc/IMG_Task%20force-poster-FINAL-ENG.pdf (accessed 26 April 2014).

CAPER (2011). National IMG database report, 2011. Ottawa, ON: Canadian Post-M.D. Education Registry, The Association of Faculties of Medicine of Canada.

CAPER (2012). Annual census of post-MD trainees, 2011–2012. Ottawa, ON: Canadian Post-M.D. Education Registry, The Association of Faculties of Medicine of Canada.

CEHPEA (2012). Annual report, 2011–2012. Toronto, ON: Centre for the Evaluation of Health Professionals Educated Abroad (http://www.cehpea.ca/pdf/annualReports/, accessed 10 September 2012).

CIHI (2010). Spending and health workforce, nursing database, regulated nurses: Canadian trends, series 2006 to 2010. Ottawa, ON: Canadian Institute for Health Information (https://secure.cihi.ca/estore/productbrowse.htm, accessed 10 August 2012).

Citizenship and Immigration Canada (2010). Facts and figures, 2010. Toronto, ON (http://www.cic.gc.ca/english/resources/statistics/facts2010, accessed 15 June 2012).

Citizenship and Immigration Canada (2011). Facts and figures, 2011, (preliminary tables). Toronto, ON (http://www.cic.gc.ca/english/resources/statistics/facts2011-summary/01.asp, accessed 15 August 2012).

CMRC (2012). Canadian Midwifery Regulators Consortium [website] (http://www.cmrc-ccosf.ca/node/2, accessed 23 June 2012).

CMA (2012). Statistical information on Canadian physicians (Master file), January. Ottawa, ON: Canadian Medical Association and Canadian Collaborative Centre for Physician Resources (http://www.cma.ca/statistical-info-canadian-physicians, accessed 20 June 2012).

CMA and CCCPR (2008). International Medical Graduates in Canada, January 16, Ottawa, ON: Canadian Medical Association and Canadian Collaborative Centre for Physician Resources (http://www.cma.ca/multimedia/CMA/Content_Images/Policy_Advocacy/, accessed 20 June 2012).

CNA (various years). Canadian Registered Nurse Examination Bulletin, CRNE. Ottawa, ON (http://www.cna-aiic.ca/en/becoming-an-rn/rn-exam/crne-bulletins/, accessed 5 September 2012).

CNA (2009). Tested solutions for eliminating Canada's registered nurses shortage, July 2009. Ottawa, ON: Canadian Nurses Association (http://www2.cna-aiic.ca/CNA/issues/hhr/default_e.aspx, accessed 15 July 2010).

Dussault G, Fronteira I, Cabral J (2009). Migration of health personnel in the WHO European Region. Lisbon, Instituto de Higiene e Medicina Tropical (http://www.euro.who.int/__data/assets/pdf_file/0010/95689/E93039.pdf, accessed 15 November 2011).

Goldmann G, Sweetman A, Warman C (2011). The portability of new immigrants' human capital: language, education and occupational matching. IZA Working Paper 5851 (http://www.iza.org).

Grignon, M, Owusu, Y, Sweetman, A (2013). The international migration of health professionals. In: Constant AF, Zimmermann KF, editors. The international handbook on the economics of migration. Cheltenham, UK: Edward Elgar:75–97.

Henry DA, Schultz SE, Glazier RH, Bhatia RS, Dhalla IA, Laupacis A (2012). Payments to Ontario physicians from Ministry of Health and long-term care sources, 1992/93 to 2009/10. ICES Investigative Report. Toronto, ON: Institute for Clinical Evaluative Sciences.

Lesky LG (2011). Physician migration to the United States and Canada: criteria for admission. In: Chiswick BR, editor. High-skilled immigration in a global labor market. Washington, DC: American Enterprise Institute Press:155–164.

Marchildon GP (2006). Health systems in transition: Canada. Toronto, ON: University of Toronto Press.

McDonald JT, Warman C and Worswick C (2011). Immigrant selection systems and occupational outcomes of international medical graduates in Canada and the United States, Queen's Economics Department Working Paper 1285. Kingston, ON: Queen's University.

McDonald JT, Worswick C (2012). The migration decisions of physicians in Canada: the roles of immigrant status and spousal characteristics. Soc Sci Med.75:1581–1588.

Medical Council of Canada (2011). Annual Report, 2011: recalibrating for the future. (http://www.mcc.ca/pdf/annual_report_2011_en.pdf, accessed 10 September, 2012).

OECD (2007). OECD in figures, 2007 edition. Paris: Organisation for Economic Co-operation and Development (http://www.oecd-ilibrary.org/economics/oecd-in-figures-2007_oif-2007-en;jsessionid=2s2v9begvqfr1.delta, accessed 5 April 2010).

OECD (2009). OECD in figures, 2009 edition. Paris (http://www.oecd-ilibrary.org/economics/oecd-in-figures-2009_oif-2009-en, accessed 5 April 2010).

OECD (2010). List of members of OECD. Paris (http://www.oecd.org/about/membersandpartners/, accessed 12 January 2012).

OMA (2012). Media statement – new labour agreement between OECTA and McGuinty government". Toronto, ON: Ontario Medical Association (https://www.oma.org/Mediaroom/PressReleases/Pages/MediaStatementOECTAAgreement.aspx, accessed 5 July 2012).

Ontario Ministry of Finance (2012). Addendum to the 2012 Ontario budget: report on expense management measures. Toronto, ON (http://www.fin.gov.on.ca/en/budget/ontariobudgets/2012/addendum.html#sec4o, accessed 26 April 2014).

Ontario Ministry of Health and Long-Term Care (2007). Guidelines for return of service (ROS) for international medical graduates (IMGs), repatriation program and registration through practice assessment. Toronto, ON (http://www.carms.ca/pdfs/OntarioROS.pdf, accessed 26 April 2014).

Ontario Ministry of Health and Long-Term Care (2012a). News release: statement from Ontario's Health Minister in response to the Ontario Medical Association, April 12. Toronto, ON (http://www.health.gov.on.ca/en/news/release/2012/apr/nr_20120412_1.aspx, accessed 5 July 2012).

Ontario Ministry of Health and Long-Term Care (2012b). News release: statement from Ontario's Health Minister April 27. Toronto, ON (http://www.health.gov.on.ca/en/news/release/2012/apr/nr_20120427_1.aspx, accessed 5 July 2012).

Picot G, Sweetman A (2012). Making it in Canada: immigration outcomes and policies IRPP Study 29:1–42 (http://www.irpp.org).

Statistics Canada (2006). Census 2006 definitions of variables. Ottawa, ON (http://www12.statcan.ca/censusrecensement/2006/ref/dict/overview-apercu/pop5-eng.cfm, accessed 10 June 2010).

Task Force Two (2006). A physician human resource strategy for Canada. Final report 2006. Ottawa, ON (http://www.physicianhr.ca/home-e.php, accessed 2 September 2012).

Thomson G, Cohl K (2011). IMG selection: independent review of access to postgraduate programs by international medical graduates in Ontario, Volume 1 and 2. Toronto, ON: Ministry of Health and Long-Term Care and the Council of Ontario Universities.

WHO (2006). World Health Report, 2006. Geneva: World Health Organization (http://www.who.int/workforcealliance/countries/57crisiscountries.pdf, accessed 5 July 2012).

WHO (2008). Global Code of Practice on the international recruitment of health personnel. Kampala Declaration, First Global Forum on Human Resources for Health, Kampala, 2–7 March, 2008.

World Bank (2011). Country income level groups. Washington, DC (http://data.worldbank.org/about/countryclassifications, accessed 19 Jan 2012).

CHAPTER 11

# Immigration and the health-care workforce in the United Kingdom since the global economic crisis

MADELEINE SUMPTION

RUTH YOUNG

©WHO

Great expectations in the United Kingdom.

## Key findings

- The immigrant health workforce grew rapidly in the first half of the 2000s, but this growth came to a halt after 2006 when the government tightened policies on international recruitment, work permits, and professional registration.
- The number of health-care professionals coming to the United Kingdom on work visas has plummeted since the mid-decade, although most of this decline predated the economic crisis. During the recessionary period, the size of the health-care workforce in the country has remained roughly stable.
- With the decline of deliberate recruitment efforts and the tightening of visa and professional registration requirements, European Economic Area (EEA) nationals have grown as a share of newly registering doctors and nurses. Particularly notable increases in recent years have come from crisis-hit EU countries such as Greece and Spain.
- The government's efforts to restrict immigration are primarily affecting less-skilled occupations (below the level of nurses and midwives). However, newly introduced policies could have a significant impact on the retention of nurses, since most will no longer be eligible for permanent settlement in the United Kingdom as they have been in the past.
- The health-care industry was sheltered from the brunt of the economic crisis, avoiding the high unemployment associated with some other occupations. As a result, immigrant health-care workers have fared better than many other immigrants in recent years, despite a weak economy. Demand for health care is expected to increase in coming years, although a very tight fiscal environment will bring growth in the National Health Service (NHS) budget (and hence the workforce) down to extremely low levels. Since most health care in the United Kingdom is publicly funded, the future economic and fiscal outlook will be crucial in determining whether the international migration of health-care workers will rebound.

The 2000s was an unusual decade for both immigration and health care in the United Kingdom. The global economic crisis hit the United Kingdom at a time when both immigration and the United Kingdom health workforce had expanded enormously. Increasing the size of the NHS workforce was one of the signature policies of the Labour government that governed from 1997 to 2010. That government will also be remembered for one of the major transformations that took place under its watch: the growth of the immigrant population from four million to seven

million between 1997 and 2010[1]. The two fields are also deeply intertwined. Health care has been a major employer for immigrant workers in the United Kingdom, and was a significant magnet for employment-based immigration over the past decade.

Immigration and health-care since the global economic crisis must, therefore, be seen in the light of the recent history of both policy fields. Immigration flows fell with the onset of the crisis – especially types of immigration that are particularly responsive to the state of the economy, such as employer-sponsored immigration and free movement from within the EU. In 2010, a coalition government was elected, the majority partner of which came to power with a clear manifesto commitment to reduce immigration. This campaign promise was not simply a response to the economic crisis (which may nonetheless have played a role), but part of a broader political impetus to slow the pace of change after the high immigration levels of the mid-2000s.

Meanwhile, the government's agenda has been dominated by efforts to reduce the budget deficit. The NHS has been protected from the brunt of the spending cuts but is still expected to face substantial financial pressure in coming years. After years of growth well above inflation, spending increases for publicly funded health care are at almost zero, while demand for health-care services continues to rise.

## Immigrant health professionals in the United Kingdom

Immigrant health professionals have long been an important component of the United Kingdom's health-care workforce, and government initiatives to recruit actively from abroad have taken place periodically for decades (Young, Weir & Buchan, 2010:7). Immigrants now make up approximately 14% of the employed population in the United Kingdom, but are much more strongly represented in the health workforce, making up more than a third of medical practitioners, pharmacists, and dental practitioners, and over one fifth of nurses (Table 28).

TABLE 28

### IMMIGRANT REPRESENTATION IN MAJOR MEDICAL OCCUPATIONS, Q1 2012

| | United Kingdom-born | Foreign-born | Total | Foreign-born (%) |
|---|---|---|---|---|
| Nurses | 451 000 | 126 000 | 577 000 | 22 |
| Medical practitioners | 143 000 | 78 000 | 220 000 | 35 |
| Pharmacists | 32 000 | 18 000 | 50 000 | 37 |
| Dental practitioners | 21 000 | 11 000 | 33 000 | 35 |
| Total United Kingdom employment | 24 898 000 | 4 059 000 | 28 957 000 | 14 |

Source: Office for National Statistics (2012a).

1 Immigrants defined as those born abroad. Source: Author's calculations from UK Labour Force Survey, Q1 1997 and 2010, made available by the UK Data Archive.

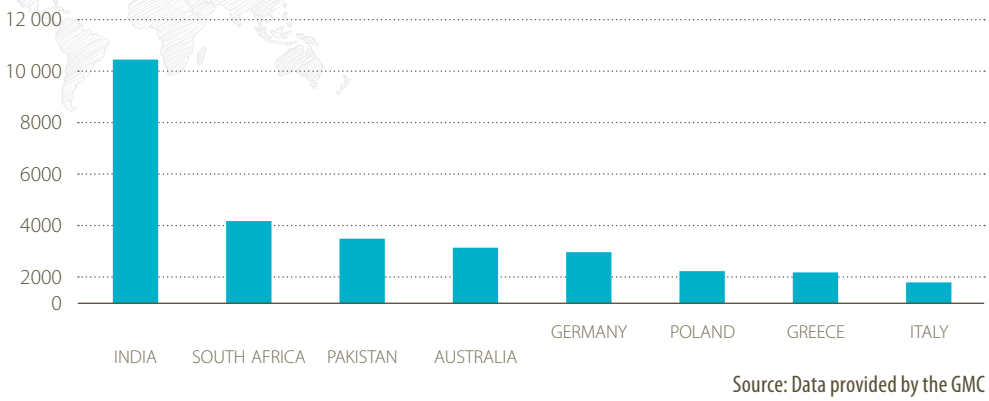
The early 2000s witnessed a particularly strong increase in the number of immigrant health-care workers. Identifying a shortage of doctors and nurses as a major impediment to improved health care, the government at the time had set explicit targets for increasing the size of the NHS workforce. The government's health plan included additional training places for domestic candidates, but since these professionals could not arrive in the labour market immediately, a disproportionate share of the growth in the initial years of the expansion programme came from the foreign-trained.

Many of the international hires came through a policy of active international recruitment (Buchan, Baldwin & Munro, 2008:25; Young, Weir & Buchan, 2010). The government concluded agreements with sending countries such as India, the Philippines and Spain to facilitate overseas recruitment of nurses, doctors and, to a lesser extent, pharmacists, dentists and allied health professionals into the NHS (DoH, 2002). For medical doctors, the government also launched an International Fellowship Programme targeted at specialists thought to be in shortage in the United Kingdom, such as psychiatrists and radiologists (DoH, 2002). Specifically in Germany India, Italy and Spain, recruitment by individual NHS organizations and through the International Fellowship Programme was facilitated by the relevant British Embassy or, in India, the High Commission. The DoH also partnered with a private firm to create a database of suitably qualified international recruits on which NHS employers could draw to fill vacant positions. In addition to direct recruitment into NHS employment, some immigrants were recruited or applied to work with private sector employers (such as nursing homes) where they gained work experience in the United Kingdom before moving on to work in the NHS (Buchan & Dovlo 2008).

