International Dialogue on Migration

International Human Resources for Health Mobility & Selected findings MoHProf project

Geneva, September, 2011
Migration Health

... Promote migrant’s health and public health of communities

Lead on migration health research, policies, and management

Migration of health care workers is one focal area
Why... migration?

1960 - 1975

Source: Population Action International

IOM, RO Brussels
A few decades later: 214 M international migrants (IOM, 2010 WMR)  
740 M Internal migrants (UNDP 2009)
Realms of mobility?

- Highly-Skilled Migration
- Low- and Middle-Skilled Migration
- Irregular Migration (10-15% of total flows*)
- Refugees, Asylum Seekers
- Internal Migration
- Family Migration
- Study Abroad
- Tourism

* ILO Estimates
Reasons behind migration trends and migration of health care workers.

- Globalization: States have freed the movement of capital, goods and services people will follow

- Ageing population: By 2050, the EU will have:
  - 48 million fewer 15-64 year olds
  - 58 million more above age 65

- Skill shortage

- Admission policies that attract the skilled – both students and workers

- Emergencies

- Inequalities
Our world according to...

Distribution of wealth

www.worldmapper.org

Migration Health Division
Our World according to…

Human Poverty Index

www.worldmapper.org
A worldwide shortage of 4.25 M of health workers is estimated by WHO.

2.5 health workers per 1000 is considered minimum standard to achieve basic health goals.

*75 countries have < 0.25 HW/1000; 45 of them have high under 5 age mortality.*

Over the last 30 years, the number of foreign trained doctors in OECD countries have increased by 240%.
Healthcare is fundamentally a labour-intensive, client-oriented, service sector based on skilled human resources: emigration of health staff can **weaken** HS, and jeopardize **health care delivery and health outcomes**.

Ex: even if migration of physicians is not larger scale loss of specialists such as anesthesiologist will already have consequences.

Furthermore High rate of emigration of doctors is associated with high rates of migration of other high skilled workers.

- More research is overall needed on qualifying and quantifying work force gap, task shifting, impact on families left behind, and so on...
Impact of health workers migration? (ii)

Impact on migrant health workers

Data is also scarce however, despite assumption that HW migrate to improve quality of life, factors are at play such as:

- lack of recognition for their skills and previous work experience;
- discrimination and undermining of capabilities due to their foreign training;
- separation from familial networks and coping in an alien environment
Impact of health workers migration? (iii)

Impact on health workers in sending countries due to shortages:

- additional burden of treatment and care;
- Less time to engage in professional advancement activities (attending conferences and professional meetings in order to exchange information and skills)

Regular exodus of trained doctors and nurses also create a **void in terms of experience** within the health care and undermine the health system’s **ability to plan and deliver education and training for its health workforce**
Brain Drain?

- Permanent migration associated with a loss of human capital
- Loss of original investment in education and training
- Loss of future development by the loss of the best and brightest
- Skills shortages in critical sectors as health care and education
- Loss of tax contributions/revenue
- "Remittance" economy

Brain Gain?

- Personal & professional opportunities
- Remittances: $414 billion in 2009
- Increase trade flows
- A skilled population abroad is a potential asset if:
  - Migrants are well integrated
  - Skills of migrants are well utilized and further developed
  - There is a network or mechanisms transferring skills and knowledge
  - Home country is able to make good use of contributions

Policy Issues
Factors influencing health care worker migration?

**Pre departure Push factors**
- Remuneration/wage differentials
- Working conditions & safety, lack of opportunities for training & advancement
- Political and social unrest
- Downsizing of the public sector
- Living conditions

**Destination Pull factors**
- Active recruitment
- Recognition of qualifications
- Professional development
- Improved quality of life
- Family reunification

**Country of origin stick/return**
- Political stability/Good Governance
- Commitment
- HR Policies: recognition of experience/training acquired
- Shared linguistic, cultural and historical ties
- Work permit for spouses; education for children

**Destination Stay factors**
- Lack of incentives and information as to opportunities at home
- Non portability of pensions
- Persistence of push factors

Diaspora
EC/DG Research co-funded, Consortium, managed by WIAD, with several research institutes worldwide, IOM and professional organizations

- Macro and Micro research in:
  - Africa (Angola, Morocco, Egypt, Ghana and Kenya, South Africa)
  - Asia (India, the Philippines) and Australia
  - North America (US and Canada) and
  - Europe (destination: Austria, Germany, France, Ireland, NL, Port, Sweden, UK; sources: Bulgaria, Lithuania, Poland, Romania, Russian Federation, Ukraine)

International Conference, Dec 7-9, 2011, in Brussels, under the auspices of the Polish Presidency of the EU
Selected findings in the African Context

- Substantial shortages and inequities in health worker density between rural and urban areas and between private and public
- Migration of HW from rural to urban, from public to private and abroad
- Critical early years period of migration
- Lack of reliable data on migration, of attention to the outflow of HP
- Shift of migration strategies and patterns due to political transformations in the EU
- Development of training programs involving receiving countries and diaspora organizations are on the rise. Time limited placements and temporary return programs are piloted
Selected findings from Asia
India and the Philippines

**Philippines**
Major source country of HP in Asia in the number of migrant professionals worldwide with close to 130,000 HPs abroad (85% nurses and 12.1% physicians)
Physicians mostly migrating for training and nurses for economic reasons

Source countries may have some information on temporary and permanent HP migrants, but data on the same migrants when they arrive in destination countries or data on circular migration especially on re-entry are not available.

