

DISCUSSION PAPER

For online discussion on Circular Migration of Health Workers 1-10 September 2012

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Background Facts and Figures

- According to the WHO World Health Report, the world has some 8.6 million physicians to attend to a population of 6.7 billion, or about 780 people per doctor. There are also 1.3 million dentists, 17 million nurses and midwives, and 1.2 million pharmaceutical workers, but health workers are not evenly distributed. In 2006, the WHO reported that there was a global shortage of 2.4 million doctors, nurses and midwives and the shortage was critical in 57 countries, 36 of them in sub-Saharan Africa (WHO, 2006). Contributing to the shortage is the emigration of health workers from poor countries. Loss of health workers through migration has caused global concerns prompting debate on policies that would allow for a more equitable sharing of these scarce human resources. Among these are policies to encourage periodic return or circular migration among the highly skilled including limiting stay through temporary employment visas, grant of multi-year visas, guarantees of readmission, making return a condition for visa extension or conversion to permanent residence, recognition of dual citizenship, and partnership agreements which provide for financial incentives.
- The Americas region (North and South combined) has only 10 per cent of the global burden of disease, according to WHO, yet accounts for more than 50 per cent of the world's financial expenditures on health and employs 37 per cent of the global health workforce (WHO, 2006). Differences between developed and developing countries are immense. In the region, Japan's per capita expenditure on health care (in current exchange rate for US dollars) are 85 times more than of India, 19 times that of China, and 57 times that of the Philippines.
- India with a population of 1.2 billion has 757,000 physicians (or a physician to population ratio of 6.5 per 10,000), while the UK has only a fifth of that number of physicians but there are 27.4 physicians per 10,000 people. The WHO estimated that per capita expenditure on health in the UK in 2009 was 78 times more than in India. The Planning Commission of India estimated that the country is short of 600,000 doctors but only about 30,000 new doctors graduate each year (and 45,000 new nurses).
- The Philippines with a population of over 90 million has about 105,000 physicians (or a physician to population ratio of 11.6 per 10,000). Many Filipino nurses and doctors have emigrated to work in foreign countries. High salaries abroad have motivated many to pursue careers in nursing with some 28,000 to 30,000 new nurses passing the licensure exams each year. However, in the case of doctors only 1,500 graduates of medicine pass the physician board exams each year representing a mere 1.5 per cent increase in the country's supply of licensed physicians.
- Vietnam has a population of about 90 million and has 107,000 physicians (or a physician to population ratio of 12.2 per 10,000). The country lost through emigration many highly-trained professionals during the war but this appears to be no longer a problem. Lack of proficiency in the English language has also limited possibilities for Vietnamese nurses to get jobs abroad.

- About half of foreign-born doctors or nurses working in OECD countries are located in the United States, almost 40% in Europe and the remainder in Australia and Canada. Many have migrated with their families and those in the US, Canada, and Australia are likely to have acquired permanent residency status. Statistics on the return of these professionals are not systematically collected (or at least are not reported) but the continued growth of various migrant populations in OECD countries suggests that return flows have not been significant.
- Foreign-born nurses represent a sizeable proportion of all nurses employed in several OECD countries as shown below:

Table 1 Percentage of foreign nurses employed per country of residence, selected OECD countries, 2008.

Country of residence	Foreign nurses as a % of total nurses employed
Australia	24.8
New Zealand	23.3
Canada	17.2
UK	15.2
Austria	14.5
Ireland	14.2
USA	11.9
Germany	10.4