From 2003 to 2005, tens of thousands of foreign-trained doctors registered to work in the United Kingdom. The largest source country by some distance was India, followed by South Africa, Pakistan, and Australia. Smaller numbers came from European countries, among which the most significant senders were Germany, Greece, Italy, and, after EU enlargement gave its citizens freedom of movement to the United Kingdom in 2004, Poland (Figure 20). Several European countries had recruitment agreements with the United Kingdom, including Austria, Germany, Italy and Spain. Foreign-trained immigrants from Europe and beyond made up a majority of newly registering doctors throughout the first half of the decade, peaking at 75% in

FIGURE 20

**NEW FIRST-TIME REGISTRANTS, GENERAL MEDICAL COUNCIL (GMC) 2003–2005**




Source: Data provided by the GMC

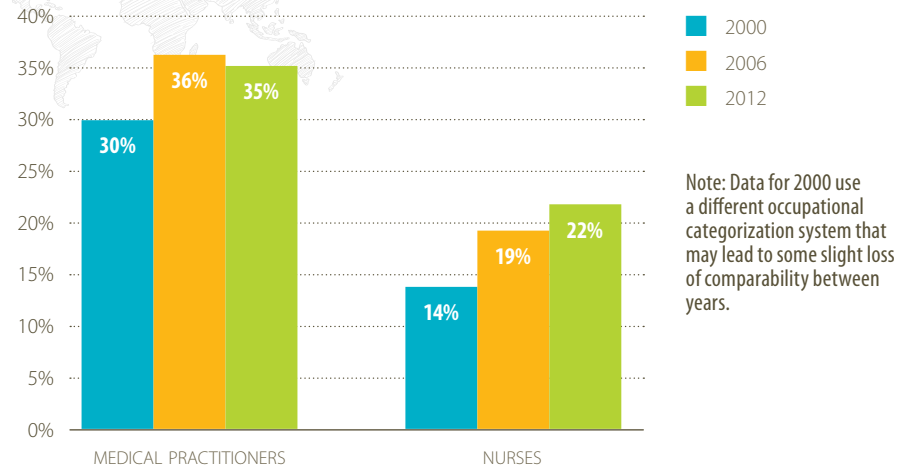
2003. Overall, the share of foreign-trained doctors registered to practice in the United Kingdom increased from 32% in 2000 to 39% in 2005[2].

These doctors are not "exclusively" foreign-trained. Many received additional specialist training in the United Kingdom. According to the UK Labour Force Survey (LFS), a significantly lower share – only 14% of medical practitioners – received their *highest* qualification overseas. Indeed, most of the medical doctors who came to the United Kingdom in this period did not do so because they had been targeted for active recruitment but entered the country as trainees with a medical degree. In the early 2000s, when the United Kingdom was actively facilitating health workforce immigration, these trainees did not require a work permit but could enter on an (easier to obtain) trainee visa.

A lower share of nurses in the country come from abroad, compared to doctors. In early 2012, 22% of nurses were born overseas, compared to 35% of doctors (Figure 21). Comparable data on the country in which registered nurses received their primary qualification are not available, although an estimated 13% of employed nurses received their *highest* qualification abroad according to the LFS in early 2012. This figure does not count foreign-trained nurses who received further training in the United Kingdom, although additional training beyond an initial degree or diploma is less common for nurses than for doctors.

FIGURE 21

**FOREIGN-BORN SHARE OF MEDICAL AND NURSING OCCUPATIONS, 2000–2012**




Note: Data for 2000 use a different occupational categorization system that may lead to some slight loss of comparability between years.

Source: Author's calculations from UK Labour Force Survey, Q1 (Office for National Statistics, 2000; 2006; 2012).

2 Data provided by the GMC. Note that these figures include individuals registered to work but who are not working. As a result, they may overstate immigration flows, since they count workers who apply to have their professional competence recognized in the United Kingdom but do not, in fact, move.

However, the *growth* in nurse migration in the early 2000s was more dramatic – both as a share of the workforce and in absolute terms – than for doctors. The United Kingdom's international recruitment policy from 1998 onwards actively targeted nurses in particular and brought thousands of nursing professionals from countries such as India and the Philippines that previously had negligible health workforce migration to the country. The share of foreign-born individuals in the nursing workforce increased from 14% to 22% from 2000 to 2012. During the 2000s, 93 000 foreign-trained nurses registered with the Nursing and Midwifery Council, making up 33% of new registrants. In 2000–2001, the peak of nursing recruitment to the United Kingdom, 53% of newly registering nurses had received their primary qualification overseas. Two-thirds came from just four source countries: the Philippines (32%), India (17%), South Africa (10%), and Australia (8%)[3].

## Developments since the mid-2000s

In 2006, the policy of mass international recruitment of health-care workers came to an end. Increased numbers of domestically trained workers had begun to enter the workforce, and there were some indications that the government might have "overshot" its targets, creating a greater supply (of foreign and domestically trained individuals) than it could afford to employ (Buchan, Baldwin & Munro, 2008).

At the same time, a number of significant policy changes were introduced to reduce health professional migration to the United Kingdom. First, IMGs coming to the United Kingdom from outside of the EEA to complete clinical training were required to have a work permit rather than a student visa (DoH, 2006). This meant that employers had to attempt to recruit local workers before they could employ a non-EEA national.

Meanwhile, nurses were removed from the "shortage occupation" list, which had previously allowed employers to recruit international candidates without first advertising the vacancy in the domestic labour force, although midwives and certain more skilled nursing positions were still deemed to be in shortage and remained on the list. (Note: The number of immigrant midwives remained relatively small, however; visa applications totalled less than 100 per year from 2000 to 2008, and foreign-born midwives identified in the UK Labour Force Survey are too few to provide reliable estimates but probably number in the low thousands. Moreover, the removal of top-up courses to help non-EEA midwives to register in the country made migration extremely difficult for this group from 2006 onwards.)

From 2006, the professional regulation requirements for non-EEA health professionals were also tightened. More stringent language requirements were introduced for non-EEA nurses, as well as a required orientation course known as the Overseas Nurses Programme (ONP). While the programme is only 20 days long, it must be delivered with an accredited provider and places are limited. Long backlogs of nurses waiting for an ONP place have been reported (Buchan, 2007). Similarly, reciprocal recognition for Australian and New Zealand pharmacists and allied health professionals (AHPs) were removed, increasing the barriers to professional registration.

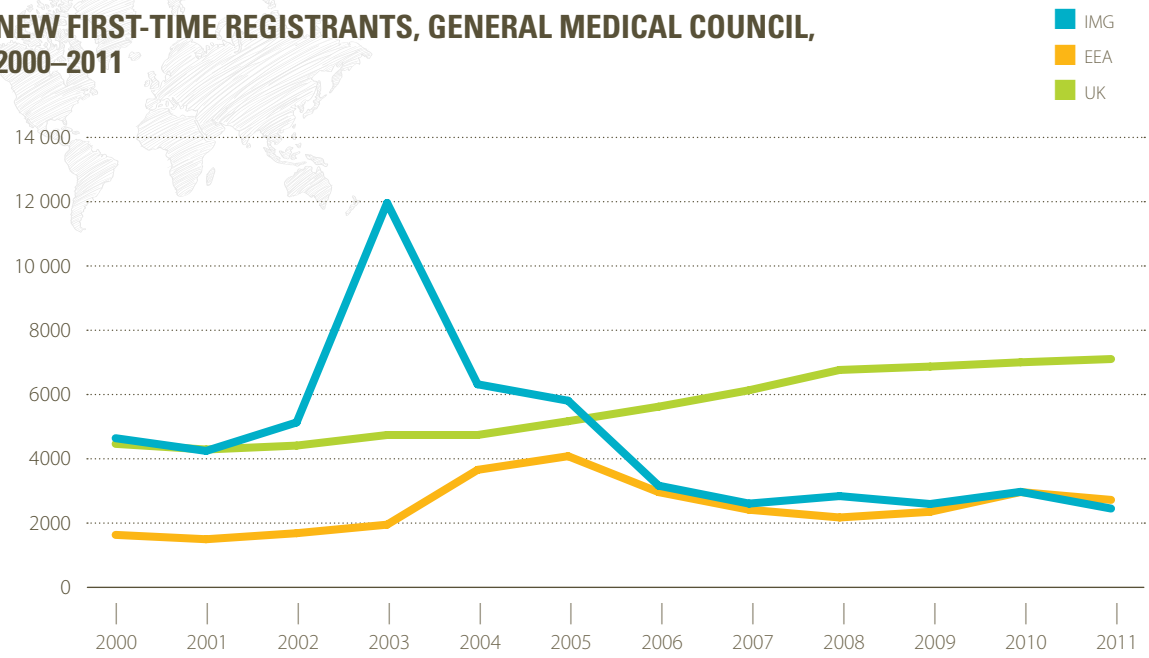
The cumulative effect of these policy changes was a dramatic reduction in health workforce immigration relative to the levels of the early 2000s. The number of foreign-trained doctors

3 Data provided by the NMC.

newly registering with the GMC fell from a 2003 peak of 14 000 to less than 5000 in 2007 (Figure 20). The decline was sharpest for doctors from outside of the EEA, whose flows are more directly controlled by immigration policies and professional regulation. (Immigrants from other EEA countries do not need a visa and have the right to more automatic recognition of professional qualifications under EU law.) Note that surge in IMG registrations in 2003 was stimulated by the impending withdrawal of the automatic recognition, for historical reasons, of qualifications from seven countries – Australia, China, Hong Kong SAR, Malaysia, New Zealand, Singapore, South Africa and the West Indies. Qualifications from those countries are now treated on the same basis as other countries outside the EEA[4]. Initial registrations from nationals of these countries averaged 1000 per year from 2000 to 2002; they spiked to over 7000 in 2003 after the policy change was announced; and then fell to between 100 and 200 per year thereafter – illustrating the importance of professional regulation in shaping application trends. While the number of doctors continued to grow after 2006, most of the growth has come from individuals qualified in the United Kingdom (Figure 22).

FIGURE 22

**NEW FIRST-TIME REGISTRANTS, GENERAL MEDICAL COUNCIL, 2000–2011**



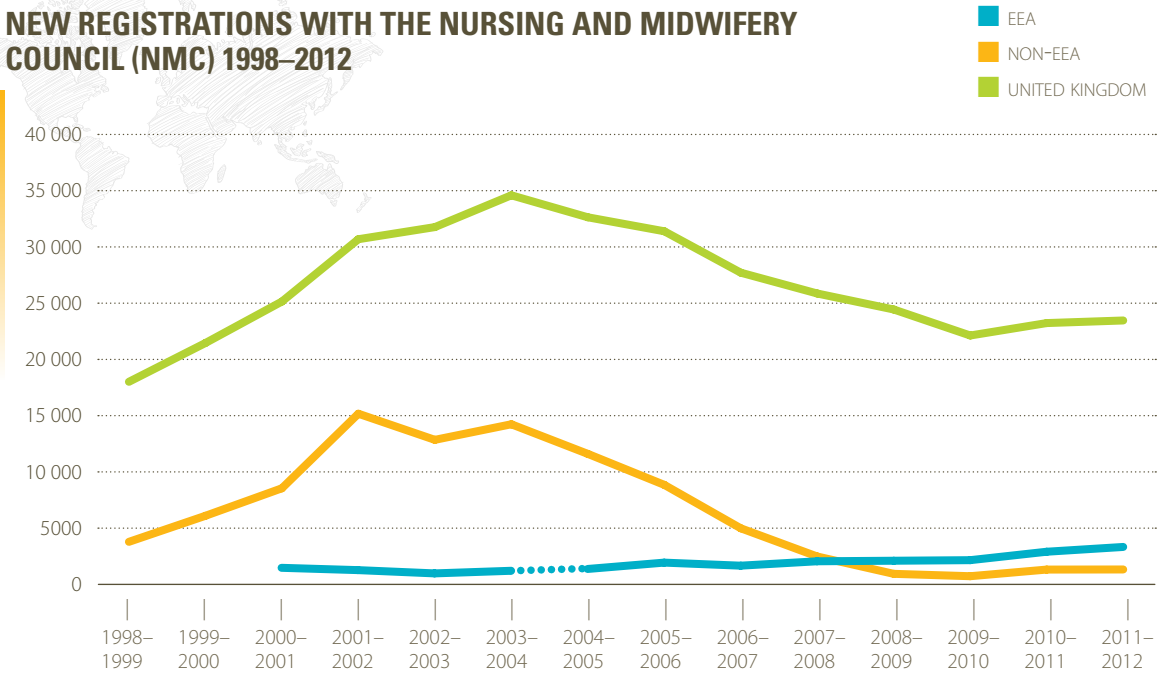

Note: EEA nationals include all current Member States, even in the pre-2004 data when these countries were not yet members of the EU. Much of the increase in EEA registrations between 2003 and 2004 results from an increase in the number of new EEA nationals registering to practice in the United Kingdom.

Source: Data provided by the GMC.

4 http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/1077/1077we29.htm (accessed 26 April 2014).

FIGURE 23

## NEW REGISTRATIONS WITH THE NURSING AND MIDWIFERY COUNCIL (NMC) 1998–2012




Note: EEA nationals are categorized according to their status at the time data were collected (thus new EU member states such as Poland are classified as non-EU nationals before 2004).

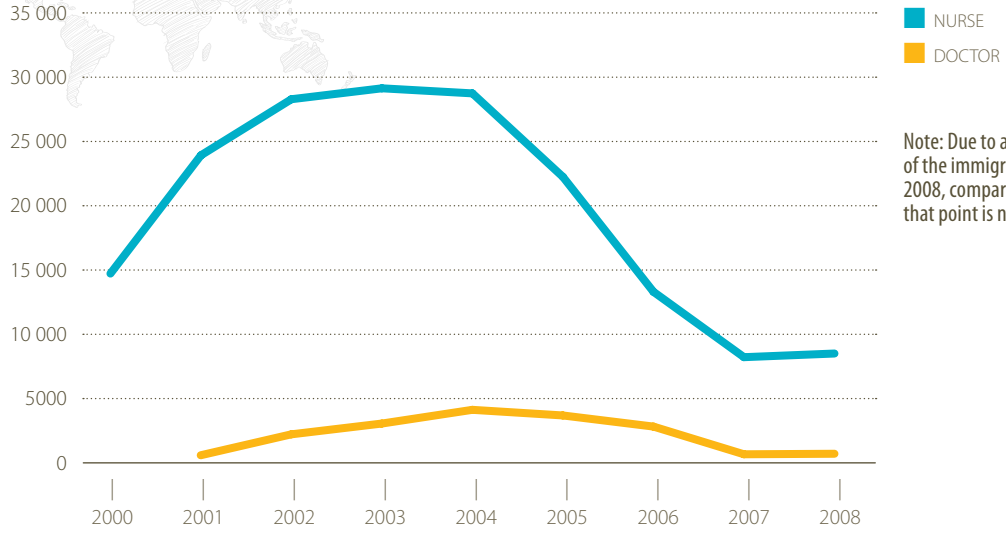
Source: Data provided by the NMC.

For nurses, new registrations from overseas peaked in 2001–2004, after which they declined steadily from 14 000 non-EU registrants in 2003–2004, to less than 1000 in 2008–2009 (Figure 23). Foreign-trained nurses from inside the EU made up a smaller share of new arrivals than for doctors, although this share grew slightly after 2007.

Work-permit data provide a similar picture: the substantial influx of nurses and doctors on work visas in the first half of the decade subsided rapidly in the second half as international recruitment policies were tightened, more professionals trained in the United Kingdom arrived in the labour market, and the expansion in health workforce slowed (Figure 24). Note that these numbers are significantly larger than the number gaining professional registration during the same period – a fact that may result from flows of health assistants and other workers that lack full nursing qualifications.

FIGURE 24

## WORK PERMITS ISSUED TO NON-EU NURSES AND DOCTORS, 2000–2008



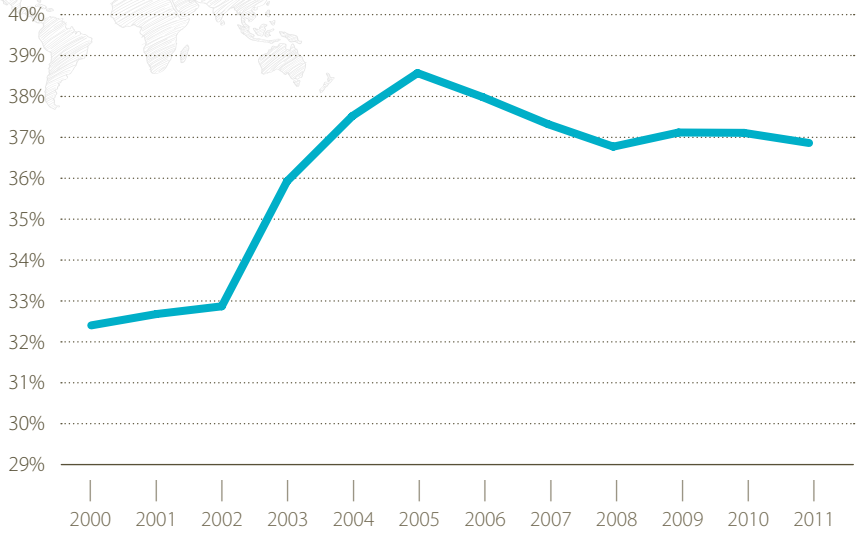

Note: Due to a major overhaul of the immigration system in 2008, comparable data after that point is not available.

