International Migration of Health Workers Evidence and Governance

Highlights from the EU Brain Drain to Brain Gain Project

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World Health Organization

Health Workforce Department

International Migration of Health Workers

I. WHO Global Code of Practice
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III. Policy Achievements
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I. The WHO Global Code of Practice

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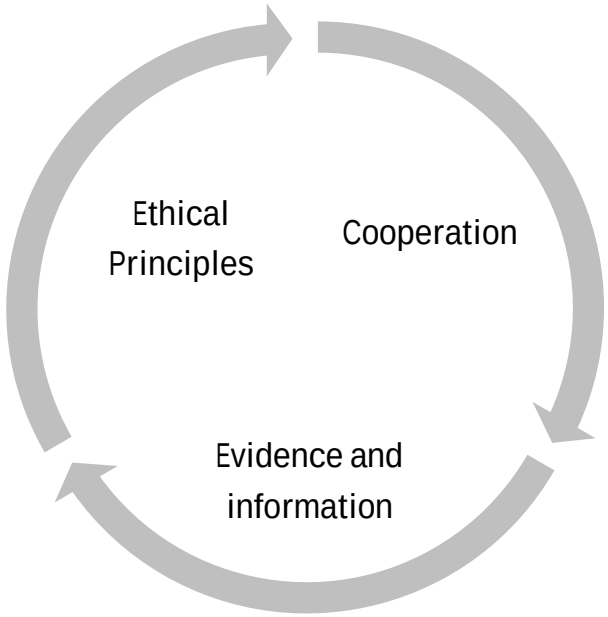
WHO Global Code of Practice

- Adopted in May 2010 though consensus by the 193 WHO Member States
  - Only the second instrument of its kind promulgated by the WHO
  - Broadest possible articulation of the challenges: elaboration of ethical norms, principles, and practices.

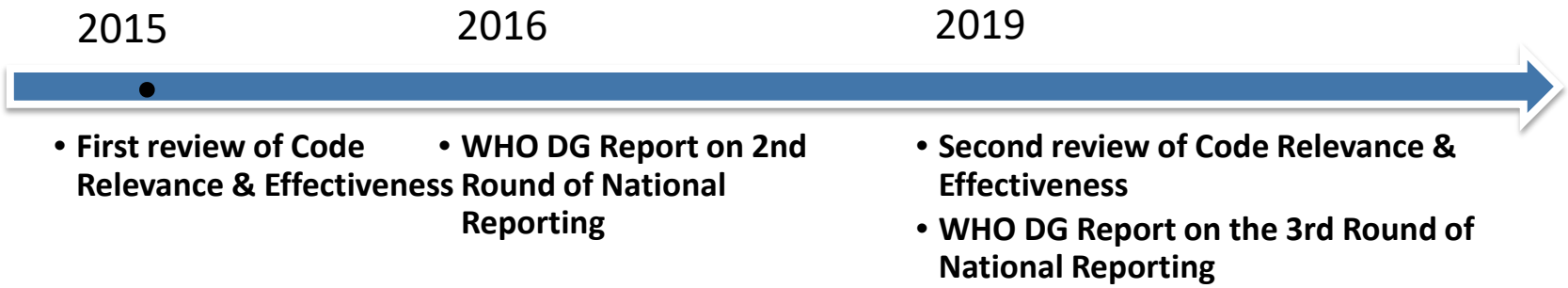
Code Structure and Substance

- Preamble
- Article 1: Objectives
- Article 2: Nature and Scope
- Article 3: Guiding Principles
- Article 4: Responsibilities, Rights and Recruitment Practices
- Article 5: Health Workforce Development and Health Systems Sustainability
- Article 6: Data Gathering and Research
- Article 7: Information Exchange
- Article 8: Implementation of the Code
- Article 9: Monitoring and Institutional Arrangements
- Article 10: Partnerships, Technical Collaboration, and Financial Support

