International Labour Organization

Compendium on recognizing the skills of migrant workers in the health sector

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Preface

Effective governance of labour migration for health workers is essential for addressing global healthcare needs and ensuring sustainable health systems. While access to quality healthcare is a fundamental human right, achieving Sustainable Development Goal (SDG) 3 – ensuring healthy lives and well-being for all, at all ages – requires policies that carefully balance public health priorities, economic sustainability and labour migration, especially as the demand for healthcare workers continues to grow.

This collection of studies, developed in collaboration with the ILO Sectoral Policies Department (SECTOR) and the ILO Labour Migration Branch (MIGRANT), examines key aspects of labour migration in the health sector. It looks at policies and systems related to the recognition of skills and qualifications, concerns about brain drain, labour market (re-)integration, and working conditions. Drawing on case studies from Egypt, the Philippines, Germany and Italy, it offers practical insights into how different countries align labour migration policies with public health needs. While limited to four case studies, this compendium—a concise but focused set of knowledge—highlights concrete examples that inform a more coordinated and strategic approach to health worker mobility.

Many low- and middle-income countries face concerns over brain drain, as the migration of skilled healthcare workers leads to workforce shortages and weakens national health systems. While efforts to achieve universal health coverage (UHC) remain a priority, the loss of trained professionals can hinder progress. The strengthening of skills recognition systems can enhance workforce planning, improve migration governance and help mitigate the negative impacts of brain drain. Equally important is the reintegration of returning migrant health workers, ensuring their skills are effectively recognized and utilized.

Collaboration between governments, social partners and key stakeholders is essential to protecting migrant health workers' rights while maximizing benefits for both origin and destination countries. Strengthening cooperation in this area is crucial to fostering a more resilient and sustainable global healthcare workforce.

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anabin	Recognition and Assessment of Foreign Educational Qualifications Database (Anerkennung und Bewertung ausländischer Bildungsnachweise) (Germany)
AZAV	Accreditation and Admission Ordinance (Akkreditierungs- und Zulassungsverordnung Arbeitsförderung) (Germany)
EFTA	European Free Trade Association
GCC	Cooperation Council for the Arab States of the Gulf (Gulf Cooperation Council)
GDP	Gross Domestic Product
GMC	General Medical Council (United Kingdom of Great Britain and Northern Ireland)
MoHP	Ministry of Health and Population (Egypt)
MRA	Mutual Recognition Arrangement
MUR	Ministry of University and Research (Italy)
OECD	Organisation for Economic Co-operation and Development
POEA	Philippine Overseas Employment Administration
PRC	Professional Regulation Commission (Philippines)
SSN	National Health Service (Italy)

▶ Introduction

In Article 25 of the Universal Declaration of Human Rights (UDHR), 1948, it is stated that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services". Access to healthcare is not only a fundamental human right but also relies on a workforce capable of delivering these essential services. The healthcare sector, in fulfilling this role, has also become an important source of employment, especially for women. According to the World Health Organization (WHO) in 2020, 67.2 per cent of workers in the healthcare sector worldwide were women (WHO, n.d.). The latest ILO estimates show that migrants in the global labour force account for 167.7 million of the 284.5 million migrants who exist globally, confirming that employment is one of the primary drivers for most migration. Women constituted 38.7 per cent of international migrants in the labour force, while 61.3 per cent were men (ILO 2024). In many destination countries, aging populations are driving an increasing demand for healthcare and domestic services. According to the ILO, the share of men and women migrants employed in the care economy in 2022 was estimated at 12.4 per cent and 28.8 per cent respectively, compared to 6.2 per cent of non-migrant men and 19.2 per cent of non-migrant women (ILO 2024). Healthcare worker migration has always been an integral part of the global health labour market. However, while migration offers opportunities for better living and working conditions for many healthcare workers, as well as the possibility of sending money home to their families, it can also present significant risks. In order to promote the effective labour market integration of migrant health workers, both in their countries of destination and in the event of their return home, policies should promote fair recruitment and the development, matching and recognition of skills and qualifications.

The governance of labour migration for health workers is directly linked to the achievement of the Sustainable Development Goals (SDGs).[1] The effective management and ethical deployment of health professionals are integral to addressing global health challenges and fostering sustainable development. The governance of international labour migration for health workers is therefore directly linked to the achievement of the goals, in particular SDG 3 (to ensure healthy lives and promote well-being for all, at all ages). The migration of health workers is also closely linked to promoting decent work and economic growth (SDG 8) towards reduced inequalities (SDG 10) and gender equality (SDG 5). As many agencies and stakeholders, across borders, are involved in the labour migration process, partnerships are also strengthened (SDG 17).