Source: UK. Home Office (2009).

After the large increase of the early 2000s, the share of foreign-trained medical doctors fell modestly to 37% by the end of 2008. This share remained roughly constant over the course of the economic crisis (Figure 25), despite the introduction of a few policies designed to tighten employment-based immigration rules across the workforce.

FIGURE 25

## SHARE OF FOREIGN-TRAINED MEDICAL DOCTORS REGISTERED WITH THE GMC, 2000–2011

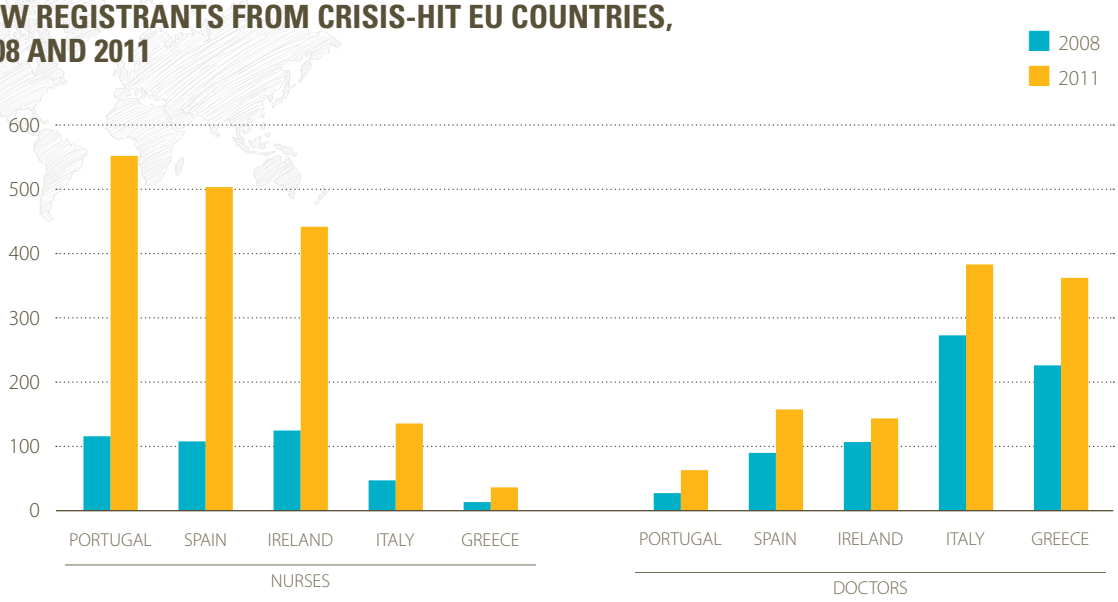



Note: Country of training is for primary medical qualification, not highest or most recent qualification.

Source: Data provided to the author by GMC.

FIGURE 26

## NEW REGISTRANTS FROM CRISIS-HIT EU COUNTRIES, 2008 AND 2011




Source: Data provided by GMC and NMC.

About one quarter of foreign-trained doctors are from the EEA, and thus do not require a visa to work in the United Kingdom. Although European citizens can move freely to work in the United Kingdom and face a much less onerous professional registration process, they may experience greater language barriers than immigrants from countries such as India or the Philippines where English is an official language. The share of European doctors on the GMC register has increased modestly since EU enlargement, from 22% in 2004 to 27% in 2011, and since the late 2000s the share of EEA nationals among new foreign-trained registrants has reached about 50%. European countries have not been a large source of nurses in absolute terms, although their share of all foreign-trained registrants has increased substantially, overtaking non-EEA registrants in 2008–2009 and making up more than 70% of newly approved applicants thereafter (Figure 23). Interestingly, the number of doctors and nurses from crisis-hit southern European countries registering to practise in the United Kingdom has increased sharply since 2008 (Figure 26).

By 2012, the dominant sending country for nurses employed in the United Kingdom was the Philippines, which was the country of birth for about 36 000 nurses (28% of all foreign-born nurses working in the country) – a legacy of the government's active recruitment there. India was the dominant sending country for medical practitioners (the country of birth for 28 000 or 37% of foreign-born doctors), and also supplied 18% of immigrant nurses (Buchan, 2007).

About two fifths, or 47 000, of the 127 000 foreign-born nurses come from countries defined by the WHO as facing a critical health-worker shortage. Almost three fifths, or 46 000, of the 78 000 immigrant medical practitioners were born in these countries[5], and just under half of the doctors who were not trained in the United Kingdom registered to practice there and received their primary qualification there[6]. These data may seem surprising in light of the fact that the

5 Author's calculations from the LFS, Q1 2012 (Office for National Statistics, 2012b).

6 MPI analysis of data provided by GMC.

United Kingdom has for over a decade had a code of practice to regulate the recruitment of health professionals from developing countries concerned about the loss of these workers. However, the data come with some caveats. First, not all of these individuals will have been trained partially or fully in their countries of origin. Second, doctors and nurses from one country, India, overwhelmingly drive these numbers. Some of the Indian health professionals were actively recruited by the United Kingdom government, but this recruitment took place with the consent and cooperation of the Indian government. (The agreement specified that four states receiving British development aid should not be targeted: Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal.) Many others arrived of their own accord, applying for traineeships or other employment vacancies. Health professionals from other developing countries have arrived in the country as asylum-seekers or refugees before making their way into the health workforce. (For example, new registrations of doctors from Sudan quadrupled from 50 to 200 between 2006 and 2011.) As a result, it is difficult to draw definitive conclusions about the United Kingdom's employers' compliance with ethical recruitment guidelines.

## Immigration policy and routes into the United Kingdom's health-care workforce

Immigrant health professionals come to the United Kingdom under a range of different visa routes. An estimated 50% of foreign nationals employed as health professionals reported work as their primary reason for migration in 2008 – a slightly higher share than the average of 40% across the workforce in the United Kingdom[7]. EEA nationals do not require a visa to work in the country, and can come and go relatively freely[8]. Health professionals from most countries, however, must be sponsored by a employer in the United Kingdom, as is the case with other skilled workers. To hire IMGs, employers must generally advertise vacancies locally and demonstrate an unsuccessful attempt to hire from within the EEA before they can sponsor a work permit. Some exceptions to this rule exist, most notably for those who gained their qualifications at an institution in the United Kingdom, and for specialist occupations deemed to face a shortage of qualified workers in the labour market. Foreign students who complete a United Kingdom medical degree are exempt from this requirement, and are also able to complete their two-year Foundation Programme of postgraduate training (to become a fully qualified doctor) on a student visa rather than a work permit[9]. Nurses coming from outside of the EEA require an employer-sponsored work visa.

Health professionals also arrive through non-employment immigration routes. One fifth of foreign nationals employed as health professionals reported family unification as their reason for migrating in 2008[10]. Others enter as refugees. Meanwhile, nationals of some countries can come on a temporary basis as "working holiday-makers" – this is a significant route for Australian nurses, for example. Nonetheless, visa data show that ordinary employer-sponsored work permits have been the major route into the health-care workforce in the United Kingdom, especially for nurses (as Figure 23 shows, above, tens of thousands of work permits were issued for nurses at the peak of active international recruitment, although not all appear to have been registered nurses).

7 MPI analysis of EU Labour Force Survey Ad Hoc Module on Migration, made available by the UK Data Archive.

8 Romanian and Bulgarian nationals faced some restrictions on their access to the labour market until the end of 2013.

9 http://www.nhsemployers.org/your-workforce/recruit/national-medical-recruitment/foundation-programme (accessed 26 April 2014).

10 MPI analysis of EU Labour Force Survey Ad Hoc Module on Migration, made available by the UK Data Archive.

The United Kingdom's immigration system underwent a major reorganization in 2008, although the implications for health professionals were relatively limited. IMGs not sponsored by an employer were restricted from applying for postgraduate training positions provided by the NHS, although they could still take these positions if sponsored by an NHS employer that had advertised the position locally first and failed to recruit a graduate from the United Kingdom.

The 2008 policy reform also introduced a more systematic methodology for statistically determining which occupations faced shortages in the labour market and thus should face an easier ride in the immigration system. The Migration Advisory Committee, a new independent body tasked with creating a list of these occupations, found little statistical evidence of a shortage among medical practitioners or nurses but added some senior consultant and specialized nursing positions to the list on the basis of qualitative evidence provided by industry groups (Migration Advisory Committee, 2008).

The committee has often erred towards including health-care occupations on the shortage list where the evidence was incomplete or of uncertain quality, in order to avoid the risk to public health that could result from an insufficient health-care workforce. The shortage occupation route has been widely used to bring in foreign health-care workers; in 2010, 32% of health professionals and 22% of associate health professionals entered under this route (Salt, 2011:92).

During the 2000s, an occupation's inclusion on the shortage list had limited importance, since workers with job offers for positions that were not on the list could still apply through other routes. However, the shortage list has increased in importance under the current government, as described below.

## Recent changes in employment-based immigration

Since the Conservative-Liberal Democrat coalition government came to power in 2010, a number of major immigration policies have been introduced, although most have not yet had a substantial impact on health care. The overarching goals of the new policies have generally been to reduce immigration and to make the system more selective.

A numerical limit on visa issuances has been introduced, although this limit is currently not binding and so does not constrain flows. To reduce immigration, the government has instead focused on adapting eligibility criteria to make it more difficult for immigrants to qualify for visas, especially if they have low prospective incomes. For example, from June 2012, immigrants must be in an occupation requiring a bachelor's degree or equivalent qualification to qualify for an employment-based visa (occupations requiring post-secondary education less than a bachelor's degree will qualify only if the job is on the shortage occupation list) (Migration Advisory Committee, 2011; UK. Home Office, 2012). Nurses, midwives and pharmacists are deemed to meet this requirement. Some less-skilled health occupations will be affected, however, including paramedics and medical/dental technicians, which are no longer eligible. Most occupations below this level, such as social-care workers and home-health aides, already failed to meet the skill criteria for work visas, although some nursing assistants, dental assistants, and home carers who had previously been eligible are no longer admitted under newly introduced rules.

The most significant policy change affecting health-care worker immigration to the United Kingdom is perhaps the new income threshold for gaining permanent residence. Most workers

in jobs that require degree-level education can qualify for a work permit, but from April 2016 they cannot stay more than six years unless they earn at least £35 000 (US$55 000) or their job is on the shortage occupation list. According to NHS recommended pay scales, only the very top nursing positions earn at this level. A registered nurse can expect to earn between £21 000 and £28 000 according to agreed NHS rates, and specialist nurses between £26 000 and £34 000. Some advanced nurses and team managers earn more than £35 000, while nurse or midwife consultants are comfortably above this threshold (NHS Careers, n.d.) (A recent analysis by the Migration Advisory Committee evaluated the impact of a slightly lower salary threshold of £31 000 and found that 87% of nurses sponsored by employers for a work permit between April 2011 and October 2011 earned less than this threshold and hence would not be eligible for settlement without a salary increase)[11].

In other words, the recent policy changes could have a very substantial impact on the retention of nurses. Non-specialized nurses whose occupations are not included on the shortage list are unlikely to qualify for long-term settlement and will be required to leave the country for at least 12 months before they can return on a work visa.

Another significant policy change introduced in 2012 is the tightening of visa policies for recent graduates. Nurses, midwives, and allied health professionals graduating from the United Kingdom's universities were, until recently, eligible for up to two years of "post-study work". This gave them relatively free rein to look for a job without the immediate need to acquire an employer sponsor and without having to find *skilled* employment immediately. Under new rules, these individuals must qualify for regular, employer-sponsored work visas at their skill level[12].

## Immigrant health-care workers in the crisis-hit labour market

While Britain has fared better than many European countries during the economic crisis and faces a better outlook in the coming years, labour market conditions deteriorated substantially in the late 2000s and unemployment remains high. The unemployment rate rose throughout 2011, peaking at 8.5% in the third quarter of 2011 before falling to 8.2% in the first quarter of 2012. The economic pain was not evenly distributed, however. Unemployment for workers in professional and scientific industries, public administration, education, and health/social services remained below 5% (Office for National Statistics, 2012b). Unemployment in professional occupations was as low as 2.2% in the first quarter of 2010, rising slightly to 2.8% in 2012.

Health professionals (a category that includes medical and dental practitioners, pharmacists, and psychologists, among others)[13] fared particularly well in this regard. They were more likely to have remained in work than practitioners of almost any other occupation. Figure 27 shows the number of working-age individuals who were either unemployed or had withdrawn from the labour force after practicing a given occupation, as a percentage of all individuals whose current or previous jobs was in that occupation. Health professionals fared extremely well in relative terms. Inactivity/unemployment rates also remained below the national average of 19% for nursing and midwifery professionals.

11 The MAC calculations are restricted to nurses who met the requisite skill level in force at the time, although this skill level has subsequently increased. (Migration Advisory Committee, 2011:86).

12 Note that the employer is exempt from numerical limits on work visas and from the requirement to recruit in the local labour market, when sponsoring a former international student.

13 The LFS data includes the following categories: medical practitioners, psychologists, pharmacists, ophthalmic opticians, dental practitioners, veterinarians, medical radiographers, podiatrists, and other health professionals.

FIGURE 27

## UNEMPLOYMENT AND INACTIVITY BY PREVIOUS OCCUPATION, WORKING-AGE POPULATION


Note: Non-employed population includes those who worked in the occupation within the last eight years but are not currently employed.

Source: Author's calculations from the LFS, Q1 2012 (Office for National Statistics, 2012b).

A similar picture emerges when restricting the analysis to immigrants alone. Even compared to other immigrants with university education, the share of inactive or unemployed working-age immigrants with experience as nursing, midwifery, or health professionals is low (Figure 28). On average, immigrant nurses and medical professionals earn at least as much as their British–born counterparts (Office for National Statistics, 2011).

FIGURE 28

## UNEMPLOYMENT AND INACTIVITY BY PREVIOUS OCCUPATION, WORKING-AGE IMMIGRANTS WITH DEGREE-LEVEL QUALIFICATIONS


Note: Non-employed population includes those who worked in the occupation within the last eight years but are not currently employed. Includes only occupations that employ more than 50 000 degree-educated immigrants.

Source: Author's calculations from Labour Force Survey, Q1 2012 (Office for National Statistics, 2012b).