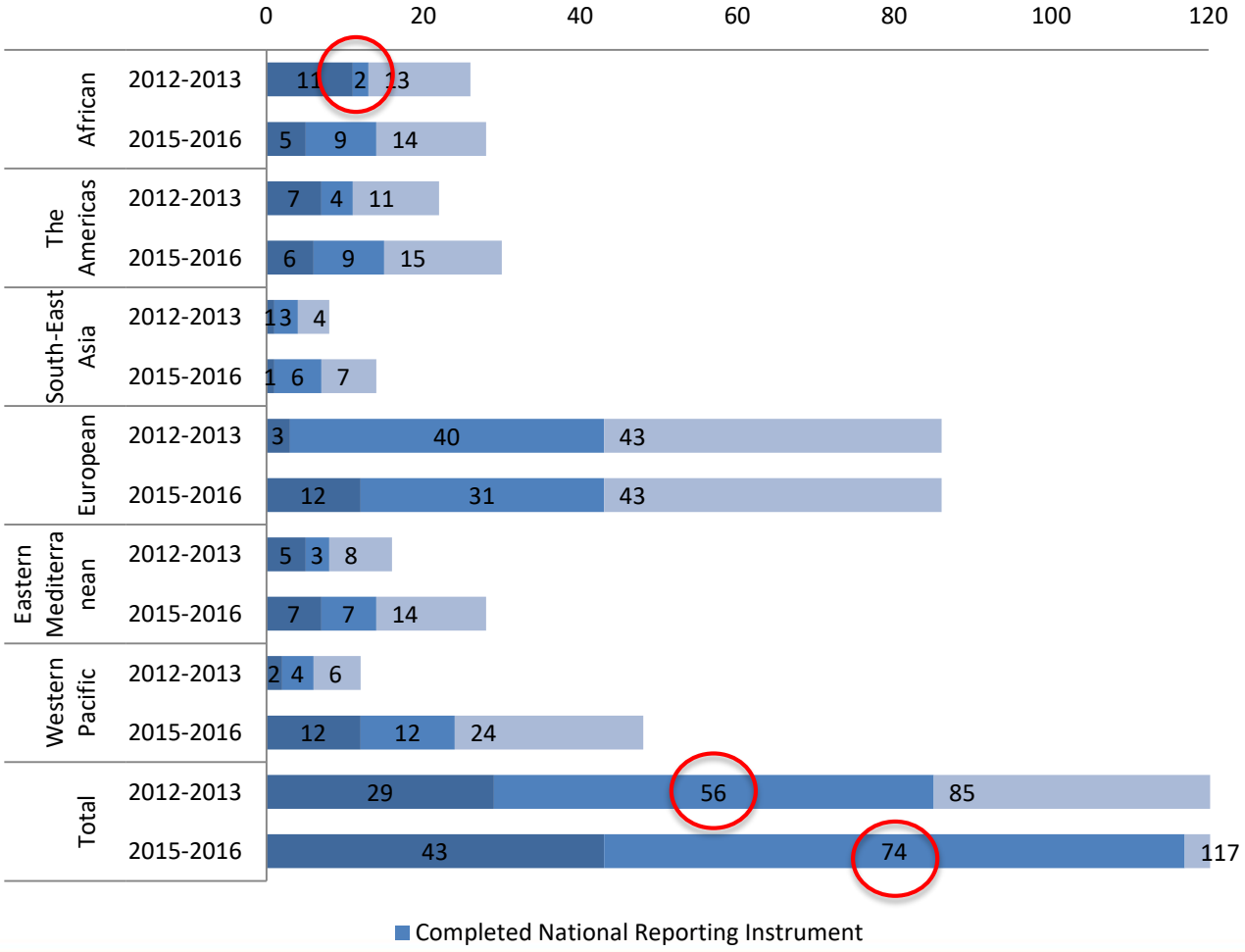


Legal and Institutional Arrangements

- While the WHO Global Code is voluntary, it contains a robust process for reporting
  - WHO's reporting on the Code is mandatory ("shall")
- Progress on the Code is to be reported upon at the World Health Assembly every three years