In addition, Objective 2 of the Global Compact for Safe, Orderly and Regular Migration (GCM) (namely, to minimize the adverse drivers and structural factors that compel people to leave their country of origin) commits to actions that include the following:

- *"Invest in programmes that accelerate States' fulfilment of the Sustainable Development Goals with the aim of eliminating the adverse drivers and structural factors that compel people to leave their country of origin, including through … health and sanitation …"* [action b]
- *"Invest in human capital development by promoting … education, vocational training and skills development programmes … in line with labour market needs …"* [action e]

[1] The Sustainable Development Goals (SDGs) were adopted in 2015 by the United Nations General Assembly. The 17 SDGs are a universal call to action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity. They cover a broad range of social and economic development issues, including poverty, hunger, health, education, climate change, gender equality, water, sanitation, energy, the environment and social justice, with a focus on the most vulnerable and a commitment that "no one will be left behind." (UN, n.d.)

Health professions are often regulated: the standards and requirements in terms of education and the licence to practise are established at the national level and vary across countries and regions. Efficient labour migration governance therefore has a key role to play in ensuring adequate and timely recognition of qualifications and skills, as well as the licensing of health sector migrant workers and the effective protection of their rights.

Each country adopts specific regulatory mechanisms based on the risk profile of healthcare professions. These mechanisms can range from minimal or no licensing requirements for professions considered to pose a lower risk of patient harm, to a combination of regulatory measures, as illustrated in box 1.

▶ Box 1: Regulatory mechanisms for healthcare professions

Regulatory measures in healthcare often relate to education and training, including **certification** and **qualification recognition**. **Certification** verifies that practitioners meet specific competency standards, while **qualification recognition** compares education and competency requirements between a practitioner's origin and destination countries. Gaps may require compensatory measures, such as additional training.

In some cases, an accredited diploma or recognized qualifications alone are not sufficient. Depending on the profession's risk level, **registration** and **licensure** may also be required. **Registration** is typically an administrative process, listing practitioners in a regulatory database. **Licensure**, however, is the most restrictive form of regulation, granting legal authority to practise only to those who meet specific qualifications and character requirements – such as a clean criminal record, adherence to professional ethics and fitness to practise.

Source: WHO (2024).

Gender concerns remain highly relevant in the health sector as women represent 70 per cent of the global health workforce (ILO 2020a). Women in the health and social work sectors tend towards lower-skilled jobs, with less pay and at the bottom end of the professional hierarchies. Evidence shows that women in the healthcare sector face both lower average earnings and a higher gender pay gap compared to other sectors (WHO and ILO 2022). Indeed, the gender of any individual may influence their access to processes such as the recognition of their qualifications and skills; there are certainly repercussions on the situation of women migrant health workers, notably in terms of equality of opportunities in employment abroad.

Labour migration policy has become all the more critical in the context of the COVID-19 crisis, during which many migrant workers served on the frontlines to help societies in essential services such as healthcare (ILO 2020b). The fair recruitment of migrant health workers, as well as their skills development, matching and recognition, form an integral part of the ILO's effort to contribute to enhancing the governance of labour migration. Concerns related to working conditions in nursing – inadequate wages, for example – can often lead individuals to take on multiple jobs and work long hours as a result, which can in turn negatively affect the quality of healthcare services, work–life balance and retention rates (Addati et al. 2018). Skills trends indicate that while up to date training and upskilling have been taking place, so too has a process of deskilling that is due to cost savings and the transfer of certain tasks to lower-paid aides – namely to less-highly trained nurses or other categories of care workers (Duffy 2011; Addati et al. 2018, 179).

Women generally have fewer opportunities than men for regular labour migration and are often employed in lower-paid, informal jobs with minimal labour protections. This vulnerability increases their risk of violence, abuse and exploitation, including trafficking, at various stages of the migration cycle. Women migrant workers also face multiple intersecting forms of discrimination that hinder their access

to safe migration pathways, fair recruitment and decent work throughout the entire process – namely, pre-departure, transit, destination, return and reintegration (UN Women 2021).

In this context, it should be noted that the ILO's International Labour Standards and Recommendations provide a robust framework for ensuring equal treatment of migrant workers – including those in the health sector – in relation to nationals. They also provide important guidance on recognition of the skills and qualifications of migrant workers.

The ILO Constitution promotes principles of social justice and the protection of persons in their working environment, including those "employed in countries other than their own". In formulating national laws and policies that concern the protection of migrant workers, governments should be guided by the underlying principles of the Migration for Employment Convention (Revised), 1949 (No. 97), the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and their accompanying Recommendations (Nos 86 and 151 respectively).

All international labour standards, unless otherwise stated, are applicable to migrant workers. These standards include the ten fundamental rights Conventions of ILO, which give effect to the 1998 ILO Declaration on Fundamental Principles and Rights at Work; standards of general application, such as those covering the protection of wages and occupational safety and health, as well as the governance Conventions concerning labour inspection, employment policy and tripartite consultation; and instruments containing specific provisions on migrant workers, such as the Private Employment Agencies Convention, 1997 (No. 181), the Domestic Workers Convention, 2011 (No. 189), and social security instruments.