These figures do not include people with medical or nursing qualifications who have never been able to find a job in their field – for reasons including foreign qualifications that have not been recognized by British regulators. The extent of such "credential recognition" barriers is extremely difficult to quantify, although they are thought to be widespread among certain groups[14]. First and foremost these include refugees, who often have incomplete documentation, come from countries whose medical qualifications are not always recognized by British regulators, or have long career gaps resulting from legal restrictions on work while seeking asylum. Others include immigrants who entered the country without a definite job lined up and thus without an employer to help them through recertification and acclimatization to the United Kingdom. For example, thousands of immigrants entered the country without a job offer on the basis of a points test alone during the 2000s, before this option was removed under the current government. Family members of UK residents or the dependents of other immigrants to the United Kingdom are not screened on the basis of their skills (or their ability to meet professional registration requirements). EU citizens exercise a right to free movement. (Among the latter, most are eligible for automatic professional registration in the country under EU law. However, eastern Europeans who gained their qualifications before their countries of origin aligned their training standards with EU rules did not benefit from these arrangements and some of them faced a more onerous registration process. Moreover, those who successfully register in the United Kingdom may still find it difficult to find employment if they lack language proficiency or if employers are wary of differences in workplace norms and practices between the United Kingdom and their countries of origin.)

During the period of active international recruitment, the DoH established guidelines and requirements for NHS employers and other organizations involved in overseas recruitment to provide orientation programmes and help immigrants adjust to practice in the country. Immigrants could also be helped through the licensing process, and employers were required to arrange for periods of supervised practice if regulators did not immediately recognize individuals' qualifications. With the end of active international recruitment and the tightening of some professional registration requirements, such support is now likely to be less widely available. The assessment process for doctors and nurses trained outside of the EEA has also been criticized as excessively stringent, in particular because of the levels of language proficiency required.

## Conclusions

Health workforce immigration to the United Kingdom has fallen from tens of thousands in the mid-2000s to a relative trickle in the past few years. With increasing numbers of domestically trained health professionals arriving in the workforce, a wide range of changes to both immigration rules and professional registration procedures had the effect of reducing new migration flows in the health sector. These policies remain in place today. Since 2008, additional measures have been introduced across the immigration system to tighten eligibility for work visas. These policies have generally aimed to reduce immigration, especially at the low- and middle-skilled levels. However, it is not clear that these changes have translated into lower immigration inflows in the health sector, since the recent reduction in registrations of doctors and nurses was concentrated in the 2005–2007 period and numbers have remained essentially flat since then.

14 For a discussion, see : Migrant and Refugee Communities Forum (2006). Losing out twice? Skill wastage of overseas health professionals in the UK. London (http://www.mrcf.org.uk/wp-content/uploads/MRCF-Report-on-Experiences-of-Migrant-Medical-Professionals-in-the-UK.pdf, accessed 26 April 2014).

Broadly speaking, there is little evidence that the global economic crisis has contributed directly to the decline in health workforce immigration, most of which took place from 2006 to 2008. In some respects, the health sector has been protected from the impact of the crisis: employment has remained steady, as have employment prospects for those with experience in the field. Strong political pressure to maintain NHS staffing levels, coupled with increasing demand for health care among an aging population, has contributed to this phenomenon.

The trajectory in coming years, however, remains uncertain. The NHS budget is likely to remain under pressure as the government attempts to bring public spending down as a percentage of GDP. This makes a significant increase in NHS staffing – and thus in international hiring – unlikely. More generally, the unprecedented health workforce immigration of the early 2000s took place in the context of a healthy economy and was presented both as a "correction" following a period of relatively low spending on health care, and as a short-term solution pending the arrival of newly qualified domestic graduates on the labour market. In other words, there is no reason to expect a repeat performance in the foreseeable future. Nonetheless, even under current policies and economic conditions, immigrant doctors and nurses remain an important component of the health workforce.

**References**

Buchan J, Baldwin S, Munro M (2008). Migration 8 of health workers: the UK perspective to 2006. OECD Health Working Papers, No. 38. Paris: Organisation for Economic Co-operation and Development. http://www.oecd.org/dataoecd/48/2/41500789.pdf

Buchan J (2007). The UK, Asia and international recruitment of nurses. Asia Research Institute Working Paper No. 87. http://ssrn.com/abstract=1317138 or http://dx.doi.org/10.2139/ssrn.1317138

Buchan J, Dovlo D (2008). International recruitment of health workers to the UK: a report for DFID. London: Department of International Development, Health Systems Resource Centre. http://www.equinetafrica.org/bibl/docs/BUChres310108.pdf

DoH (2002). International recruitment of consultants and general practitioners for the NHS in England: current initiatives and guidance to NHS employers on an infrastructure to support international recruitment. London: Department of Health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4067145.pdf

DoH (2006). Change to the immigration rules for postgraduate doctors and dentists. London: Department of Health. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Workforceplanninganddevelopment/InternationalrecruitmentNHSemployers/DH_4131259

Migration Advisory Committee (2008). Skilled, shortage, sensible: the recommended shortage occupation lists for the UK and Scotland. London: Home Office. http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/first-lists/0908/shortageoccupationlistreport?view=Binary

Migration Advisory Committee (2011). Analysis of the points based system list of occupations skilled to NQF level 4 and above for Tier 2. London: Home Office. http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/analysis-of-the-pbs

NHS Careers (n.d.). Pay for nurses. London. http://www.nhscareers.nhs.uk/details/default.aspx?id=4

Office for National Statistics (2000). UK Labour Force Survey, Q1 2000. Newport, Wales.

Office for National Statistics (2006). UK Labour Force Survey, Q1 2006. Newport, Wales.

Office for National Statistics (2011). UK Labour Force Survey Quarterly Bulletin 1 2011. Newport, Wales.

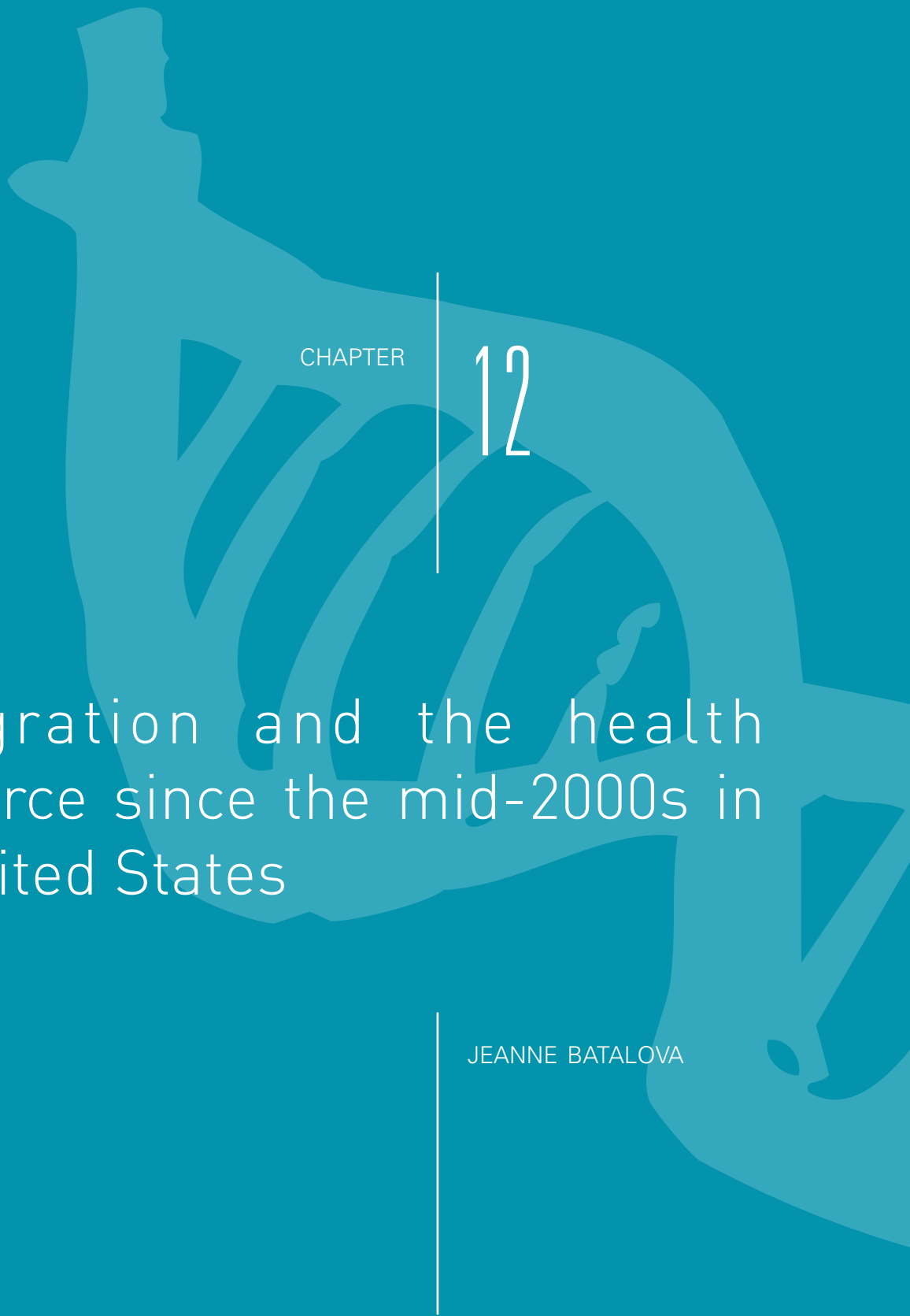
Office for National Statistics (2012a). Labour market statistics data tables. Newport, Wales. http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/june-2012/index-of-data-tables.html#tab-Unemployment-tables

Office for National Statistics (2012b). UK Labour Force Survey, Q1 2012. Newport, Wales.

Salt J (2011). International migration and the United Kingdom report of the United Kingdom Sopemi correspondent to the OECD. London: Migration Research Unit. http://www.geog.ucl.ac.uk/research/mobility-identity-and-security/migration-research-unit/pdfs/Sop11.pdf

UK. Home Office (2012). Statement of intent and transitional measures: tier 2 of the points based system. London. http://www.homeoffice.gov.uk/publications/immigration/changes-tier-two/statment-of-intent-tier2?view=Binary

Young R, Weir H, Buchan J (2010). Health professional mobility in Europe and the UK: a scoping study of issues and evidence. London: National Institute for Health Research Service Delivery and Organisation Programme. http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1619-134_V01.pdf



CHAPTER 12

# Immigration and the health workforce since the mid-2000s in the United States

JEANNE BATALOVA



Doctors and nurses at work, ReSurge International.

Health-care was one of the few industries in the United States that experienced employment growth across the 2007–2009 recession and projections indicate that health-care professions will be among the fastest growing in the years ahead (Goodman & Mance, 2011; Wood, 2011; Lockard & Wolf, 2012). New jobs for registered nurses, who already compose the largest portion of the health-care workforce (Institute of Medicine of the National Academies, 2010), are expected to outnumber those for all other occupations between 2010 and 2020 and job growth for home health aides is predicted to outpace nearly every other occupation (Lockard & Wolf, 2012).

These changes are expected to take place against a backdrop of considerable demographic and policy change. By 2021, an estimated 33 million previously uninsured individuals will acquire health insurance coverage as a result of health-care reforms[1] and, by 2030, 78 million "baby boomers" will become eligible by age for public health insurance coverage through Medicare (CBO, 2012a; Alliance for Health Reform, 2011). While these transitions are certain to create a greater demand for health services, the ways in which this demand will translate into workforce needs is less clear.

Labour shortages are notoriously difficult to measure and, aside from methodological concerns, substantial disagreement exists about their solutions (Sumption, 2011; Lowell 2012). Nonetheless, mainstream media outlets have reported widely on an impending doctor shortage expected to accompany the enactment of health-care reform in the United States (Lowrey & Pear, 2012; Long, 2012; Wayne, 2012; Sarah, 2012). The US Department of Health and Human Services, which measures present-day shortages, estimates that over 7000 primary-care physicians would be needed to remove all shortage area designations in the United States as of September 2012 (US Department of Health and Human Services, 2013).

Despite concerns of nursing workforce shortages during the mid-2000s attributed to limited capacity at training institutions (Aiken, 2007; American Association of Colleges of Nursing, 2012), the domestic supply of nurses has increased considerably since the beginning of the recession in the United States. Behind this trend was an unexpectedly high number of US-trained workers entering the workforce, coupled with rising numbers of young workers entering

1 The Congressional Budget Office (CBO) estimated in March 2012 that, by 2021, the number of *uninsured*, non-elderly people would decrease by 33 million as a result of health-care reforms under the *Affordable Care Act* (CBO, 2012a). As a result of a June 2012 Supreme Court ruling, CBO offered a revised estimate indicating that three million more people than previously estimated would remain uninsured (CBO, 2012b). For more background, see Pear (2012).

the profession (Staiger, Auerbach & Buerhaus, 2012; Squires 2013). How long this trend will endure is less certain. As the economy recovers, women who had re-entered the workforce may once again withdraw from it as job opportunities for men in their households improve. The nursing workforce also relies heavily on members of the "baby boomer" generation heading toward retirement. As a result, nursing shortages could well re-emerge in the future (Staiger, Auerbach & Buerhaus, 2012).

The United States is the top destination worldwide for health professionals (Polsky et al., 2007; Aiken, 2007). Despite the fact that the *share* of foreign-trained and foreign-born doctors and nurses in the United States is smaller than in some other OECD countries, the sheer size of the United States workforce has resulted in very large health workforce migration in absolute terms (OECD, 2007).

In the United States, immigrants account for about the same share of workers employed in health-care occupations as they do for all employed workers (16%)[2]. Immigrants are over-represented in both high-skilled and low-skilled occupations in the health-care sector (Batalova & Fix, 2013). In 2009, for example, more than a quarter of practicing physicians and surgeons were foreign-born, as were about one fifth of persons employed as dentists; pharmacists; and nursing, psychiatric, and home health aides[3]. Further, there is evidence that many foreign-trained doctors, nurses, and other types of skilled health professionals do not practice in the United States after encountering substantial barriers to practice[4]. This predicament may lead to "brain waste", i.e. when highly skilled immigrants are unable to secure employment that appropriately utilizes their education and skills.

This case study provides a portrait of foreign-born health-care workers in the United States. The study focuses in particular on doctors and nurses, examining the size and nature of these populations over the course of the 2007–2009 recession alongside their origins and labour market outcomes. It also provides estimates of the number of doctors and nurses from countries defined by the WHO as facing critical health-care worker shortages.

As a backdrop for these analyses, the study provides an overview of the United States' immigrant admission policy and visa options for health-care workers, current immigration policy developments, and efforts to improve the workforce integration of immigrant health-care workers.

## Data and methods

Data from the US Census Bureau's 2000 Census and multiple years of the American Community Survey (ACS)[5] are used to examine trends in employment over time and key characteristics of immigrants employed in health-care occupations. To examine changes over the recessionary period, comparisons are drawn between pooled ACS data from 2005–2007 and from 2008–2010. Pooling data from multiple years allows for greater statistical accuracy when identifying and analysing the characteristics of smaller groups of workers.

2 MPI analysis of pooled ACS 2008–10.

3 MPI analysis of pooled ACS 2008–10.

4 Examples of these barriers include English language proficiency, professional licensing and other credentialing requirements, and the sometimes substantial costs associated with retraining (Fernández-Peña, 2012).

5 These data are accessed using Ruggles, Trent Alexander, Genadek, Goeken, Schroeder & Sobek (US Census Bureau, 2010). Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010. http://usa.ipums.org/usa/index.shtml

These pooled data are referred to by their respective mid-point years, 2006 and 2009. Unless otherwise noted, all data come from Migration Policy Institute (MPI) analysis of US Census Bureau surveys and define workers as persons ages 18 or older who are employed in the civilian labour force.

These Census and ACS data provide information on whether an individual is foreign-born, his or her immigrant year of arrival in the United States, and, in most instances, birthplace. They also provide information on educational attainment, employment status, and occupation and earnings for employed workers. They do not, however, provide information on the country in which educational credentials were obtained, detailed information about the field of study for advanced degrees, or modes of entry for the foreign-born.