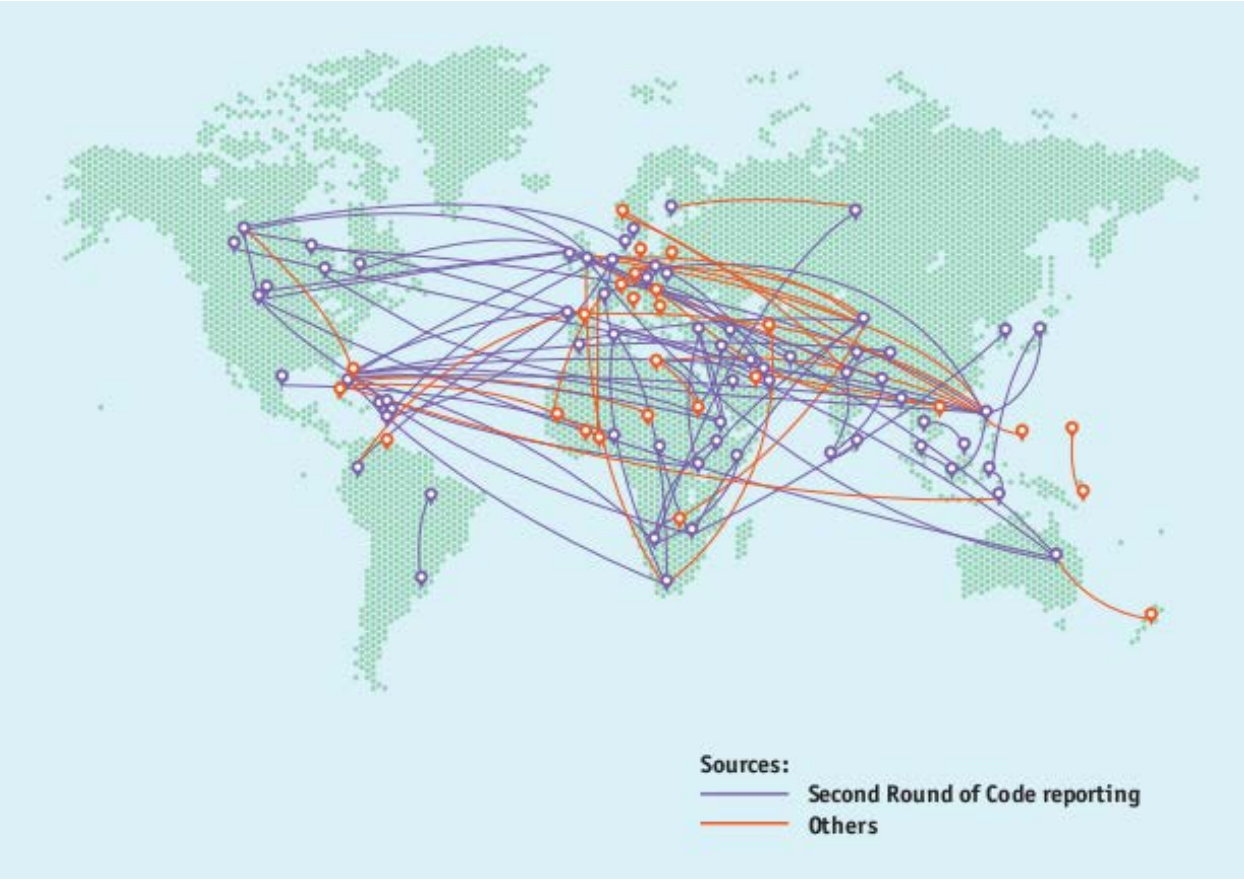


Increasing Legitimacy and Value



- **37% increase** in countries appointing NDAs
- **32% increase** in countries submitting complete national reports
- Reports **publically** available

Improving Information: Bilateral Agreements



2nd round Code reporting

- 34 countries identified bilateral agreements
- 65 agreements identified
- 22 countries reported taking ethical considerations into account, as called for by the Code