More specifically in the health sector, the Nursing Personnel Convention (No. 149) and Recommendation (No. 157), 1977, indicate key labour standards in view of the special nature of nursing work; in particular, the latter refers to bilateral or multilateral agreements that endeavour to:

> *"(a) harmonise education and training for the nursing profession without lowering standards;*
>
> *(b) lay down the conditions of mutual recognition of qualifications acquired abroad;*
>
> *(c) harmonise the requirements for authorisation to practice." (ILO 1977, para. 62)*

The same Recommendation later states the following:

> *"(1) Foreign nursing personnel should have qualifications recognised by the competent authority as appropriate for the posts to be filled and satisfy all other conditions for the practice of the profession in the country of employment; foreign personnel participating in organised exchange programmes may be exempted from the latter requirement.*
>
> *(2) The employer should satisfy himself that foreign nursing personnel have adequate language ability for the posts to be filled.*
>
> *(3) Foreign nursing personnel with equivalent qualifications should have conditions of employment which are as favourable as those of national personnel in posts involving the same duties and responsibilities." (ILO 1977, para. 66)*

To support the reconciliation of work and family responsibilities, workers with family obligations – particularly women – benefit from the provisions of Convention No. 156 and Recommendation No. 165 (1981). This Convention is closely linked to the fundamental principles of non-discrimination and equality of opportunity and treatment in employment, as outlined in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111) and the Equal Remuneration Convention, 1951 (No. 100). These principles are further reinforced by broader international human rights instruments, such as the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

Among the international instruments aimed at protecting workers, including migrants, the following ILO conventions are noteworthy: Maternity Protection Convention, 2000 (No. 183) and Violence and Harassment Convention, 2019 (No. 190).

In the Human Resources Development Recommendation, 2004 (No. 195), the sixth Part (titled "Framework for recognition and certification of skills") points out the following:

> *"11.*
>
> *(1) Measures should be adopted, in consultation with the social partners and using a national qualifications framework, to promote the development, implementation and financing of a transparent mechanism for the assessment, certification and recognition of skills, including prior learning and previous experience, irrespective of the countries where they were acquired and whether acquired formally or informally.*
>
> *(2) Such an assessment methodology should be objective, non-discriminatory and linked to standards.*
>
> *(3) The national framework should include a credible system of certification which will ensure that skills are portable and recognized across sectors, industries, enterprises and educational institutions.*
>
> *12.*
>
> *Special provisions should be designed to ensure recognition and certification of skills and qualifications for migrant workers." (ILO 2004, paras 11–12)*

The ILO Multilateral Framework on Labour Migration (2006) provides guidelines for the migration process (Principle VII), which include "promoting the recognition and accreditation of migrant workers' skills and qualifications and, where that is not possible, providing a means to have their skills and qualifications recognized" (ILO 2006, para. 12.6).

The World Health Organization (WHO)'s guidance on qualification recognition includes the following statement:

> *"Recognition of qualifications across jurisdictions should be based on assessing similarities and differences in education and whether they provide the necessary competence for entry to practice. … The standards and processes for evaluating qualification should be transparent, fair, objective and nondiscriminatory." (WHO 2024)*

In 2016, the ILO developed General Principles and Operational Guidelines for Fair Recruitment. The objective of these principles and guidelines is to inform the work of international organizations, governments and social partners on promoting and ensuring fair recruitment in all branches of economic activities, including the health sector. They could be of particular interest when developing bilateral, regional and multilateral labour migration agreements for health personnel to ensure mutually beneficial arrangements and to avoid potential negative outcomes for all parties involved. These agreements should be comprehensive in nature, covering not only skills recognition and training, along with migrant rights' protection issues, but also addressing migration and development concerns such as "brain drain".

In this context, it is also important to mention the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010), which indicates voluntary principles and practices for the ethical international recruitment of health personnel, including the following:

> *"… Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional*

> *responsibility on the basis of equality of treatment with the domestically trained health workforce …" (WHO 2010, para 4.4)*
>
> *"Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws …" (WHO 2010, para. 4.6)*
>
> *"Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries." (WHO 2010, para. 3.8)*

Further to this, in its article on health workforce development and health systems' sustainability, the Global Code also points to the need for measures for *"… skills transfers, and the support of return migration, whether temporary or permanent"* (WHO 2010, para. 5.2).

A key aspect of this study is the impact of healthcare staff mobility on the country of origin, the destination country and migrant workers themselves. The analysis will therefore focus on brain drain and brain gain, as well as the risks associated with brain waste (see box 2).

▶ Box 2: Potential impacts of healthcare personnel migration

Brain drain refers to the permanent or long-term international migration of skilled individuals who have received significant educational investment from their home countries. This movement leads to a transfer of skills and knowledge from the country of origin to the host country, often resulting in a substantial loss for the source nation, given the critical role that human resources play in its development. In particular, the emigration of skilled professionals from developing countries – especially the least developed ones – can have severe consequences for sustainable development. For the countries that benefit from the skills and experience of immigrating skilled workers, this movement represents **brain gain**.