### Immigrant health-care workers: profile and trends

The health-care sector accounts for 18% of the United States GDP (Papademetriou & Sumption, 2011). As a proportion of the GDP, no other country in the OECD spends more on health than the United States (Lowell, 2012). The same is true in terms of per capita health spending (OECD, 2012). In 2009, about 11 million workers age 18 and over were employed in health-care occupations, accounting for 8% of the 140 million total workers employed in the United States.

About 1.7 million immigrants, or 8% of all immigrant workers, were employed in health-care occupations[6].

## Employment in health care before and after the 2007–2009 "Great Recession"

The United States health-care sector added employment across the 2007–2009 recession, despite significant job losses that occurred in the country's economy overall (Wood, 2011).

The health-care sector remained relatively resilient during the recession in part because of the essential nature of the services it provides and because of demographic realities such as population growth and aging that contribute to the need for health services (Goodman & Mance, 2011; Wood, 2011). The federal government also intervened to provide additional funding to health-care providers and to promote access to health-care insurance for the rising number of poor and unemployed Americans (Rowland, 2009; Wood, 2011)[7].

The health-care sector was also a bright spot for immigrant employment during the economic downturn (Batalova & Fix, 2013; Papademetriou, Sumption & Terracas, 2010). Despite deep job losses experienced by the foreign-born overall, and a marked slowdown in migration to the United States (Papademetriou, Sumption & Terracas, 2010), employment in health-care occupations grew for immigrants as well as natives (see Table 29). Both nativity groups also experienced employment growth in health-care professions in the period that preceded the recession. While this pattern of growth is perhaps unsurprising, it is striking that total immigrant employment in health-care occupations has increased more quickly than US-born employment

6 MPI analysis of pooled ACS 2008-10.

7 Federal funding for Medicaid and the Children's Health Insurance Program, public health insurance programmes, was temporarily increased and, under the Consolidated Omnibus Budget Reconciliation Act, subsidies were temporarily made available to unemployed workers to help pay for continued employer-based health insurance coverage (Rowland, 2009; Wood, 2011).

## PERCENT CHANGE IN NATIVE-BORN AND FOREIGN-BORN HEALTH-CARE EMPLOYMENT BY OCCUPATIONAL GROUP, 2000–2006 AND 2006–2009

TABLE 29

| Health-care workers | % change in employment, 2000–2006 | | % change in employment, 2006–2009 | |
|---|---|---|---|---|
| | Native-born | Foreign-born | Native-born | Foreign-born |
| Total health-care workers | 14 | 34 | 9 | 18 |
| Dentists | -3 | 36 | 2 | 20 |
| Pharmacists | 10 | 43 | 6 | 19 |
| Physicians and surgeons | 9 | 21 | 7 | 7 |
| Physician assistants | 62 | 100 | 4 | 8 |
| Registered nurses | 11 | 29 | 8 | 22 |
| Therapists | 23 | 33 | 11 | 21 |
| Licensed practical and vocational nurses | 7 | 40 | 4 | 11 |
| Clinical laboratory technologists and technicians | 8 | 20 | 3 | 20 |
| Other health-care practitioner and technical occupations | 25 | 50 | 10 | 19 |
| Nursing, psychiatric, and home health aides | 9 | 37 | 12 | 19 |
| Dental assistants | 14 | 50 | 6 | 19 |
| Other health-care support | 26 | 55 | 13 | 24 |

Note: Analysis includes only civilian employed workers ages 18 and older.
Source: MPI analysis of the US Census Bureau's Census 2000 (2010) pooled ACS 2005–2007 and pooled ACS 2008–2009.

across the past decade. In the pre-recessionary period, the number of immigrant health-care workers grew more than twice as quickly as the number of US-born health-care workers (34% versus 14%). This trend continued between 2006 and 2009, with employment for immigrant health-care workers growing twice as quickly as those for the US-born (18% and 9%).

Employment growth has been spread across nearly every health-care occupation examined in this study over the past decade, for both immigrant and US-born workers. Increases in the number of foreign-born workers occurred more quickly than those for US-born workers in *every* health-care occupation during the pre-recessionary period. Immigrant employment gains continued to outpace those for the US-born in almost every health-care occupation from 2006 to 2009, although generally not by as wide a margin as during the pre-recession era.

A separate, industry-level analysis indicates that immigrant employment in the health-care sector increased the fastest in low-skilled professions from 2007 to 2010; US-born employment in the health-care sector increased the fastest in high-skilled professions during the same period (Batalova & Fix, 2013).

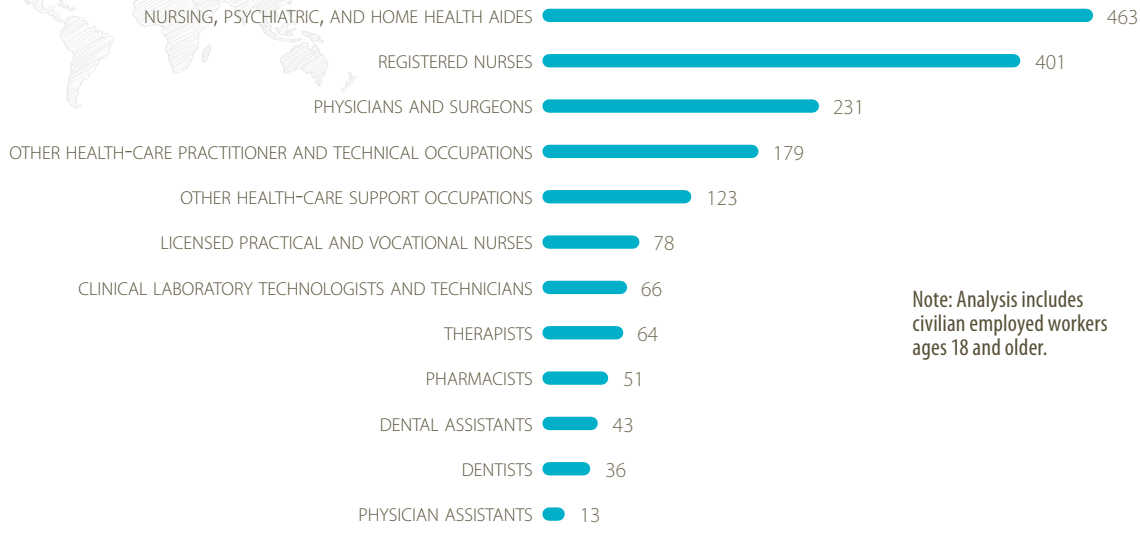
## Portrait of the immigrant health-care workforce

Health-care professions vary greatly in their educational and training requirements. For example, 11 or more years of higher education and training is generally required for medical doctors while for some home health aides there may be only a training requirement (American Medical Association, 2012; Bureau of Labor Statistics, 2014)[8]. Previous sector-level research has shown that the distribution of US-born and immigrant health-care workers along the skill spectrum is largely similar and that almost half (47%) of immigrants working in the health-care industry hold low-skilled jobs, while a quarter hold middle-skilled jobs, and 27% hold high-skilled jobs (Capps, Fix & Lin, 2010).

Nursing, psychiatric, and home health aides represent the largest segment of the immigrant health-care workforce, accounting for 463 000 (or 27%) of the 1.7 million foreign-born health-care workers in 2009 (Figure 29). These "direct care" positions have low educational barriers to entry, especially relative to many other professions in health care, and do not always require a high school degree (Martin et al, 2009)[9]. Nursing, psychiatric, and home health aides – 22% of whom are foreign born – are often involved in care of the elderly and are likely be increasingly in demand as the "baby boom" generation transitions into old age. Although the ACS does not collect information on immigrants' modes of entry to the United States, according to one study, direct-care workers tend to enter the United States through family-based, humanitarian, and other immigration channels not directly related to employment (Martin et al., 2009).

FIGURE 29

**FOREIGN-BORN HEALTH-CARE WORKERS BY OCCUPATION ('000s), 2009**




Note: Analysis includes civilian employed workers ages 18 and older.

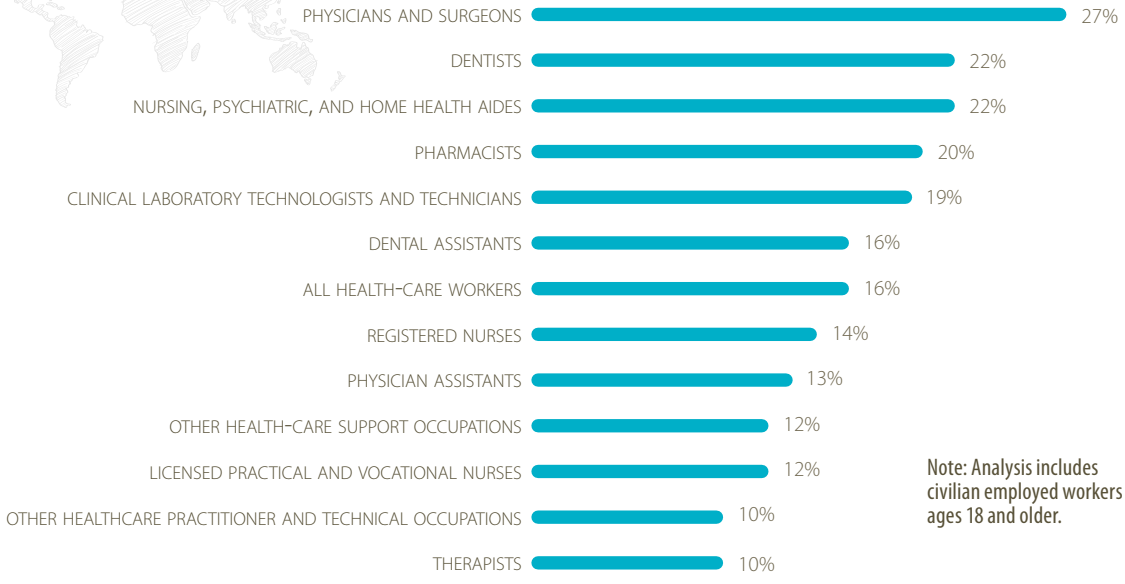
Source: MPI analysis of the US Census Bureau's Census 2000, pooled ACS 2005–2007 and pooled ACS 2008–2010.

8 In the *Occupational Outlook Handbook, 2014-15 Edition*, the US Department of Labor's Bureau of Labor Statistics notes that "[a]lthough a high school diploma or equivalent is not generally required, most home health aides have one before entering the occupation" (Bureau of Labor Statistics, 2014).

9 For more information on general requirements for home health aides, psychiatric aides, and nursing assistants, see the Bureau of Labor Statistics (2010) Occupational Outlook Handbook listings for "Home Health Aides," "Psychiatric Technicians and Aides" and "Nursing Assistants and Orderlies". http://www.bls.gov/ooh/ (accessed 26 April 2014).

FIGURE 30

## FOREIGN-BORN SHARE OF EMPLOYMENT FOR ALL HEALTH-CARE PROFESSIONS BY HEALTH-CARE OCCUPATION, 2009




Note: Analysis includes civilian employed workers ages 18 and older.

Source: MPI analysis of pooled ACS 2008–2010.

Registered nurses account for the second-largest segment of the immigrant health-care workforce (see Figure 30). In 2009, immigrant nurses accounted for 23% of all immigrant health-care workers and 14% of the total nursing workforce in the United States. This nursing workforce is significant both in domestic and international terms: it accounts for the largest number of workers of any profession in the health-care workforce and no other country has a larger nursing workforce (Aiken, 2007; Institute of Medicine of the National Academies, 2010).

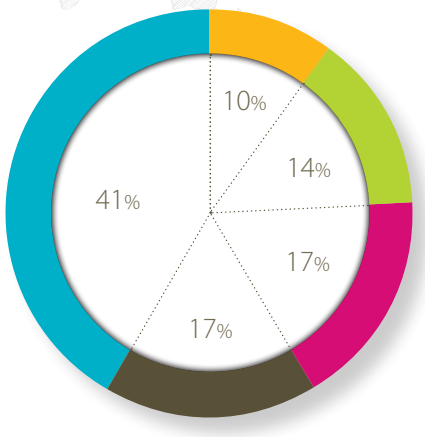
Physicians and surgeons represent the third largest segment of the foreign-born health-care workforce and a substantially smaller share (13%) of all immigrant health-care workers compared to nursing, psychiatric, and home health aides and registered nurses. Yet physicians and surgeons, who the study refers to interchangeably as doctors, are more likely than any other type of health-care professional to be immigrants. In 2009, more than one-in-four doctors practicing in the United States was foreign-born. Other high- and middle-skilled health-care professions with above-average shares of immigrant workers include dentists (22%), pharmacists (20%), and clinical laboratory technologists and technicians (19%).

## Regions and countries of origin

Asia is the most common sending region for immigrant health-care professionals. In 2009, 41% of immigrant health-care workers were Asian born compared to 17% born in Latin America, 17% in the Caribbean, 14% in Northern America, Europe, or Oceania, and 10% in Africa (see Figure 31). In general, immigrants from Latin America (excluding the Caribbean) are under-represented in health-care professions compared to their share of all civilian employed immigrant workers aged 18 and older; immigrants from other world regions are over-represented[10].

FIGURE 31

### REGION OF BIRTH FOR FOREIGN-BORN HEALTH-CARE WORKERS, 2009




AFRICA
NORTH AMERICA, EUROPE, AND OCEANIA
CARIBBEAN
LATIN AMERICA (EXCEPT THE CARIBBEAN)
ASIA

Note: Analysis includes foreign-born, civilian employed workers ages 18 and older. Northern America, Europe, and Oceania category also includes those persons for whom birthplace information was not available.

Source: MPI analysis of pooled ACS 2008–2010.

While the regional distribution of immigrant workers varies across specific health-care occupations, Asia is still the predominant source region for immigrant workers in the majority of health-care professions. Exceptions to this pattern are almost all found in health-care support occupations. For example, the Caribbean is the most common region of origin for nursing, psychiatric, and home health aides (34%) and Latin America the most common for dental assistants (40%).

With respect to the countries of origin for immigrants working as doctors and nurses in the United States, in 2009 more than one of every five foreign-born doctors (22%) were born in India and another quarter were born in Canada, China, Iran, Korea, Pakistan and the Philippines, (3–6% each).

The Philippines is by far the leading country of origin for foreign-born nurses. In 2009, more than one third of immigrant nurses in the United States were born in the Philippines (34%); another one fifth were born in Canada, India, Jamaica and Nigeria combined (3–6% each).

10 MPI analysis of pooled ACS 2008–10.

Estimates from the ACS also suggest that a meaningful share of foreign-born doctors and nurses practicing in the United States were born and perhaps educated in countries facing critical health workforce shortages. In T*he World Health Report 2006 – Working together for health*, WHO estimated that 57 countries worldwide met their criteria for a critical health-care worker shortage: less than 23 doctors, nurses, or midwives per 10 000 persons (WHO, 2006).

WHO estimates that 2.4 million of these types of health-care workers would be required to remove these shortage designations and, under a broader definition of health-care workers, the estimate of global health-care worker needs is even higher (nearly 4.3 million) (WHO, 2006).

This study estimates that roughly 163 000 foreign-born doctors and registered nurses (including nurse midwives) were born in a country designated by WHO as facing a health-care worker shortage[11]. This represents just over a quarter (26%) of all immigrant doctors and registered nurses practicing in the United States.

Among these workers, more than half (58%) arrived to live in the United States at age 25 or later – suggesting that roughly 95 000 foreign-born doctors and registered nurses may have completed their health-care training prior to arriving in the United States[12].