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II. Evidence

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Key Sources

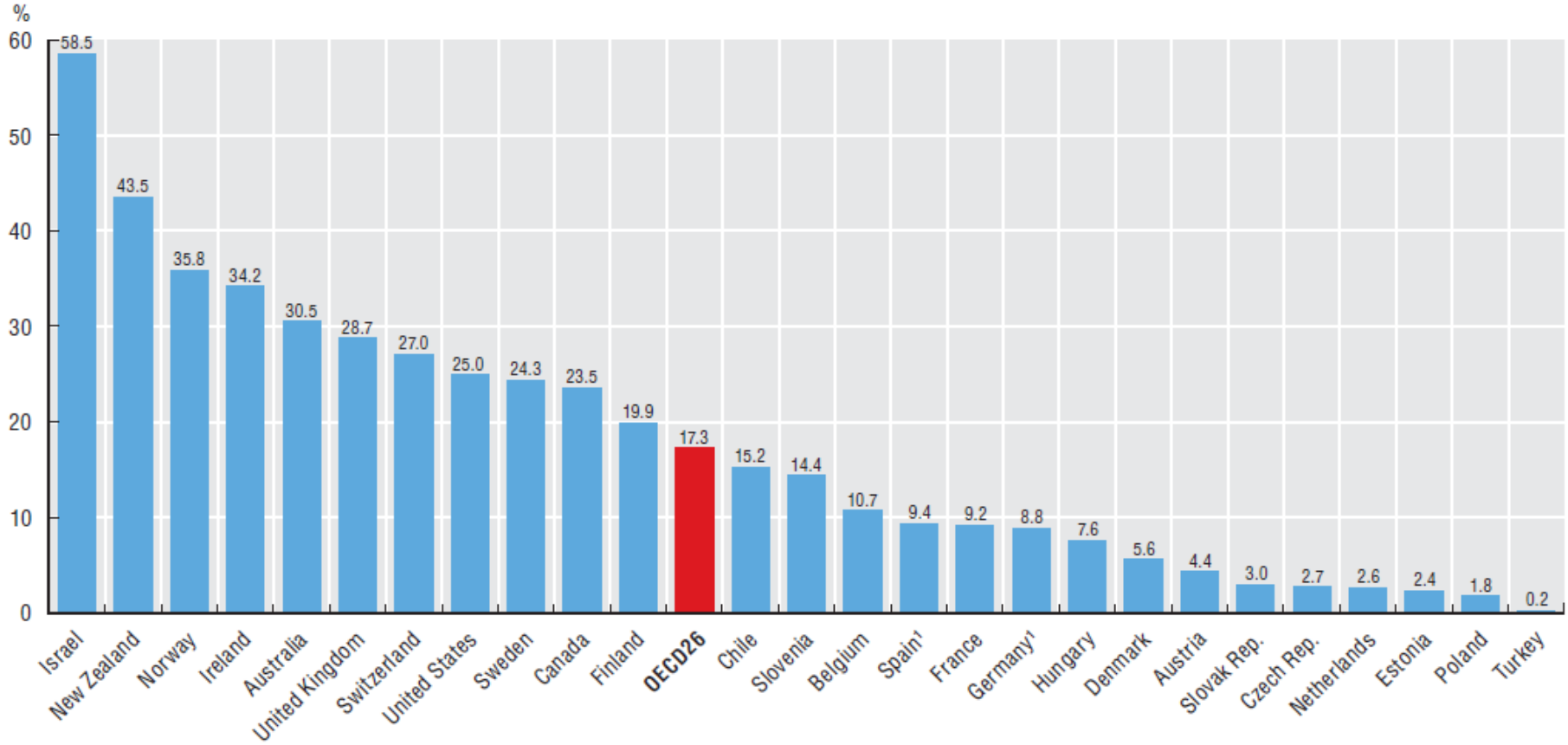
- 2nd Round of Reporting WHO Global Code of Practice on the International Recruitment of Health Personnel

- OECD, International Migration Outlook, 2015

- EU Brain Drain to Brain Gain Project
  - India (Kerala), Ireland, Nigeria (Cross River State), Uganda, and South Africa