Source: ILO 2007; ILO 2013; MPI, n.d.

Brain waste refers to the underutilization of a worker's educational qualifications in the labour market, occurring when their attained level of education exceeds the requirements of their job. Among immigrants, this phenomenon often arises when their skills and credentials are not fully recognized or utilized in the host country's labour market.

Source: ILO 2011.

The present compendium analyses the existing modalities of qualification and skill requirements for migrant health workers as well as any obstacles and challenges faced by them, with a particular reference to women migrant workers. The analysis also focuses on the situation of medium- and highly skilled migrant health workers. It covers two countries of origin for migrant health workers (Egypt and the Philippines) and two countries of destination (Italy and Germany). The selected countries represent different national and regional contexts and have been engaged with the migration issues of health workers for a long period of time. The work involved desk research and in-depth interviews with key informants – including policymakers, employers' and workers' organizations, civil society organizations such as professional associations, as well as migrant health workers. The objective has been to assess experiences and determine lessons learnt, and by drawing on these, to provide general indications of

how to facilitate and enhance a gender-responsive[2] access to recognition processes, as well as to address any specific challenges that women migrant health workers may encounter – thereby linking it to the protection of their rights.

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[2] This refers to a policy or programme in which gender norms, roles and relations are considered and where measures are adopted to reduce their negative effects, including gender inequality (UNESCO-IIEP, n.d.).

Methodology

The methodology of this research was designed to comprehensively examine the processes for the recognition of migrant health workers' skills and qualifications in both destination countries and countries of origin. For destination countries, the research analysed the existing modalities of qualification and skill requirements for migrant health workers, as well as any obstacles and challenges faced by them, with a particular reference to women migrant workers. For origin countries, the research focused on skill and qualification recognition in the context of the labour market reintegration of returning migrant health workers, as well as any issues related to brain drain and brain gain. In all cases, the analysis focused on the situations of a range of medium- and highly skilled migrant health workers,[3] with an emphasis on medium-skilled professionals. Accordingly, the research will target mainly the following occupational profiles: physicians, nurses and midwives.

The research covered four countries, namely Egypt, Germany, Italy and the Philippines, which represent origin and destination countries, as well as different regional contexts. For each case study, a national consultant conducted the research and generated individual country reports.

These reports served as the basis for the ILO to develop a conclusive chapter, drawing insights from national policy lessons and experiences. This chapter offers overarching guidance on enhancing access to qualification and skills recognition for migrant health workers. Final considerations address gender equality aspects, incorporating the unique policy requirements of both origin and destination countries.

For the country case studies a mixed-method approach was applied. A desk review of relevant policies, strategies and programming documents was conducted and integrated with a review of relevant academic literature and publications produced by the ILO and the WHO. Qualitative research was undertaken through interviews with key informants (including but not limited to government officials, experts and representatives of medical associations). Originally, the research was also intended to cover the access of women migrant health workers to skill and qualification recognition processes; however, due to limited data availability, this was not entirely possible.

The study has limitations that originate from the potential biases of key informants or their non-response when invited to provide their opinion; in addition to this, the definition of sufficient representation posed a challenge during the study, given the broad spectrum of migrant health workers' experiences. Despite its limitations, the study marks a significant milestone in the effort to analyse both the complexities of skill and qualification recognition processes and the consequent choices made by migrant health workers in their migration trajectories.

[3] ILO Statistics classifies workers at a medium skill level (level 2) as "skilled manual workers" in accordance with International Standard Classification of Occupations (ISCO) Broad Occupations Groups. Skilled manual work is characterized by routine and repetitive tasks in service, cognitive and production activities. Medium-skilled workers include those in occupations such as skilled agriculture and fishery, clerical work, personal care work, craft and related trades and plant, machine operators and assemblers (ISCO-08). The education levels – as defined by the International Standard Classification of Education (ISCED) 2013 – that are attained by medium-skilled workers are typically post-secondary, non-tertiary education (Level 4) or upper-secondary education (Level 3).

By contrast, ILO Statistics classifies two levels of highly skilled workers (levels 3 and 4), in accordance with ISCO Broad Occupations Groups. These workers are broadly employed as legislators, senior officials, managers, professionals, technicians and associate professionals. The education levels – as defined by ISCED 2013 – that are attained by highly skilled workers are typically: Doctoral (Level 8); Master (Level 7); Bachelor (Level 6) and short cycle tertiary education (Level 5).