The majority of these professionals who entered the country at age 25 or later were born in India (51%) with smaller shares born in Nigeria (12%), Pakistan (8%), and Haiti (5%).

A degree of caution should be exercised when interpreting these estimates given that: (1) the data we employ do not provide birthplace information for all 57 of the countries designated by WHO as having health-care worker shortages; (2) we use a rough proxy for identifying foreign-educated persons (i.e. arriving in the United States at age 25 or older) because information on place of education is unavailable; (3) individuals captured in these estimates may intend to return to and practice in their countries of origin; and (4) these estimates do not capture foreign-born doctors and nurses who are not practising as such.

As is the case for many other immigrants, health professionals from critical health-care workforce shortage countries may enter the United States through immigration channels not explicitly linked to employment. These channels include those designed to promote humanitarian relief, family unification, and diversity in immigrant admissions (the green card lottery). For example, more than half of health-care worker shortage countries are located in sub-Saharan Africa (36 countries) and African immigrants are more likely than other immigrants to be admitted to the United States as refugees/asylum-seekers and diversity immigrants; they are less likely than other immigrants to be admitted through employment- and family-based routes (Global Health Workforce Alliance, 2012; Capps, McCabe & Fix, 2011).

## Labour market outcomes

In 2009, median annual earnings for immigrants employed full-time, full-year in the health-care professions ranged from US$26 000 for nursing, psychiatric, and home health aides to US$155 000 for physicians and surgeons (see Figure 32). This wide range in earnings reflects

11 For a comprehensive list of the 57 countries defined by WHO as facing severe health workforce shortages, see: Global Health Workforce Alliance (2012). In the data employed for this study, birthplace information is not available for all 57 countries designated by WHO as critical health-care worker shortage countries.

12 MPI analysis of ACS pooled 2008–10. Analysis includes civilian employed doctors and registered nurses aged 18 and older.

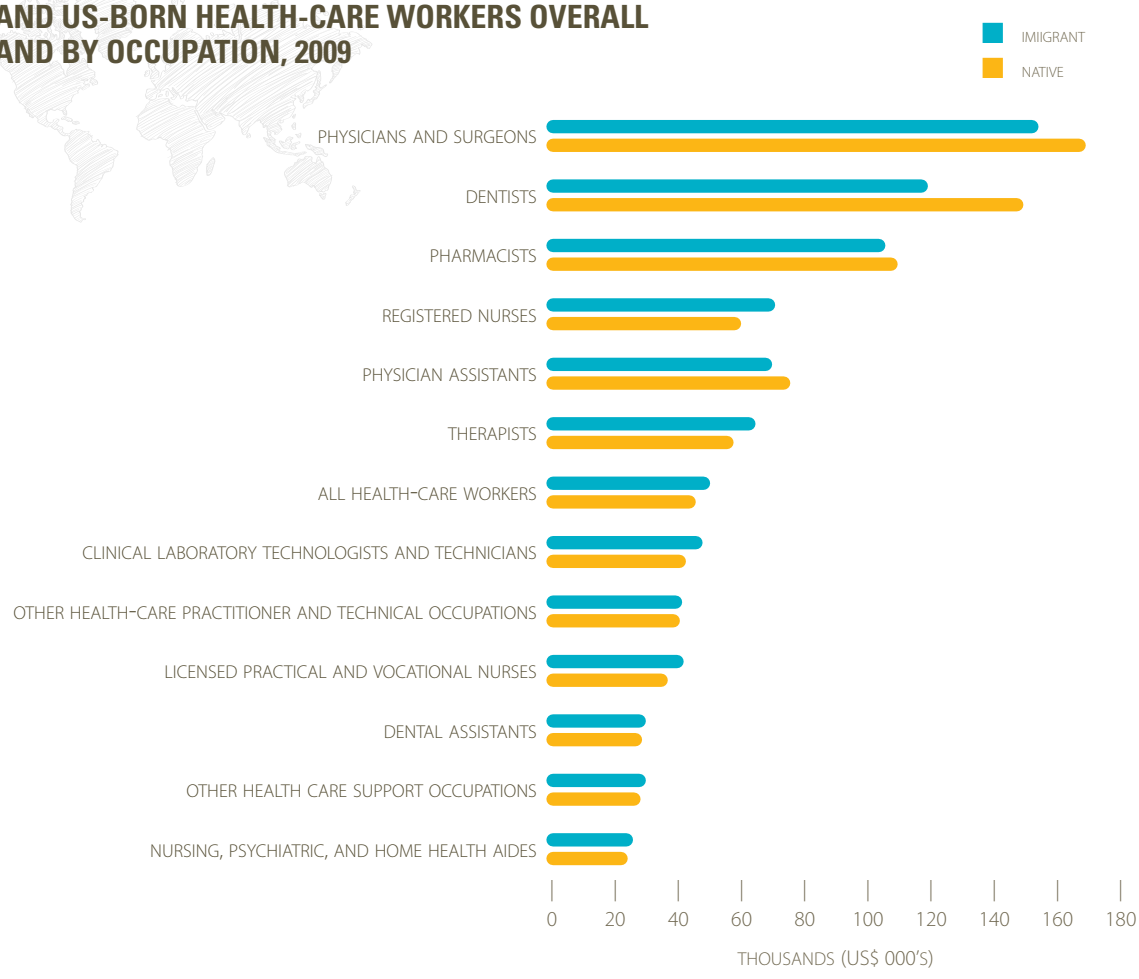
the variety of skill levels found in health-care professions. Still, median annual earnings for immigrants overall employed in health-care roles surpassed those for immigrant workers overall: in 2009, these figures were US$50 000 and US$33 000, respectively[13].

Immigrant health-care workers overall who work full year and full time report also higher median annual earnings than their US-born peers. This earnings advantage, however, is not expressed across all of the health professions or to the same degree.

Notably, immigrants working as registered nurses are most likely among health-care professionals to out-earn their US-born counterparts: the median reported earnings of foreign-born nurses were US$11 000 higher than those for US-born nurses in 2009.

FIGURE 32

**MEDIAN ANNUAL EARNINGS ('000s) FOR FOREIGN- AND US-BORN HEALTH-CARE WORKERS OVERALL AND BY OCCUPATION, 2009**




Note: Analysis includes full-year, full-time civilian employed workers ages 18 and older with greater than zero earnings. Full-year workers are employed 50 or more weeks of the year and full-time workers are employed 35 hours or more per week. Earnings are in 2010 US dollars.

Source: MPI analysis of pooled ACS 2008–2010.

13 In fact, median annual earnings were higher for almost every group of immigrant health-care workers than for immigrants overall in 2009. The only exceptions were immigrants employed in health-care support positions: as dental assistants; as nursing, psychiatric, and home health aides; and in other support roles.

The earnings differentials between immigrants and natives working as doctors and dentists are the largest among the health-care professions, however, in this case, the earnings advantage in favours US-born workers. Median earnings for US-born doctors and dentists in 2009 were US$15 000 and US$30 000 higher, respectively, than those for their immigrant peers. These two health-care professions were, nonetheless, the highest earning for immigrants and natives alike.

These largest earnings gaps – those for doctors, nurses, and dentists – may be explained in part by factors that are not measurable in the data employed for this study. There may be substantial disparities in salaries, for example, among physician specialties and for different types of nurses (Hawkins, 2010; Department of Labor, 2012; American Academy of Nurse Practitioners, 2011)[14].

For registered nurses, the diverse set of educational and training programmes that serve as preparation for licensure may also contribute to the nativity gap in earnings. The field accepts credentials ranging from those that generally take two to three years to obtain (a diploma or associate's degree in nursing) to a four-year bachelor's of science in nursing (BSN) (Department of Labor, 2012). Advanced practice registered nurses, such as nurse anaesthetists and nurse practitioners, must obtain an advanced degree (Department of Labor, 2012).

Overall, foreign-born registered nurses are better educated than their US-born peers: in 2009, 70% of foreign-born registered nurses reported having obtained a bachelor's or higher degree compared to 53% of US-born nurses[15].

## Immigrant admission policy

Most immigrants to the United States come through family unification. Employment-based immigration is relatively small (about 15% of the total permanent inflow, including family members of principal applicants) (Sumption & Bergeron, 2013). As a result, the migration of health professionals (either temporary or permanent) is largely *not* the result of deliberate efforts to target these workers through immigration policies.

### Visa options for health-care workers

Employment-based immigration avenues available to health-care professionals depend mainly on a prospective immigrant's level of education and skill generally required for his or her profession in the United States[16]. Because most work visas require an employer sponsor, it also depends on professional connections in the country and the existence of recruiting agencies and networks.

The main temporary worker visa, known as the H-1B "specialty occupations" visa, generally requires a bachelor's degree or more. As a result, the visa can be used to admit physicians, surgeons, therapists, as well as nurse practitioners and certain specialties that require the additional education (e.g. operating room nurses). Registered nurses are generally not eligible,

14 Advanced practice nurses – including nurse anaesthetists, nurse practitioners, and nurse midwives – cannot be identified in all years of data employed for this study.

15 MPI analysis of pooled ACS 2008-10. Analysis includes civilian employed workers ages 25 and older.

16 As a precondition to receiving either permanent or temporary visas, certain groups of health-care professionals, including registered nurses, physical therapists, and physician assistants, have to complete a screening programme that includes a credential review of the applicant's foreign education and licensure; English language proficiency examination; and, in the case of nurses, successful completion of the nursing professional exam (Aiken, 2007).

since this position does not require a bachelor's degree – although this may gradually change as degree-level education becomes the norm for entry-level nurses in the United States.

While health professionals make up only a small share of the H-1B visas employers request, the absolute numbers are relatively large by international comparison. Between 2006 and 2011, an average of 6–7% of H-1B visa holders worked in medical occupations, equivalent to approximately 7000 per year. Physicians and surgeons was the largest individual occupational group. Interestingly, the highest number of H-1B visas that went to health-care professionals was in 2008 (8000). At this time, the economic recession fears had slashed visa demand for information technology workers in half. Since the number of H-1Bs is capped at 85 000 and is heavily oversubscribed in most years, lower demand for IT workers created space for hospitals, doctor offices, and other employers interested in foreign health-care professionals to apply for the visas (Batalova, 2010).

To qualify for work visas, health professionals must have already completed necessary training and be fully licensed to practice in the United States. Even among experienced foreign-trained doctors, this usually requires a United States residency permit. IMGs completing residencies in the United States often come on a different type of temporary visa—the J-1. This visa is sponsored by the Educational Commission for Foreign Medical Graduates, reducing the administrative burdens for employers. Unlike the H-1B, however, foreign physicians on J-1 visas are usually required to return to their home country for at least two years before re-entering the United States. The requirement is designed to encourage the circulation of health professionals back to their home countries. However, the home-residence requirement can be waived under certain circumstances, including if the home country provides a "statement of no objection" or if the individual agrees to take employment at health-care facilities in the inner city or rural areas that serve, for the large part, poor patients (Brown-Mahoney, Pittman & Nuttbrock, 2012).

Registered nurses are not eligible for these temporary worker visas. Unless they can immigrate through family or humanitarian channels, the visa regime they face is thus more complicated. Currently, they must generally enter on permanent visas. The permanent visa system is heavily backlogged due to numerical limits on visa issuances, and application approval for permanent residence generally takes about four to six years. Waiting times are even longer for workers from high-demand countries, notably China, India and the Philippines – the main source countries for doctors and nurses coming to the United States. While employers were willing to wait for long periods during times of high demand, one expert reports that recent increases in the domestic supply of nurses during the economic crisis have "decimated" the international recruitment industry that previously brought large numbers of nurses to the United States on permanent visas (Squires, 2013).

Periodic policy adjustments have attempted to smooth the route to the United States for employer-sponsored nurses – such as a special nursing visa initially introduced in the 1989 and reintroduced in 1999 with a cap of 500 workers per year; and a one-off allocation of additional visas for nurses and physical therapists in 2005. These efforts have generally been one-off and not automatically renewed on expiration.

Immigrants in low- and middle-skilled jobs in the United States health workforce are less likely to come through employment routes because limited visa opportunities exist for immigrants without a bachelor's degree. Thus, the majority of immigrants working in low- and middle-skilled

occupations come through family reunification, humanitarian protection, and diversity-based channels as well as illegally (Martin et al., 2009). It is important to note that some of highly trained immigrants were not able to restart their professional careers in the United States and ended up working in low-skilled occupations in the health-care and other industries (Batalova & Fix, 2008).

### Current immigrant policy developments

Despite widespread dissatisfaction with the US immigration system, the contentious politics of immigration has prevented consensus on reform. Several bills considered in the past decade, however, give an indication of the types of reforms that may be enacted if legislation moves forward in the future. This includes major reform bill that passed the Senate (but not the House of Representatives) in June 2013.

Several of the reforms that have been proposed would affect health workforce migration, in some cases profoundly. Proposed policies that have been considered in both chambers of Congress would increase the number of H-1Bs available, making it easier for employers to hire high-skilled workers including physicians. The House's SKILL Bill of 2013 would expand employment-based immigration, including adding 4000 visas reserved specifically for certain health-care workers (Migration Policy Institute, 2013). For nurses, a reform package could reintroduce the H-1C nurse visa, which expired in 2009. The 2013 Senate bill would also create a potential opening to the migration of nurses by establishing a new temporary visa for low- and middle-skilled workers that have fewer eligibility restrictions than current visas at this skill level.

## Improving the economic integration of foreign professionals

Newly arrived immigrant professionals often experience significant barriers in re-starting their careers in a country of destination. The proverbial story of an immigrant doctor driving a taxi is frequently recognized as an extraordinary waste of human capital, aptly referred to as "brain waste". MPI's own estimates suggest that more than 1.6 million – or about one in five – college-educated immigrants in the United States were either unemployed or under employed in low-skilled occupations in 2011[17]. While the extent of brain waste affecting immigrant health-care professionals is hard to quantify given the data limitations, the following example provided by the founder of *Welcome Back*, an organization that helps such immigrants, is illustrative. Of the 5000 Welcome Back's clients who used to be medical doctors in their home countries, only 110 were able to secure a medical residency position in the United States, a required step in obtaining a licence to practice medicine in the country[18]. The rest had to consider alternative careers, such as medical translators, community health-care workers, or medical researchers, or turn to low-skilled jobs that require little education but offer no economic mobility.

Cross-national research demonstrates that while the immigration and credentialing policies in Australia, Canada, Israel, the United Kingdom and the United States are different, the experience of downward mobility and skill underutilization of college-educated newcomers is shared (Lewin-Epstein, Semvonov & Kogan, 2003; Reitz, 2005; Akresh, 2008). The main culprits behind so-called "brain waste" are remarkably similar across different contexts including low language

17 Author's calculations of the US Census Bureau's 2011 American Community Survey (2010).

18 Author's interview with José Ramón Fernández-Peña, Associate professor at San Francisco State University's DoH Education, Co-director of Community Health Works, and the founder and director of the Welcome Back Initiative.

proficiency and lack of professional networks in the new home country, lack of transferability of foreign credentials and skills, non-recognition of validated credentials and competencies by state regulators, professional associations and employers, and limited education and training programmes to fill the gaps in immigrants' education (Friedberg, 2000; Creticos et al., 2006; Mattoo, Neagu & Özden, 2008).

These barriers are typically within the policy and programmatic purview of states, local governments, and educational and training institutions. Australia and Canada have been active in experimenting with policies to address brain waste's causes, setting up national and provincial-level regulatory bodies and supporting NGOs that would address barriers in foreign (as well as out-of-province) credential recognition[19]. In contrast, the United States, known for its decentralized federal system, has barely scratched the surface (Rabben, 2013).