Share of foreign trained doctors in OECD countries

2013 or latest year available



Source: OECD, 2015

International migration on the rise

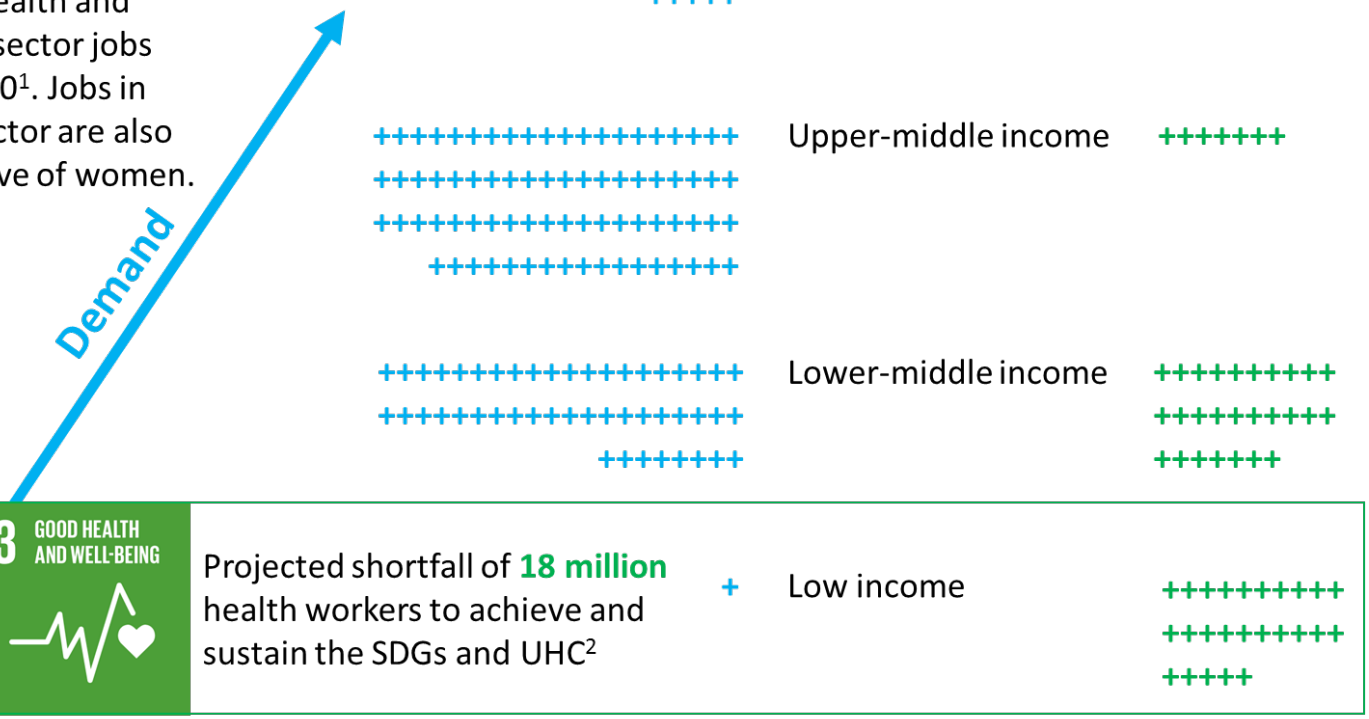
Share of foreign-born health workers in OECD countries	2000–2001	2010–2011
Doctors	19.5 %	22 %
Nurses	11 %	14.5 %

The number of migrant doctors and nurses working in OECD countries has **increased by 60%** over the past 10 years (from 1,130,068 to 1,807,948).

Source: OECD, 2015

A Global Supply and Demand Mismatch

Global economy is projected to create **around 40 million** new health and social sector jobs by 2030[1]. Jobs in the sector are also inclusive of women.



1 World Bank . 2 World Health Organization

Complex Patterns of Mobility: A blurring of "source" and "destination"

South to South movement

Nigeria, Cuba, and Democratic Republic of the Congo (DRC) are respectively the

1st, 3rd and 4th

largest sources of immigrant medical doctors who entered South Africa between 2011-2015.

More than

1/2

of emigrant nurses from Kerala (India) are estimated to reside in Gulf countries according to the Kerala Migration Survey.

In 2014 approximately

1/5th

of all new entrants licensed to practice in Nigeria were foreign medical graduates with an estimated half from Asia and one third from African countries.

Approximately

1/2

half of doctors in Trinidad and Tobago are foreign born and foreign trained; with one third from India, and a quarter each from Jamaica and Nigeria.

North to South movement

Almost

1/3rd of GP's

who registered in Uganda (2010-2015) were trained and held nationality in Europe or North America. Nationals from 74 countries registered in Uganda during the period.

UK was the

2nd

largest source of immigrant medical doctors who entered South Africa (2011-2015).

Temporary migration

- Of doctors who received their basic medical qualification in South Africa and registered in Ireland, only

1/5th

reported practising only in Ireland.

Globalization of medical education

- In the General Division of Ireland's Health Services Executive, less than

1/2

of European medical school graduates (excluding Ireland's) are EU passport holders.

- From 2010-2016, 38 foreign nationals from 10 countries (including Kenya, India, Iran, Mexico and Poland.) received their basic medical qualification in Uganda.

Intra-regional movement

Over

1/2

of emigrant GPs from Uganda (2010-2015) are estimated to have moved within Africa, primarily to Southern and Eastern Africa with Namibia and Kenya as leading destinations.

2/3rd

of Argentina's foreign-trained doctors originate from Bolivia and Colombia.