▶ Country case studies

Egypt

The Egyptian health system at a glance

Article 18 of the Egyptian Constitution stipulates the following:

> *"Every citizen has the right to health and to comprehensive healthcare which complies with quality standards. The State shall maintain and support public health facilities that provide health services to the people and shall enhance their efficiency and their equitable geographical distribution. The State shall allocate a percentage of government spending to health equivalent to at least 3 per cent of Gross National Product (GNP), which shall gradually increase to comply with international standards." (SSCHR, n.d.)*

The Egyptian Government has planned to create a health insurance system to cover all its citizens. Accordingly, the Universal Health Insurance Law No. 2 of 2018 foresees a mandatory health insurance for all citizens, which also covers work injuries. It is applicable to Egyptians working or living abroad, and can be also extended to foreigners who are earning their income or living in Egypt, subject to reciprocity (Article 59) (SIS, n.d.-a).

The Government will guarantee free healthcare services to people who are unable to pay the contribution fees. The Universal Health Insurance Law was originally foreseen to be fully implemented by 2032; but because of early successes, the government has accelerated the timeline to 2027. The universal health insurance system will cover a broad variety of services, including medical examinations, tests such as X-rays and scans, treatments and surgery.

Health services are provided by a mix of public and private health facilities, with the public sector being the largest provider of affordable care to the population (see table 1). Health facilities include general and specialized hospitals, primary healthcare centres and rural health units. The Ministry of Health and Population (MoHP) serves as the main public authority overseeing healthcare services, policy development and regulation. It directly manages 30 per cent of the health services through its own hospitals (COR, n.d.).

In addition, the public health sector also includes services provided by the Ministry of Higher Education and Scientific Research and various parastatal (quasi-governmental) organizations, such as the Health Insurance Organization (HIO) and the Curative Care Organization (CCO). Several ministries, such as the Ministry of Interior and the Ministry of Defense, operate their own health facilities. The private health sector comprises for-profit and non-profit entities, including traditional healers, pharmacies, private hospitals and NGOs – many of which are religiously affiliated and registered with the Ministry of Social Affairs.

Table 1: Distribution of health facilities between public and private sectors, Egypt, 2018

	Hospitals		Beds	
	Total number	**Share (%)**	**Total number**	**Share (%)**
Public	691	37	95 683	73
Private	1 157	63	35 320	27
Total	**1 848**	**100**	**131 003**	**100**

Source: UNDP and MPED 2021.

The data suggests that private hospitals, with an average of 30 beds, may be easier to manage compared to public hospitals, which average 138 beds. Additionally, it is worth noting the bed occupancy rates in MoHP hospitals, reported at 50 per cent. This situation may result in inefficiencies, potentially limiting the MoHP's capacity to allocate sufficient resources to primary and preventive care (Radwan and Adawy 2019).

In 2021, the total health expenditures amounted to 4.61 per cent of national GDP (World Bank n.d.-a). The primary healthcare financing source is out-of-pocket expenditure, representing more than 54 per cent of total health expenditure, followed by government spending through the Ministry of Finance, which is around 37 per cent. Pharmaceutical expenditure was between 26 and 37 per cent of total health expenditure (Fasseeh et al. 2022).

Data on the health workforce are scarce and lack precision. The Central Agency for Public Mobilization and Statistics (CAPMAS) in Egypt estimated that, in 2020, 120,622 doctors (including dentists) and 201,623 nurses worked in the public sector and 31,338 doctors (including dentists) and 24,142 nurses in the private sector (CAPMAS 2023). In Egypt, the density of physicians (including generalist and specialist medical practitioners) was at 6.83 per 10,000 people as of 2020 – approximately 0.62 less than 2014 – and globally, the World Health Organization (WHO) estimated the physician density to be 17.2 per 10,000 population in 2022 (WHO, n.d.).[4]

The total number of nurses is equivalent to 1,8 per 1,000 Egyptians (World Bank n.d.-b). This indicator underlines that Egypt is confronted with a noteworthy nursing shortage compared with the world average (3,8 in 2019) and with that of high-income countries such as the United States of America (12,5 in 2020), the United Kingdom (9,2 in 2021) and Italy (6,6 in 2021). These shortages can be attributed to many causes, including working conditions (Hashish and Ashour 2020). The WHO's Egypt Nursing Profile highlights several challenges faced by this profession, including concerns about public perception and issues with motivation, which may be influenced by the level of salaries and limited incentives (WHO 2012).

In Egypt, there is a significant disparity in the distribution of health workers between rural and urban areas. Urban areas tend to have a higher concentration of health workers compared to rural regions. Moreover, an analysis of Labour Force Surveys (LFS) data indicates that the majority of health and social care workers in Egypt reside in urban areas, while a smaller percentage live in rural areas (ILO 2023). The latest data available from 2015 show that the share of doctors per 10,000 population was at 15.6 in

[4] It should be noted that, in global terms, the WHO estimated in 2006 that at least 2.3 medical staff (physicians, nurses and midwives) per 1,000 people are needed to provide adequate coverage with primary care interventions (WHO 2016). The ILO has also developed a method to identify a minimum threshold of health worker availability, based upon an approach that identifies vulnerable countries in terms of their social protection systems and outcomes. According to this approach, the minimum workforce availability of skilled health workers is indicated to be 4.1 per 1000 population (ILO 2014).