Source: OECD 2008

- Some Asian countries provide many of the health professionals employed in the OECD countries. In the United States more than half of the foreign-born doctors and 40% of the nurses originated from Asia. In Australia, Asian doctors represented 43% of all doctors, in Ireland 48% and in the United Kingdom as much as 55% (OECD).
- The Philippines and India are the biggest sources of foreign health workers for the OECD countries. According to an OECD report in 2010, Filipino-born nurses and Indian-born doctors each represent about 15% of all immigrant nurses and doctors in the OECD. About 56,000 (8%) of doctors trained in India have migrated to OECD countries. There are no statistics on how many return but there are anecdotal evidence of overseas Indian doctors returning for short periods of stay to share their skills and know-how with their counterparts in India. Some overseas Indian doctors have established modern hospitals in India and return annually to practice. OECD statistics indicate that about 16,000 physicians and 110,000 nurses born in the Philippines are working in Europe and North America. There are no statistics on how many return, but in recent years about 75 per cent of nurses leaving the country each year go to the Gulf States for short-term contractual employment, and return home or move to another country after the end of their contracts.
- In recent years other countries have also emerged as important destinations, but mainly for temporary contractual employment. According to Philippine authorities some 12,000 nurses leave the country annually to work abroad, some 74 per cent of them bound for destinations other than the OECD such as the Gulf States. Most of these health workers do return to the Philippines after completion of their contracts but a significant number also find their way to an OECD destination after.

Demand for Health Professionals

Highly educated professional workers are generally welcome everywhere and physicians and related medical professionals are among those given high priority for admission especially in the OECD countries. The US alone has 337,000 foreign-born nurses, the UK 82,000, Canada 49,000 and Australia 47,000 (OECD, 2007). The demand for foreign medical workers is driven by an aging population, an aging health workforce and the introduction of new technologies needing health professionals in developed countries. It may also be driven by spending for health care in the developed countries which rose rapidly over the past decade until the financial crisis led to a virtual freeze by 2010. The Association of American Medical Colleges estimates that in 2015 the US will have 62,900 fewer doctors than needed. And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care. Even without the health care law, the shortfall of doctors in 2025 is expected to still exceed 100,000 (Lowery and Pear, 2012).

Cost of Out-Migration of Health Professionals

Training of physicians who end up working abroad is an enormous burden on origin states. In India medical education is highly subsidised by the state and the cost is very high. The Grant Medical College in Mumbai estimated that it costs the Government up to \$ 62,000 to train one physician over 5 1/2 years. About 60 per cent of graduates are trained in state universities. In the Philippines subsidy for medical education is only in a few state universities which produce only a few hundred new physicians each year. The bulk of the 1,500 new physicians each year are trained in private medical schools. In Vietnam a rather dated study estimated that in 1997 it cost \$ 9,527 to produce one physician or medical doctor in local currency or about 14 times the cost of training one nurse (Bicknell et al, 2001).

To origin countries the emigration of health professionals represent lost investments and a subsidy to the rich countries which benefit from their services. A study estimated the loss suffered by nine sub-Saharan countries (Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe) that invested through subsidies in physician's education. The estimated costs of a physician's education ranged from \$ 21,000 in Uganda to \$ 58,700 in South Africa. The overall estimated loss of returns from investment for all physicians currently working in the destination countries was \$ 2.17 billion, with costs for each country ranging from \$ 2.16 million for Malawi to \$ 1.41 billion for South Africa. Expressed as a percent of gross domestic product the losses were largest in Zimbabwe and South Africa. The benefit to destination countries of recruiting trained physicians was largest for the United Kingdom (\$ 2.7bn) and United States (\$ 846m) (Mills et al 2011). In the US, in the late 1990's it was estimated that medical education cost \$72,000 to \$83,000 per student/year, or about \$ 288,000 to \$ 332,000 for a 4 year course needed to produce one physician (Bicknell et al).

Consequences related to achieving Better Health Outcomes due to the Migration of Health Professionals

In India and the Philippines only 58 percent and 62 percent, respectively, of childbirths have been attended by skilled health personnel, while almost all births are so attended in the developed world (WHO 2010). Fewer individuals and families have access to a health worker, more so, to quality health care in these developing countries. The emigration of health

professionals is not helping narrow the health equity deficit between countries. Infant mortality rate (IMR) and maternal mortality rate (MMR) are still very high in both India and the Philippines which supply the OECD with many health professionals. In 2008, the IMR and MMR in India were 52 and 254, respectively, and in the Philippines, 26 and 162, respectively. By comparison in the United Kingdom, the IMR was 5 and the MMR was 7; in the United States, the figures were 7 and 13, respectively (WHO 2010).