Relevance of Temporary Mobility

Country of BMQ	Practicing within the Republic of Ireland only, 2015
Ireland	**90.2%**
Pakistan	62.1%
Sudan	53.2%
United Kingdom	65.5%
South Africa	**18.4%**
Romania	56.5%
India	72.3%
Nigeria	63.1%
Egypt	53.7%
Poland	69.2%
Hungary	61.2%

Source: Brugha and Walsh, EC Brain Drain to Brain Gain Project Case Studies

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III. Policy Achievements

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National Level Achievements

- All focus countries designated national authorities to report on the Code.
- All three African focus countries submitted complete national reports during the second reporting round, contrasting with only two African countries reporting during the first round.
- Ireland successfully linked its registry (Medical Council of Ireland) and employment (Health Services Executive) data – with important relevance, globally.
- Explicit consideration of the Code and the findings of the EAG “relevance and effectiveness” report have informed Ireland’s National Strategic Framework for Health Workforce Planning.
- Nigeria initiated the development of a National Health Worker Migration Policy, endorsed at the 3rd National HRH Conference in 2017 as a key objective.

Global Level Achievements

- An expert advisory group ((EAG) was supported to review the relevance of and evidence the effectiveness of the Code. Findings pointed to continuing relevance, emerging effectiveness, value and legitimacy of the WHO Global Code, with reporting at the WHA.
- A special supplement on the WHO Global Code was published in the *Human Resources for Health Journal*, with 14 peer reviewed articles.
- Research protocol developed, with innovations in methodology.
- Evidence from the project informed the report of the *High-Level Commission on Health Employment and Economic Growt*h, Working for Health Action Plan, and associated UN and WHA resolutions.
- Project findings and examples of innovative approaches have fed into the discussions on the Global Compact for Safe, Regular and Orderly Migration, with country experience shared from South Africa and Uganda.

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IV. Next Steps

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High Level Commission on Health Employment and Economic Growth

As an immediate action, calls on ILO, OECD and WHO , with relevant partners, to:

1. **Establish an international platform on health worker mobility**
   - *Maximize benefits from health worker mobility*
   - *Initiate dialogue, expand evidence, consider new options and solutions*
   - *Strengthen and support implementation of the WHO Global Code and relevant ILO Conventions and Recommendations*
   - *Link to the Global Compact for Safe, Orderly and Regular Migration*

Opportunity to Scale Up Innovative Practice

National : South Africa, Foreign Health Professionals Policy

Sudan, National Health Worker Migration Policy

Bilateral: Sudan and Saudi Arabia Bilateral Agreement

- Sharing of education and training, reduction of recruitment fees
- Supports return and rural practice

Regional: East African Community, Regional Harmonization Process

- Harmonized medical and dental education, registration/licensure, and practice

Key lessons from the project

- All countries are source and destination, albeit to varying degrees.
- Policies for the integration of foreign health professionals (South Africa example) are relevant across all countries.
- Strategic linkages must and can be made across the health labour market: production, licensing and registration, employment, and migration.
- Potential to improve global reporting of immigration data across countries, with information sharing facilitated through the Code.
- **Targeted support to implementation of the Code in low-income and middle-income countries fundamental.**