Al Daqahliyya, 7.7 in Assiut, 6.1 in Al Minya, 7.9 in Suez, 5.7 in Al Beheira, 6.4 in Sohag, 4.4 in Qena, 4.7 in Fayoum, 4.1 in Beni Sueif and 3.7 in Al Qalyubiyah (UNFPA 2020). This rural–urban disparity represents a challenge in achieving equitable access to health workers across different regions in Egypt. To improve the working environment and performance of doctors, it is essential to ensure that hospitals in all areas are adequately equipped with necessary medical supplies.

This situation is further complicated by "dual practice", where medical staff work in both private and public sectors, each offering different wage levels – a practice that is very common in Egypt, with the majority of public sector physicians engaging in private activities. While dual practice can help retain health professionals in the public sector, especially in contexts with limited resources and regulatory capacity, there is widespread concern that – where health professionals work in both public and private sectors – accessibility and quality of public healthcare services may be reduced due to absenteeism and over-servicing (McPake et al. 2016).

The gender distribution of the health workforce is balanced at 50 per cent for women physicians and 55 per cent for women dentists (WHO 2021). Women represent 90 per cent of nurses and midwives, 78 per cent of pharmacists and 70 per cent of psychotherapists (WHO 2021). In general, Egypt has a relatively young health workforce, with more than half of health and social care workers aged under 35 years (ILO 2023).

In addition, recent evidence shows that, in Egypt, approximately 31 per cent of healthcare workers are employed outside the health and social care sector. These workers are often found in industries including but not limited to public administration and defence, wholesale and retail, education and manufacturing (ILO 2023).

The level of wages is considered to be one of the main driving factors of health workers' migration, including doctors and nurses (Hashish and Ashour 2020; Schumann, Maaz and Peters 2019). In Egypt, the gender pay gap in the health sector is at 20 per cent (WHO and ILO 2022).

Medical education for doctors in Egypt

In 2022, the World Directory of Medical Schools listed 45 medical schools in Egypt (WDOMS, n.d.). The access to medical schools is competitive: a good grade-point average score in final exams in high school is required for successful selection. Then, in order to be admitted to medical school, one must pass the Medical College Admissions Test (MCAT); it is computer-based and assesses candidates in areas such as problem solving, critical thinking and knowledge of scientific concepts.

The basic medical-education course to become a doctor lasts five years, plus two years of clinical training. The last year is devoted to an internship programme, which is mandatory to obtain a licence to practise as a general practitioner (Abdelaziz et al., 2018). At the end of the cycle, students acquire a bachelor's degree in medicine (MBBC).

All medical graduates are mandated to work in the government sector for at least three years, until they become specialists. Doctors who wish to achieve a medical specialization can apply for Medical Residency, which typically lasts for three to four years, depending on the specialty. However, some specialties may require a longer period of training, such as surgery (six years).

Some of the most popular specialties for medical residency include internal medicine, pediatrics, surgery, obstetrics and gynecology, radiology, pathology, anesthesiology, psychiatry and emergency medicine.

For attending the medical residency programmes, specializing doctors can benefit from the scholarships offered by the MoHP and other organizations, allowing them to cover tuition and living expenses for the duration of the programme. The equivalence of academic degrees issued by

foreign higher education institutes is the competence of the Supreme Council of Universities (SIS, n.d.-b).

Foreign doctors and health workers who speak Arabic and English are allowed to apply for Egyptian scholarships, after equivaling their certificates from the Supreme Council of Universities and obtaining the necessary approvals for training and residency in Egypt from the relevant authorities. Applicants are accepted if training places are available for them in the specializations they are applying for, in accordance with the rules governing this matter. The applicants follow the same training and examination system applied to their Egyptian peers in their respective specializations.

In order to register for the first time in the records of the Ministry of Health, doctors must pass the national examination to qualify to practise the profession, under the supervision of the Egyptian Health Council. The list of exams includes those for human medicine, dental professional licence, pharmacy, nursing, veterinary medicine and physiotherapy.

Egyptian Law No. 12 of 2022 established the Egyptian Health Council, a public service body that reports to the President of the Republic. The Council is responsible for standards, procedures and rules for exams that qualify for obtaining a licence to practise medical professions.

The Council grants an accredited certificate, called the "Egyptian Board", to all graduates of the faculties of the health sector after they complete the training programme and pass the standardized test for each of the health specializations.

It adopts scientific, vocational training and higher health specialized programmes for post-university education, and approval of professional certificates for those who pass these programmes in the various branches of medical health work from the relevant training authorities accredited by the Council.

Under Egyptian law, the practice of regulated professions is prohibited to individuals who are not members of their relevant syndicates.[5] This applies to physicians, nurses, physiotherapists, pharmacists, veterinarians, dentists and laboratory technicians. This requirement automatically excludes foreigners who wish to practise these professions in Egypt. Syndicates are professional associations of both employers and workers, and they are responsible for developing and monitoring compliance with the rules that regulate the practice of their specific professions (ILO 2021).