Finding a satisfactory solution to this global problem has proven very illusive. In the U.S. reported median annual earnings for registered nurses in 2002 was \$ 48,090; in hospitals and nursing homes where foreign nurses worked, earnings averaged \$ 49,190 and \$ 43,850, respectively. By comparison in the Philippines, registered nurses were paid annual salaries of between \$ 2,000 and \$ 2,400 in 2002. Economic gains through better salaries and potential amount of remittances are often seen as pull factors for migration. Closing the gap between salaries for health workers in the OECD and in the source countries is not a real option given the wide difference in levels of development. In fact the income gap between these countries has been widening instead of narrowing over the past decades. Migration management was perceived as a way to ensure the right to health in source countries and the right of health professionals to move and seek employment overseas. Codes of practice and government to government agreements were designed to balance these interests.

Suggested issues for discussion

1. Have there been government to government agreements which sufficiently satisfy the right to health of families in source countries, the right of health professionals to move and seek employment overseas and their right to decent work? If not, how can agreements be designed to achieve more acceptable compromises?
2. The European Commission has promoted “partnership policies” to address problems of illegal migration as well as the adverse consequences of health worker migration. One important form of partnership is the promotion of “circular migration”, an approach involving some kind of “rotation” through periodic return of health workers to their home countries. Policies to promote it include guarantees re-admission, recognition of dual citizenship, multiple-entry and multi-year visas, etc. Because trained health workers can also render services in their countries when they return this can be a “win-win” approach to mitigate shortages of health workers. However, the approach has been criticized as unrealistic: employers want to keep their experienced foreign workers, while the workers want greater job security, family reunification and maintenance of their families’ standards of living in the destination countries. Workers seeking to maintain their incomes also tend not to return to their own countries, but seek employment in another.
 - For the health worker who returns to his or her country of origin, how can disadvantages from disrupted service and loss of seniority be mitigated through employment guarantees? What are the options for returning health professionals?
 - Is there a way to ensure that employers benefit from such policies? How can resistance of employers to rotation be reduced by subsidizing or minimizing the cost of recruitment? For example, at present hospitals in the US are reported to incur costs of between US\$ 5000 to \$ 10,000 to recruit one nurse from the Philippines.

- There is a “trade off” between income security for the health workers and better access to health services for communities left behind? What information is necessary to make these alternative benefits comparable?
3. The Commonwealth countries have adopted the so-called “ethical recruitment policies” and the WHO Global Code of Practice on Ethical Recruitment of Healthcare workers was recommended to member states in order to protect countries “at risk” of losing more of their much needed health workers. There is however little evidence on how such policies work.
- Have these policies actually been implemented?
 - Have they managed the “drain” in health professionals in source countries?
 - If not, how can they be made more effective?
4. It has been suggested that the better option is to increase the supply of skilled workers (especially health workers), in source and in destination countries. In the case of health workers the cost of training is much higher than for most other fields of study. Training a medical doctor involves a huge investment requiring at least 5 years. There is also the need to motivate graduates of medical training, such as nurses who leave the health workforce because of poor employment conditions in health services, to return. Destination countries may contribute technical and financial resources for training more health workers in source countries.
- How can the responsibility (and thus the burden) for training highly-skilled migrant workers be shared between origin and destination states? What principles should be considered for such sharing?
 - Are there public as well as private sector arrangements outside the health sector that can serve as models for organizing mutually-beneficial migration of health workers?
 - Should licensing overseas-educated medical workers be an integral part of such schemes?

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