Yet in the past decade, a number of programmes, agencies, and NGOs sprung up with the goal of helping immigrant professionals in health care and other fields to navigate the complex process of professional integration. Among the most prominent is the network of *Welcome Back* centres that provides counselling and educational programmes to foreign-trained health professionals, including doctors and nurses. Created in 2001 in San Francisco, California, the Welcome Back network expanded to 10 sites across the country and provides foreign-trained health-care professionals with orientation and pathways to the education and professional English language training they need to successfully rejoin the health-care field[20].

Another one is a privately funded programme run by the University of California Los Angeles Medical School that aims to help Spanish-speaking, bilingual physicians to pass necessary steps to practice in the United States in exchange for delivering health care in underserved Hispanic communities in California. The programme addresses the typical barriers faced by foreign-trained doctors by offering two to three years of medical instruction, pays for students to take Kaplan's USMLE preparatory classes, and offers English classes and clinical observership (Rabben, 2013).

Recognizing that health care has to be provided not only in a competent but also culturally sensitive manner, ACCESS, the largest organization servicing the Arab American community in the United States, developed programmes that would focus on the Arab American community's health needs. Located in Dearborn, Michigan, the ACCESS centre serves as a training facility for medical residents, nurses, and public health professionals in collaboration with the University of Michigan School of Public Health and Wayne State University Schools of Medicine, Pharmacy and Nursing[21].

There are also programmes and initiatives that help foreign-trained nurses prepare for the licensing examination and obtain clinical experience. For example, a programme administered by the Service Employees International Union in New York City provided English instruction and training at the Lehman College Nursing School, as well as hospital employment after students

19 In 2003 and 2004, the Government of Canada provided a total of US$68 million for the next six years to implement the Foreign Credential Recognition (FCR) programme. Through this initiative, the federal government works with provinces, territories, regulatory bodies, employer groups, unions, universities, sector councils, and other partners to develop fairer and more accessible recognition processes for highly skilled immigrants. (Human Resources and Skills Development Canada, 2005). Similarly, Ontario established its own Office of the Fairness Commissioner in 2007 with the goal to ensure that everyone qualified to practice in a regulated profession in Ontario, be it medicine, teaching, engineering, or accounting, can get a licence to practice.

20 Learn more about the 10 Welcome Back Center locations here: http://www.welcomebackinitiative.org/wb/ (accessed 26 April 2014).

21 Learn more about the ACCESS Community Health and Research Center initiative in Access (2011).

passed the licensing exam. Several Area Health Education Centres (AHECs), federally subsidized agencies around the country, are also engaged in helping foreign health professionals navigate the complexities of certification.

One of the most recent initiatives is called *IMPRINT* or *Immigrant Professional Integration*, which is a coalition of organizations that focuses on facilitating immigrant professional integration. The coalition shares best practices on and provides help with credential evaluation, education advising, English instruction, and professional acculturation. But it also aims to develop recommendations for federal and state policy-makers regarding barrier removal for immigrant professionals[22]. While the presence of these local-, state-, and nation-wide initiatives is critical in building the attention to the brain waste phenomenon and its significant and long-term consequences for immigrants, communities in which they live, and the United States' economy overall, at the moment their impact is still small-scale and might be limited geographically or by ethnic group.

**References**

Access (2011). Community Health and Research Center. http://www.accesscommunity.org/site/PageServer?pagename=Community_Health_and_Research

Aiken L (2007). U.S. nurse labor market dynamics are key to global nurse supply. HSR. 43:1299–1320. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955371/pdf/hesr0042-1299.pdf

Akresh I (2008). Occupational trajectories of legal US immigrants: downgrading and recovery. Pop Dev Rev.34:435–456.

Alliance for Health Reform (2011). Health care workforce: future supply *vs. demand*. Washington, DC. http://www.integration.samhsa.gov/images/res/Workforce,%204.22.pdf

American Academy of Nurse Practitioners (2012-2011 AANP National NP Compensation Survey. Austin, TX.

American Association of Colleges of Nursing (2012). Nursing faculty shortage. Washington, DC. http://www.aacn.nche.edu/media-relations/FacultyShortageFS.pdf

American Medical Association (2012). Requirements for becoming a physician. Chicago, IL. http://www.ama-assn.org/ama/pub/education-careers/becoming-physician.page.

Batalova J (2010). H-1B temporary skilled worker program. Migration Information Source. http://www.migrationinformation.org/USFocus/display.cfm?ID=801.

Batalova J, Fix M (2008). Uneven progress: the employment pathways of skilled immigrants in the United States. With Peter A. Creticos. Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/research/uneven-progress-employment-pathways-skilled-immigrants-united-states

Batalova J, Fix, M (2013). Eroding gains. In: Fix M, Papademetriou D, Sumption M. Immigrants in a changing labor market: responding to economic needs. Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/research/immigrants-changing-labor-market-responding-economic-needs

Brown-Mahoney C, Pittman MA, Nuttbrock AM (2012). United States profile: mobility of health professionals. http://www.mohprof.eu/LIVE/DATA/National_reports/national_report_USA.pdf

22 Learn more about IMPRINT here: http://imprintproject.org (accessed 26 April 2014).

Bureau of Labor Statistics (2014). Occupational outlook handbook, 2012–13 Edition, Registered Nurses. Washington, DC. http://www.bls.gov/ooh/Healthcare/Registered-nurses.htm#tab-4

Capps R, Fix M, Lin S (2010). Still an hourglass? Immigrant workers in middle-skilled jobs. Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/pubs/sectoralbrief-Sept2010.pdf

Capps R, McCabe K, Fix M (2011). New streams: black African migration to the United States. Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/pubs/AfricanMigrationUS.pdf

CBO (2012a). Updated Affordable Care Act. Washington, DC: Congressional Budget Office. http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf

CBO (2012b). Estimates for the Insurance Coverage Provisions of the Affordable Care Act. Updated for the Recent Supreme Court Decision. Washington, DC. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf

Creticos P et al. (2006). The Integration of immigrants in the workplace. Chicago, IL: Institute for Work and the Economy. http://www.workandeconomy.org/images/The_Integration_of_Immigrants_in_the_Workplace_Pre-publication_Release_7-31-06.pdf

Department of Labor (2012). Occupational outlook handbook, American Academy of Nurse Practitioners, What's an NP? Washington, DC. http://www.aanp.org/all-about-nps/what-is-an-np

Fernádez-Peña JR (2012). Integrating immigrant health professionals into the US health care workforce: a report from the field. J Immigr Minor Health.14:441–448.

Friedberg R (2000). You can't take it with you? Immigrant assimilation and the portability of human capital. J Labour Econ.18:221–246.

Global Health Workforce Alliance (2012). List of 57 countries facing human resources for health crisis. Geneva. http://www.who.int/workforcealliance/countries/57crisiscountries.pdf.

Goodman CJ, Mance SM (2011). Employment loss and the 2007–09 recession: an overview. Mon Labor Rev. April, pp.3–12. http://www.bls.gov/opub/mlr/2011/04/art1full.pdf

Hawkins (2010). 2010 Physician inpatient/outpatient revenue survey. Irving, TX: Merritt Hawkins. http://www.merritthawkins.com/compensation-surveys.aspx#

Human Resources and Skills Development Canada (2005). Foreign credential recognition backgrounder. Ottawa, ON. http://www.hrsdc.gc.ca/eng/cs/comm/hrsd/news/2005/050425bb.shtml

Institute of Medicine of the National Academies (2010). The future of nursing – leading change, advancing health. Report Brief. http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Report%20Brief.pdf

Lewin-Epstein N, Semvonov M, Kogan K (2003). Institutional structure and immigrant integration: a comparative study of immigrants' labor market attainment in Canada and Israel. Intl Migr Rev. 37:389–420.

Lockard CB, Wolf M (2012). Occupational employment projections to 2020. Mon Labor Rev, January, pp. 84–108. http://www.bls.gov/opub/mlr/2012/01/art5full.pdf

Long M (2012). Health law's survival means more demand for fewer doctors. WSJ, June 28, 2012. http://blogs.wsj.com/health/2012/06/28/health-laws-survival-means-more-demand-for-fewer-doctors

Lowell L (2012). The foreign born in the American healthcare workforce: trends in this century's first decade and immigration policy (draft). Migration News, March 2012. http://migrationfiles.ucdavis.edu/uploads/rs/files/2012/9/ciip/lowell-us-health-care.pdf

Lowrey A, Pear R (2012). Doctor shortage likely to worsen with health law. NYT, July 28, 2012. http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html

Martin S, Lowell BL, Gozdziak EM, Bump M, Breeding ME (2009). The role of migrant care workers in aging societies. Report on research findings in the United States. Washington, DC: Georgetown University. http://www12.georgetown.edu/sfs/isim/Publications/GrantReports/ElderCareReport.pdf.

Mattoo A, Neagu IC, Özden C (2008). Brain waste? Educated immigrants in the US labor market. J Dev Econ. 87:255–269.

Migration Policy Institute (2013). Side-by-side comparison of 2013 Senate Immigration Bill with individual 2013 House bills. Washington, DC. http://migrationpolicy.org/research/side-side-comparison-2013-senate-immigration-bill-individual-2013-house-bills

OECD (2007). International migration outlook: SOPEMI 2007 Edition – Part III. Immigrant health workers in the broader context of highly skilled migration. Paris: Organisation for Economic Co-operation and Development. http://www.oecd.org/els/internationalmigrationpoliciesanddata/41515701.pdf

OECD (2012). OECD health data 2012 – how does the United States compare? Paris. http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf

Papademetriou DG et al. (2010). Migration and immigrants two years after the financial collapse: where do we stand? Washington, DC: Migration Policy Institute. http://www.migrationpolicy.org/pubs/MPI-BBCreport-2010.pdf

Papademetriou DG, Sumption M (2011). The role of immigration in fostering competitiveness in the United States. Washington, DC: Migration Policy Institute. http://migrationpolicy.org/research/role-immigration-fostering-competitiveness-united-states

Pear R (2012). Court's ruling may blunt reach of health law. NYT, July 24, 2012. http://www.nytimes.com/2012/07/25/health/policy/3-million-more-may-lack-insurance-due-to-ruling-study-says.html?_r=1&hp

Polsky D et al. (2007). Medical migration to the US: trends and impacts. Philadelphia, PA: Leonard Davis Institute of Health Economics, University of Pennsylvania. http://www.upenn.edu/ldi/issuebrief12_6.pdf

Rabben L (2013). Credential recognition in the United States for foreign professionals. Washington DC: Migration Policy Institute. http://www.migrationpolicy.org/pubs/UScredentialrecognition.pdf

Reitz J (2005). Tapping immigrants' skills: new directions for Canadian immigration policy in the knowledge economy. IRPP Choices, February. http://www.hireimmigrants.ca/resources/research/files/Reitz_IRPP_TappingImmigrantSkills%5B1%5D.pdf

Rowland D (2009). Health care and Medicaid – weathering the recession. New Eng J Med.360:1273–1276. http://www.nejm.org/doi/full/10.1056/NEJMp0901072

Sarah K (2012). Success of health reform hinges on hiring 30,000 primary care doctors by 2015. The Washington Post, February 10. http://www.washingtonpost.com/business/success-of-health-reform-hinges-on-hiring-30000-primary-care-doctors-by-2015/2012/02/06/gIQAnsIQ4Q_story.html

Squires A (2013). Strengthening health systems in North and Central America. Washington DC: Migration Policy Institute. http://www.migrationpolicy.org/research/strengthening-health-systems-north-and-central-america-what-role-migration

Staiger D, Auerbach D, Buerhaus P (2012). Registered nurse labor supply and the recession – are we in a bubble? N Eng J Med. 366:1463–1465. http://www.nejm.org/doi/pdf/10.1056/NEJMp1200641

Sumption M, Bergeron C (2013). Remaking the Green-card System. Washington DC: Migration Policy Institute. http://www.migrationpolicy.org/research/remaking-us-green-card-system-legal-immigration-economic-opportunity

Sumption M (2011). Filling labor shortages through immigration: an overview of shortage lists and their implications. Migration Information Source, February 2011. http://www.migrationinformation.org/Feature/display.cfm?ID=828

US Census Bureau. American Community Survey (ACS). 2005–11 (2010). Accessed from Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis, MN: University of Minnesota.

US Census Bureau. Decennial Census 2000 (2010). Accessed from Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis, MN: University of Minnesota.

US Department of Health and Human Services (2013). Health Resources and Services Administration, Designated Health Professional Shortage Areas (HPSA) Statistics. http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2

Wayne A (2012). Doctor shortage may swell to 130,000 with cap. Bloomberg, 29 August. http://www.bloomberg.com/news/2012-08-29/doctor-shortage-may-swell-to-130-000-with-u-s-cap.html

Wood CA (2011). Employment in health care: a crutch for the ailing economy during the 2007–09 recession. Mon Labor Rev. http://www.bls.gov/opub/mlr/2011/04/art2full.pdf

WHO (2006). Health workers: a global profile. In: The World Health Report 2006 – Working together for health. Geneva: World Health Organization. http://www.who.int/whr/2006/whr06_en.pdf

©WHO

French country doctor.

# Conclusions

AMANI SIYAM

MARIO ROBERTO DAL POZ

THOMSON PRENTICE

## Monitoring the Code's implementation

With regular monitoring of the implementation of essential provisions of the Code, WHO aims to provide WHO Member States and other interested stakeholders with the evidence base necessary to advance national action and global cooperation on the ethical international recruitment of health personnel. Chapter 1 has assessed countries' implementation of the Code. To date, 85 countries have designated a national authority, three-quarters of which are based in the ministry of health, the others in institutes of public health, health authorities, health boards and HRH observatories. At least 56 countries, mostly in Europe, have completed and returned their NRIs. These countries represent more than 80% of the world's population living in destination countries, and a minority of the known source countries.

Overall, 37 countries have taken steps towards implementing the Code. Already, 33 have reported taking actions to communicate and share information on health-worker recruitment, migration issues and the Code among relevant ministries, departments and agencies. In some cases the Code has been translated into the national language (e.g. in Finland, Norway and Thailand).

Countries have adopted multiple approaches to raise awareness of the Code and promote dialogue concerning it. For example, the government of Canada is working on disseminating awareness materials for foreign workers entering the country at embassies and high commissions abroad. Norway has reported a number of strategic objectives aimed at addressing its health workforce challenges inherent in the Code. The Philippines has adopted a participatory multi-stakeholder assessment process.

Quite a few countries have acted to involve all stakeholders in decision-making processes involving health personnel migration and international recruitment. Some changes to relevant laws or policies are being considered. However, only 10 countries say they maintain records of all recruiters authorized by competent authorities to operate within their jurisdiction, and only nine say that good practices are encouraged and promoted among recruitment agencies.

## Challenges to the implementation of the Code

In stating their challenges, countries have named three main constraints. The first and most common concerns the engagement of multiple stakeholders (at national and sub-national levels,

in the public and private sectors) involved in decision-making processes on health personnel migration and international recruitment. Typically, stakeholders represent various sectors and different interests, which makes it more difficult for them to adhere to a single core set of principles.

The second constraint lies in the lack of coordinated and comprehensive data on health personnel migration, which is usually shared between multiple agencies and entities within and among countries. Reporting countries emphasize the need for more efforts and technical cooperation to improve existing health information systems, including information on laws and regulations related to health personnel recruitment.

Thirdly, countries indicate lack of a shared understanding of the nature of the connections, at country level, between workforce migration, current and future health workforce needs, and short- and long-term workforce planning which could hamper the Code's implementation.