Nursing education in Egypt

There are two different pathways to becoming a licensed nurse in Egypt, each under the responsibility of a different ministry, namely the Ministry of Health and Population (MoHP) and the Ministry of Higher Education (MoHE). The first route involves a five-year technical post-secondary school nursing diploma, while the latter entails a four-year Bachelor of Science in Nursing (BSN) programme governed by the MoHE and the Nursing Sector Group of the Supreme Council of Universities. The technical diploma combines classroom instruction with practical experience in hospitals, while the BSN programme offers a comprehensive foundation in nursing theory and practice, including clinical experiences (Brownie et al. 2018). A nurse can become a midwife by passing an exam for midwifery after the BSN.

As is the case for other regulated professions, practising the profession of nurse requires a licence from the MOHP and membership of the National Professional Nurses Association. The processes involve having the qualifications evaluated for equivalency, the securing of a job offer from an Egyptian healthcare facility (which is a prerequisite for obtaining a work permit), and the application for a

[5] The Egyptian Medical Syndicate (EMS) is the government-recognized union of doctors which has been assisting the Ministry of Health in conferring licences to physicians in Egypt (SIS n.d.-c).

residence permit, which includes undergoing a medical examination and obtaining necessary clearances.

Migration of health professionals: modalities and challenges

Many Egyptian health professionals search for job opportunities abroad. The pulling factors are linked to the expected terms and conditions of employment in destination countries, but also the prospects of professional development and job satisfaction. The preferred target destinations appear to be the Member States of the Cooperation Council for the Arab States of the Gulf (GCC) and, increasingly, those of the Organisation of Economic Co-operation and Development (OECD) (OECD 2021).

To identify employment opportunities, potential migrants can search for employment vacancies ads, benefit from the support of their personal and family networks in the countries of potential destination or rely upon recruitment agencies. The Ministry of Manpower in Egypt plays a crucial role in overseeing and guiding the migration of Egyptian health workers. Among other things, they support the regulation of work permits, provide pre-departure training, and coordinate with foreign countries and agencies – on bilateral agreements, for example. As for all migrant workers, the employment contracts of doctors and other health professionals recruited through private agencies are checked and authorized by the Ministry of Manpower, so as to ensure fair terms and conditions of employment that are aligned with international labour standards.

Data on Egyptian health professional migration outflow is of limited availability, and most of the available information focuses on medical doctors. According to some estimates, the primary destination of Egyptian doctors is Saudi Arabia, followed by other Member States of the GCC and those of the OECD (Schumann, Maaz and Peters 2019). Demand for Egyptian health workers in the GCC Member States has been sustained for decades, but it seems to be decreasing due to nationalization policies (Alsahi 2020).[6]

Concerning the migration procedures, one should note that all the GCC Member States require as a first step that medical doctors' documents (namely educational certificates, experience, health licence and good standing certificates) be verified by the Dubai-based DataFlow Group.[7] The second step differs depending on the country:

- Saudi Arabia requires that candidates undertake the Prometric Exam for Doctors, a standardized examination that assesses their medical expertise and is supplied by AMIDEAST in Cairo.[8] Doctors who pass the test do not need to demonstrate the equivalence of their Egyptian medical degree in order to apply for employment in the country. Egyptian doctors enjoy equal treatment with national medical staff in Saudi hospitals, though some differences may exist in their wage levels (Zawawi and Al-Rashed 2020).
- Potential migrant doctors to the United Arab Emirates must have the authenticity of their diplomas verified, and are then interviewed by an evaluation committee – usually set up by the Ministry of Health (in Dubai and Abu Dhabi). The evaluation certificate delivered by the committee recognizes the skills and experience of the medical degree holders. In the United Arab Emirates, doctors are considered to have outstanding specialized talent and can receive a 10-year residence visa (a "Golden visa") after obtaining an approval document from the Ministry

[6] Labour nationalization schemes aim to reduce the reliance on foreign labour by encouraging – and often compelling – private sector industries to hire nationals instead of foreign expatriates (Randeree 2012).

[7] DataFlow Group provides Primary Source Verification services, assessing documents from their original sources (Overseas Healthcare Consultant, n.d.).

[8] Founded in 1951, AMIDEAST is a leading American non-profit organization engaged in international education, training and development activities in the Middle East (AMIDEAST, n.d.).

of Health and Prevention to practise the profession of medicine (United Arab Emirates Government, n.d.).

In the OECD Member States, the number of Egyptian doctors was estimated to be 10,176 in 2020 (foreign-trained physicians[9]). No figures on Egyptian migrant nurses are mentioned among the top 20 origin countries (OECD, n.d.).