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Thank you

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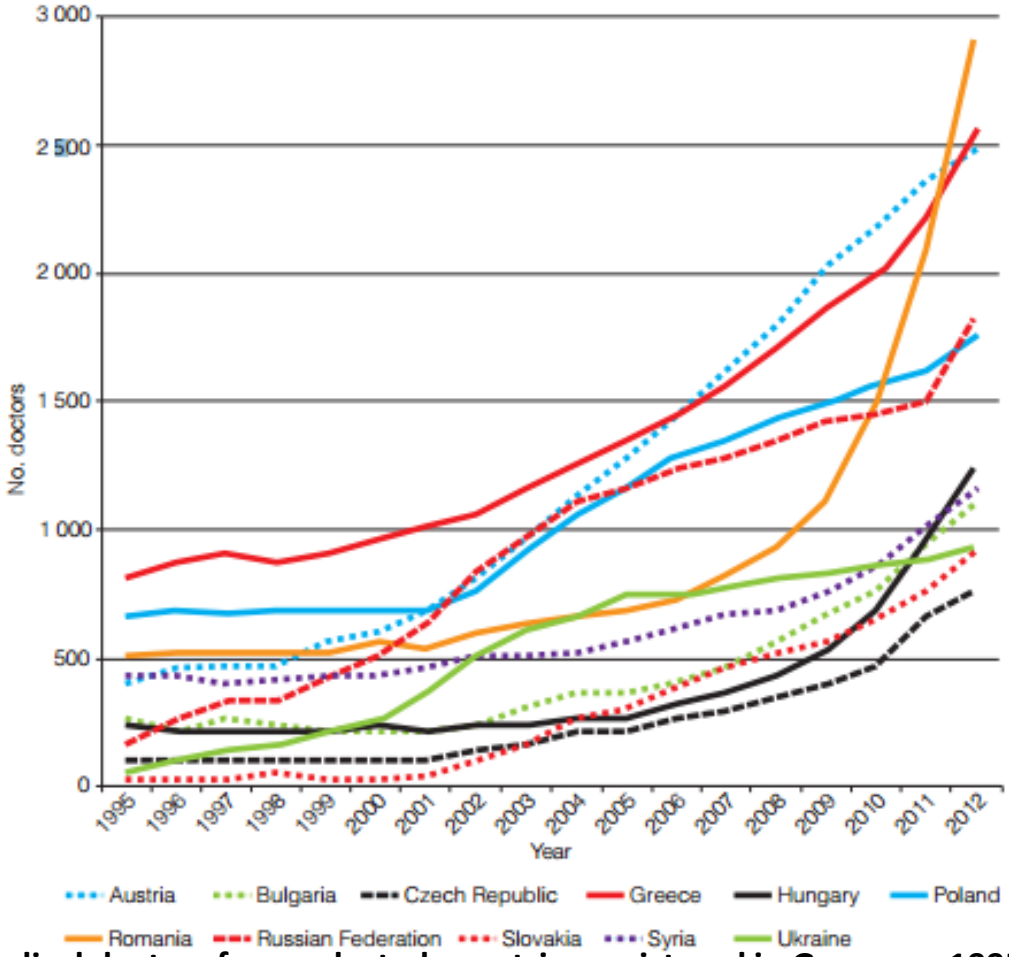
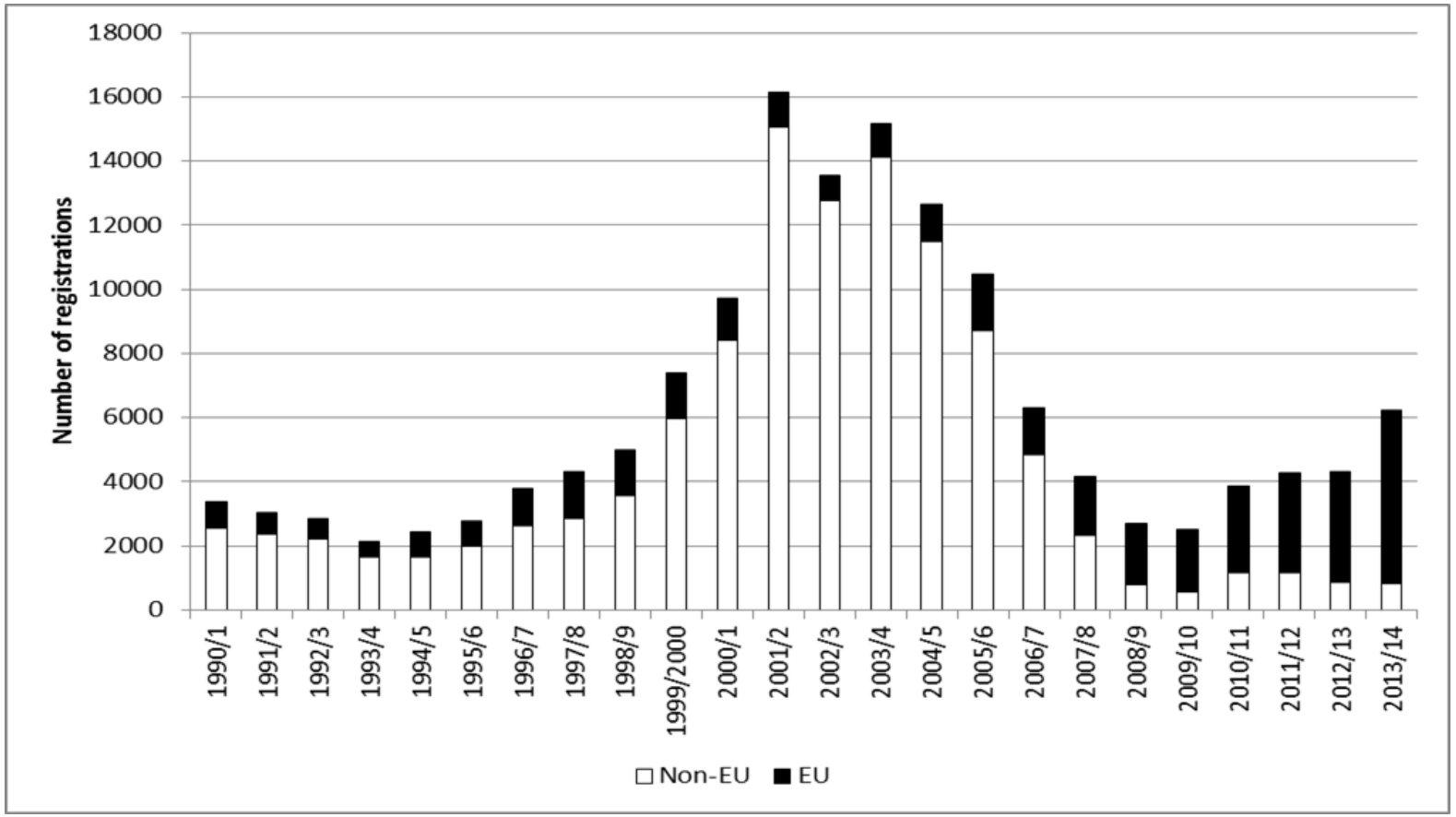
Things Change: Germany