**India**
Ranks second with an estimated 100,000 HP worldwide.
Unlike the Philippines, India mostly sends out physicians, which make up about 65% of their HP and nurses comprising 26% of their HP working aboard

Domestic shortages of HP is of the biggest problem in health care, though lack of data to estimate migration’s role
Selected findings on U.S. Health care workforce

- Approximately 14M jobs
- International Medical Graduates = 26%
- Foreign Nurses = 17%
- US holds 20% of world wide stock of nurses
- Average age of RNs in 2004 = 46.8 yrs

**Projected Shortage of 200,000 family practice physicians, 1 million registered nurses by 2020**

Implications of Patient Protection and Affordability Care Act 2010 (U.S. Health Reform) for Health Care Workforce

- Increased demand for primary care providers as newly insured have options
- Uncertain how technology and new scope of practice may factor into demand
- Increases the need for health workforce planning: ~1/5 jobs will be in health sector
Selected findings on Canada

- Physician density below OECD averages
- I.Med.Grads remain steady for 30 years at 25% of physician workforce
- British and Irish-trained MDs tend to remain, Many other IMGs very mobile and relocate to U.S. and UK
- Internationally trained nurses = 7% overall but 43% of home care nurses
- 1/3 of graduate nurses migrate out of country or leave the profession in 5 years – concern for upcoming shortages

Nov 2010 Quebec-France bilateral agreement on mobility of HP and integration of migrants

Toronto airport, 2010  photo - RPB
Selected findings from Europe (France, Germany, Sweden, United Kingdom)

- Sufficient data on immigration in all countries available, but often scattered in different organisations.
- Data on emigration of health professionals is weak, anecdotal or missing and workforce planning is inadequate.
- Shortages are in remote areas and within some specialties (geriatrics, anesthesiology, home care), but on the rise with ageing population’s needs and ageing Health workforce.
- The most significant group of migrants in the health/social sector work in the informal sector in care of the elderly, home care etc. some 100 000 according to estimates in Germany (3months sets), in Austria recent regularization/legalisation showed within a few months numbers in the 20 000, mostly from Eastern Europe.
Recommendations for further research

Monitor recruitment systems/actors, the working conditions and continuing education possibilities: need to look at retaining strategies and flexibility in (and harmonization of) options to improve health professionals’ qualifications.

Role of training programmes and qualification possibilities (volume, student mobility, etc).

- **Validity of qualifications across the border** and how this can be translated into the quality of care.

- **Utilization/optimization of the health work force, impact of pension reforms, Integration of health professionals after migration** how to avoid **brain waste**; loss to other sectors.

- **Regional disparities between rural and urban areas:** need to further explore the relation between regional disparities and migration; the role of retention programmes and other good practices.
Recommendations for further research

- **Lack of data on emigration from the EU and Better data**: What is importation of human resources - foreign born or foreign trained?

- **Mechanisms of temporary migration**: investigation of existing, mechanisms, motivation, conditions and outcomes

- **Irregular employment and consequences for the sector**: how this irregular employment (often under-skilled, other times over-skilled) is filling specific gaps and how this affects the quality of services and work opportunities in this sector

- **The gender and diversity issues**: need of more knowledge on the issue of diversity and equal opportunities regardless of gender and ethnic origin for career development

**Inconsistencies within the various national policies**: need of analysis whether national labour and migration policies are consistent with the HR shortages, how healthcare systems are affected and what are the challenges faced on a country level
Thank you for your attention

« The best thing to do is to have planted a tree 20 years ago....

The next best thing is to plant a tree today “
African proverb

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For Sending countries

Core issues for policy responses

- Protection of migrant workers and support services
- Opening more legal avenue for their citizens to gain access to labour markets in destination countries;
- Optimizing the benefits of organized labour migration with a focus on enhancing development;
- Institutional capacity building, inter-ministerial coordination, multi-stakeholder and inter-state cooperation
Sending countries: Strategies of governments

- Identify and address push and pull factors from a multidisciplinary perspective (Ministry of Health, Labour, Finance, Foreign Affairs, Immigration etc)

- Data collection and evidence is needed to inform human resource development frameworks at the national, regional and international level

- HRH strategies for retaining health care workers by a mix of incentives (including non-financial compensation), by increasing private sector responsibility as well as review of retirement policies

- National human resource for health policies/strategies should encourage the return of skilled health workers from the Diaspora

- National policies to allow dual citizenship and flexible residential rights

- Common regional strategies and sharing of successful initiatives

IOM, MRF Brussels
For Destination countries

Core issues for policy responses:

- Detecting, assessing and predicting shortages of labour
- Demographic factors
- Ensuring the rights of migrant workers: (incl. placement and post placement assistance)
- Managing irregular migration
- Attitude of the host population

“The ultimate goal of any health human resources strategy is self-sufficiency, including the education and retention of domestic graduates and the proper utilization of internationally educated health care professionals”

Ethical Principles for Health Force, Ontario Govt Recruitment Centre
Destination countries

Strategies of governments

- Identify long term solutions to address their shortage of human resources for health
- Implementation of ethical codes of practice for international recruitment of health workers
- Assist sending countries with capacity building and development programmes that will strengthen health systems
- Assist Diaspora organizations with capacity building programmes and strengthening of the health systems in source countries
- National policies to allow dual citizenship and flexible residential rights
- Common regional strategies and sharing of successful initiatives

IOM, MRF Brussels