Since the adoption of the Code, CSOs have identified emerging challenges such as economic austerity measures that are affecting national health systems, the shift in focus towards internal EU health workforce distribution imbalances, and the insufficient interaction between development NGOs and other civil society actors, such as patient federations, labour unions and professional associations that have a stake in health workforce (Chapter 2).

## Discussion

In countries with fragile health systems, health workforce migration is difficult to tackle in a reality of numerous challenges and the inescapable paradox of remittances generated by migrant workers in general. However, the root problem of the crisis extends far beyond the issue of migration alone. Evidence drawn from a comparative analysis of OECD countries shows that the HRH needs in developing countries, as estimated by WHO at the regional level, largely exceeds the number of health immigrants working in these countries (OECD, 2007).

Health systems will continue to face a series of current and future challenges caused by the changes in demography, technology and economic environment – within this changing context the workforce shortages are bound to worsen (Glinos et al., 2011). Globally, there is an imperative need to transform the production of health workers, encompassing labour market analysis as well as the transformation of education and training of the health workforce, at national and transnational levels (WHO, 2013).

In the EU, WHO is collaborating in developing an action plan for the health workforce by bringing countries together in response to the key challenges it faces in the medium to longer term. The aim is to promote a sustainable workforce in Europe (Dussault Perfilieva & Pethick, 2012). Although foreign-trained doctors and nurses make up a significant share of the health workforce in the major English-speaking destinations, these flows seem have not been strongly affected by the global economic crisis and are expected to remain strong in coming decades as aging populations increase demand for health services (Chapter 8).

Clearly there is a challenge to build an international and comparable information base on health personnel migration data and statistics. Results in the first round of reporting on implementation

of the Code show that few countries are currently in a position to provide data on health professionals moving from one country to another on an annual basis. Where data are available, there is an imperative need to create a consensus on key indicators to collect in favour of strengthening health workforce information systems in countries (Chapter 7) (Commission on International Migration Data for Development Research and Policy, 2009).

## Conclusion

Only about one in four WHO Member States responded to the first round of monitoring the WHO Code implementation, and this limits generalizations of the lessons learnt. Part of the explanation for the low response may be the relative newness of the Code and some countries' unfamiliarity with it (Edge & Hoffman, 2013). However, although the Code is still in its early years, its implementation has stimulated small but important moves from principles to actions. This publication illustrates that while the Code is a mechanism to globally reason the implication of health workforce migration, the transition from deficit to sufficiency is attainable if countries take bold steps to address their health workforce needs in changing demographic, economic and technological contexts. In the future, regular and systematic reviews of the implementation of the Code are also an essential component in keeping the Code up to date and useful as an instrument of global health policy.

### Data collection

The six potential data sources reviewed in Chapter 7 all offer some valuable information, but they also face some more or less severe shortcomings. Cost and administrative feasibility constraints also need to be taken into account to identify the best options to improve the available data sources. Based on this review, professional registries, surveys of health personnel, and requests for recognition of foreign credentials seem to be the most promising sources to monitor international migration of health professionals worldwide.

Depending on the sources used, the following data developmental work would be needed in order to be able to collect data that would be internationally comparable and more widely available:

- harmonizing the information on migration-related issues collected in *professional registries;*
- promoting the development of a common survey module (a common set of questions) on migration-related issues that could be used in regular national *surveys of health personnel*; and
- achieving greater national and international co-ordination of data that can be derived from individual requests for *recognition of their foreign credentials*.

This effort should be given high priority in the main destination countries in order to provide sound evidence on which to base policy-making.

## Health worker migration: Individual country evidence

### The economic crisis

One clear conclusion emerging from the research, and discussed in Chapter 8, is that the global economic crisis and rising unemployment levels it provoked have *not* been significant drivers of health workforce migration.

Across immigrant-receiving countries as a whole, the economic crisis disrupted a number of significant, employment-driven immigration flows. Lower demand for labour (and rising unemployment) reduced demand for many types of immigrant workers – especially more economically sensitive ones such as labour migration and free-movement within the EU. However, the health sector has been largely insulated from this trend. The health workforce held steady or grew in the study countries despite substantial job losses in other sectors.
The crisis may eventually have an impact on health workforce migration by putting pressure on public finances and thus the available public funding for health care. Government budget deficits grew at the end of the 2000s in all the study countries, although the structure of public financing for health differs between them. Meanwhile, the demand for health care is expected to increase in all study countries as their populations age.

These dynamics – pitted against constraints on public finances and the unpredictable effects of changing technologies and divisions of labour within the health workforce – will be important in determining the pressure for health workforce migration in coming decades.

Further related evidence is contained in chapters 2, 9, 10, 11 and 12, and summarized here by country, listed alphabetically.

**Australia**
In the coming decade, skilled migration is set to remain a national priority for Australia, with strong relevance for the health professions. Long-term workforce demand will be met through dramatically expanded domestic training… Australian Health Ministers have set a goal for domestic self-sufficiency by 2025. Their policy imperative is thus to recruit migrant professionals who can contribute effectively within the next 13 years… Self-sufficiency is defined as a situation in which all of Australia's requirements for medical, nursing and midwifery professionals in 2025 can be met from the supply of domestically trained graduates without the need to import overseas trained doctors, nurses and midwives to meet a supply gap. (Chapter 9)

**Belgium**
There is no evidence so far that the economic crisis has influenced the employment of health personnel from abroad. On the other hand, there are indications that doctors of foreign origin often serve in less-attractive positions such as hospital emergency-services, or are on duty during weekends and holidays in general practices. (Chapter 2)

**Canada**
Thus far the recession appears to have had no appreciable effect on the admission of new immigrants and the integration of health professionals into Canadian practice. Although not directly related to the recession but concurrent with it, if anything the changes in recent years have involved steps towards the improved integration of IEHPs into the Canadian workforce. Looking forward, financial constraints will affect the mostly publicly funded and/or subsidized health workforce in the near future as government debt and deficits are addressed. The large and increasing number of IEHPs practicing (and not practicing) in Canada suggests that shortages in some less well-off countries may be exacerbated, although there appear to be substantial increases in international health professional and medical schools preparing graduates for export that may offset some of this effect in the future. (Chapter 10)

**Italy**
The Italian health service is undermined by public budget constraints caused by the financial crisis, and Italy runs the risk of slowly becoming a net exporter of health professionals… In the current context of lack of financial and human resources and widespread insecurity, foreign-trained health workers who entered the national health service in the last decade have today become a vital resource for the health system. (Chapter 2)

**The Netherlands**
Newly developed policies and legislation are changing the Dutch health workforce landscape. Budget cuts of up to 40% on home care will in the short-term cause unemployment among public sector nurses and caretakers, prompting the Minister of Health to reinvestigate the expected shortages of health personnel. …In the private sector, however, recruitment agencies are anticipating the needs for care of elderly and chronically ill people and are already actively recruiting qualified foreign personnel from other European countries. (Chapter 2)

**Poland**
Low salaries are a major problem, especially for young medical doctors and mid-level health personnel, such as nurses and midwives: doctors commencing postgraduate courses receive a basic monthly salary of about 480 Euro, unchanged since 2009. These factors will certainly have an impact on increasing the outflow of health workers in the coming years, as long as working conditions do not change. (Chapter 2)

**Romania**
"The official income for physicians is very low in Romania and average incomes in the health sectors have deteriorated compared to other sectors within the past years, due to the economic crisis. This situation worsened in July 2011, when the government issued a law on 25% salary reduction for people working in public institutions; this has been applied also to medical doctors and nurses and hence resulted in an incentive to move abroad. Between 2007 and 2013, around 14 000 medical doctors left their jobs in the national public health system and chose to practice abroad; therefore, Romania spent (and subsequently lost) for the specialist training of these professionals more than 3.5 billion Euros. (Chapter 2)

**United Kingdom**
The immigrant workforce grew rapidly in the first half of the 2000s, but this growth came to a halt after 2006 when the government tightened policies on international recruitment, work permits, and professional registration. The number of health-care professionals coming to the country on work visas has plummeted since the mid-decade, although most of this decline predated the economic crisis. During the recessionary period, the size of the health-care workforce has remained roughly stable.

The health-care industry has been sheltered from the brunt of the economic crisis, avoiding the high unemployment associated with some other occupations. As a result, immigrant health-care workers have fared better than many other immigrants in recent years, despite deteriorating economic conditions.

Demand for health care is expected to increase in coming years, although a very tight fiscal environment will bring growth in the NHS budget (and hence the workforce) down to extremely low levels. Since most health care in the United Kingdom is publicly funded, the future

economic and fiscal outlook will be crucial in determining whether the international migration of health-care workers will rebound… Nonetheless, even under current policies and economic conditions immigrant doctors and nurses are set to remain an important component of the United Kingdom's health workforce: in 2011, 42% of newly registering doctors and 22% of newly registering nurses were trained outside of the United Kingdom. (Chapter 11)

**United States**

The health-care industry, unlike many other sectors of the US economy, was one of the few industries that added employment across the recession and projections indicate that health-care professions will be among the fastest growing in the years ahead… against a backdrop of profound demographic and policy change. By 2021, an estimated 33 million previously uninsured individuals will acquire health insurance coverage as a result of health-care reforms and, by 2030, all of the 79 million "baby boomers" will become eligible by age for public health insurance coverage through Medicare. While these transitions are certain to create a greater demand for health services, the ways in which this demand will translate into workforce needs in the coming years is less clear. (Chapter 12)

## Key messages

Countries and different stakeholders have provided clear messages that more efforts and technical cooperation are needed to extend knowledge and research, and to improve existing health workforce information systems, including information on laws and regulations related to health personnel recruitment. Partnering with CSOs is crucial for global and national dialogue as demonstrated in the European region where their efforts have influenced policy-makers and parliamentarians, and gained commitment to implementing the Code.

The political imperative of moving towards universal health care and monitoring its progress (WHO, 2014) provides opportunities that can be seized for much greater integration between health workforce planning on the one hand and policy-making and overall efforts at strengthening health systems on the other. It also calls for the establishment of linkages with other sectors, civil society and the political establishment.

**References**

Commission on International Migration Data for Development Research and Policy (2009). Migrants count: five steps toward better migration data. Washington, DC: Global Development (http://www.cgdev.org/files/1422146_file_CGD_migration_FINAL_web.pdf, accessed 14 December 2012).

Dussault G, Perfilieva G, Pethick J (2012). Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel in the European Region (A policy brief). Geneva: World Health Organization (http://www.euro.who.int/__data/assets/pdf_file/0013/173020/BRIEF_NRI_annex_060912VeryFinal.pdf, accessed 26 April 2014).

Edge J, Hoffman S (2013). Empirical impact evaluation of the WHO Global Code of Practice on the international recruitment of health personnel in Australia, Canada, UK and USA. Globalization and Health.9:60.

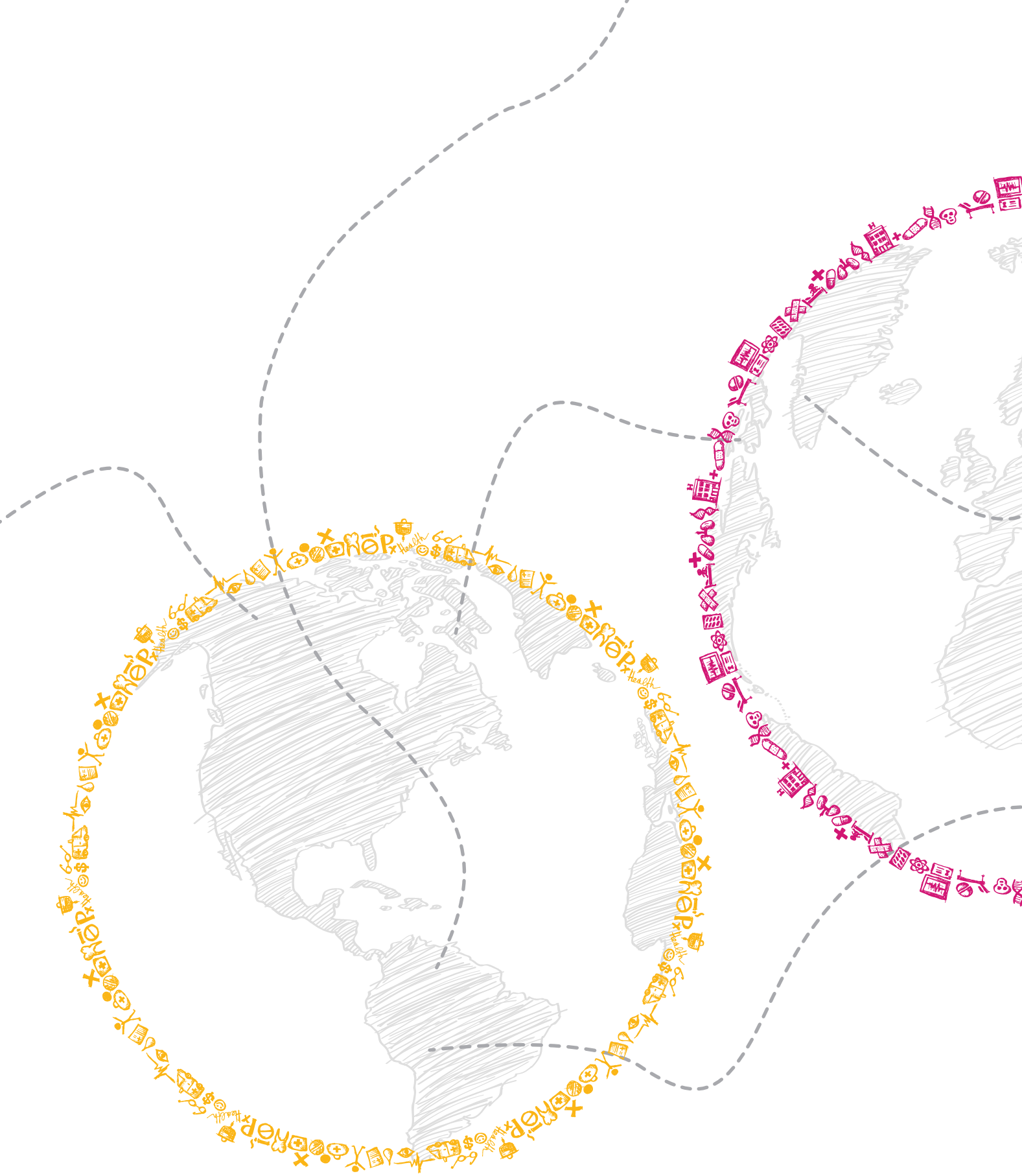
Glinos IA, Wismar M, Maier CB, Palm W, Figueras J. (2011). Health professional mobility and health systems in Europe: conclusions from the case-studies. In: Wismar M, Maier CB, Glinos IA, Dussault G, Figueras J, editors. Health professional mobility and health systems: evidence from 17 European countries. Geneva: World Health Organization (Observatory Study Series No. 23, http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf, accessed 23 August 2013).

OECD (2007). PART III: Immigrant health workers in OECD countries in the broader context of highly skilled migrants. International Migration Outlook: SOPEMI 2007 Edition. Paris: Organisation for Economic Co-operation and Development.

WHO (2013). Guidelines on transforming and scaling up health professionals' education and training. Geneva: World health Organization (http://whoeducationguidelines.org/, accessed 26 April 2014).

WHO (2014). What is universal health coverage? Geneva (http://www.who.int/features/qa/universal_health_coverage/en/, accessed 26 April 2014).

# Notes



**The Heath Workforce Department**
Health Systems and Innovation (HIS)
World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
http://www.who.int/hrh/migration/code/practice/en/

ISBN 978 92 4 150714 1