Medical doctors from selected countries registered in Germany, 1995-2012

Source: German Federal Chamber of Physicians, 2013

Things Change: UK, new international nurses



Diversity in Source Countries

Ireland

In 2015, approximately 20,000 BQM doctors were on Ireland's medical register, with international medical graduates constituting approximately 40% and Eastern Mediterranean Region the leading source.

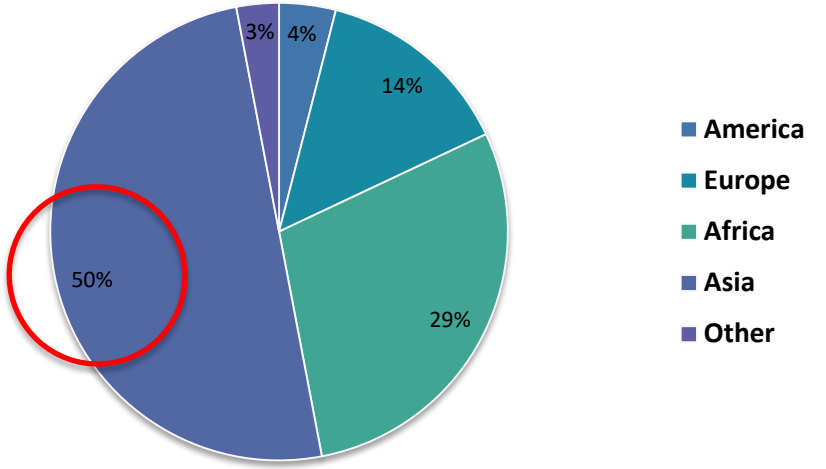
Source	2012	2015
Ireland	10,656 (65.1%)	10,906(62.1%)
EMRO	2,187(13.4%)	2,656(15.1%)
EURO	1,575(9.6%)	2,325(13.2%)
AFRO	1,227(7.5%)	969(5.5%)
SEARO	492(3.0%)	438(2.5%)
WPRO	168(1.0%)	166(0.9%)
AMERO/ PAHO	66(0.4%)	99(0.6%)

Distribution of BMQ registration on Medical Council of Ireland , by WHO regions (2012 &2015)

Nigeria

In 2014, approximately 17% of all new entrants licensed to practice in Nigeria were foreign medical graduates. Analysis of Applicants for temporary registration – a proxy for source of foreign medical doctors entering the country - shows that:

Temporary registration of medical doctors in Nigeria, by region of origin (2014)



Source: EC Brain Drain to Brain Gain Project Case Studies

Evidences from the 2nd Round of Reporting

- Two thirds of Argentina's foreign-trained doctors originate from Bolivia and Colombia
- Approximately half of doctors in Trinidad and Tobago are foreign born and foreign trained, with one third from India, and a quarter each from Jamaica and Nigeria
- Belize's foreign-trained doctors are all originate in Cuba
- Almost all the foreign-trained doctors in Kiribati originate in Fiji