Across EU Member States, the recognition of qualifications issued in non-EU countries and the rules for licensing and practising can differ greatly. One exception is Italy: based on a bilateral agreement signed on 14 April 1951 and still operational, Egyptian doctors can register directly with the Italian Professional Register, without the need for their qualification to be recognized by the Ministry of Health.

In the United Kingdom, which is no longer a Member of the EU, Egyptian doctors numbered 435 in 2017 and 756 in 2018; their numbers then increased by almost 200 per cent in the following three years, to 1,301 in 2019, 1,220 in 2020, and 1,312 in 2021 (GMC 2022).

Egyptian doctors who wish to practise in the United Kingdom should ensure that their medical education is recognized by the latter's General Medical Council (GMC).[10] Doctors with non-UK medical degrees will need to have their qualifications independently verified before registration is granted. Verification is carried out by the Educational Commission for Foreign Medical Graduates (ECFMG) through their online system – known as the Electronic Portfolio of International Credentials (EPIC) service. The ECFMG will verify the qualification's authenticity directly with the relevant awarding institution.

The GMC uses the Professional and Linguistic Assessments Board (PLAB) test to ensure that migrant doctors have the basic medical competence and communication skills necessary to practise in the United Kingdom. Doctors wishing to take the PLAB test should have already successfully completed the International English Language Testing System (IELTS) or Occupational English Test (OET). The first part of the PLAB test can be taken at several test centres abroad, while the second part must be taken in the United Kingdom. The PLAB centres in Egypt are located in Alexandria and Cairo.

Some Egyptian doctors who migrate are sponsored by the Royal College of Surgeons or the Royal College of Physicians, of which they become members. The Royal Colleges check the education and expertise of these doctors before sponsoring them for registration with the GMC. In addition to recognized medical education diplomas, these doctors must submit evidence of their internship training years, reports from recognized referees, logbooks in case of surgical positions, proof of English language proficiency, proof of continuous gapless practice and certificates of good standing from previous employers in the countries in which they have worked. They also pay fees to the Colleges to carry out the sponsorship processes. To begin the processes, these doctors must provide proof of specific demand from employers in the United Kingdom.

The conditions of work and of living vary between the GCC Member States. They are generally considered to be both favourable and improving. Women even seem to have a preferential treatment in certain specialties – such as obstetrics and gynaecology, as well as dermatology – where there is a particular demand for them.

While this report provides examples of migration procedures for Egyptian doctors working abroad, it does not encompass the full range of requirements for all countries. For detailed information on specific country requirements, it is necessary to consult the relevant country-specific authorities.

[9] Doctors who have obtained their first medical qualification (degree) in another country and are entitled to practise in the destination country.

[10] In the United Kingdom, the General Medical Council is an independent body responsible for both setting the standards that doctors and those who train them need to meet as well as supporting their attainment. See their website: https://www.gmc-uk.org

Regarding the immigration of foreign health workers to Egypt, specific requirements and limitations apply, as outlined in box 3.

▶ Box 3: Immigration of health workers to Egypt

Requirements for immigrating to Egypt as a doctor

- **Medical Degree:** The degree must be equivalent to medical qualifications in Egypt.
- **Work Experience:** Relevant work experience may also be required.
- **Medical Licence:** Obtaining a licence from the Ministry of Health and Population is mandatory. Applicants must submit their medical qualifications and credentials for review. Once approved, the licence allows the doctor to practise medicine in Egypt.
- **Visa and Work Permit:** A valid visa and work permit are essential for anyone seeking regular employment in Egypt.
- **Language Proficiency:** Applicants may be required to pass language exams, including a test of Arabic, as part of the visa application process.

Requirements for immigrating to Egypt as a nurse

- **Educational Qualifications:** Applicants must hold a nursing degree from a recognized university in their country of origin. The credentials must meet the standards set by Egyptian healthcare authorities.
- **Work Experience:** Some level of relevant work experience may be required.
- **Nursing Licence:** Applicants must possess a valid licence from their country of origin. The credentials will be evaluated to ensure that they are equivalent to those issued by Egyptian educational systems.
- **Job Offer:** Typically, a job offer from an Egyptian healthcare facility is required. The employer must sponsor the immigration process and provide proof of employment, such as a contract or a letter of employment.
- **Visa and Work Permit:** A valid visa and work permit are essential for anyone seeking regular employment in Egypt.
- **Language Proficiency:** Applicants may be required to undergo a language proficiency test, including demonstrating knowledge of Arabic, as part of the work permit application process.

Source: Visalibrary, n.d.

Consequences of health worker migration

Brain drain

Egypt has been experiencing a shortage of physicians despite thousands of medical students graduating annually, and the loss cannot be replaced by new recruitment (see box 4). In February 2021, the Minister of Health and Population Hala Zayed reported that 67 per cent of all Egyptian doctors were working abroad; she attributed this figure to the lack of appropriate post-university training and the reluctancy of doctors to work in places too far from their residence (*AhramOnline* 2022). According to the WHO, as mentioned at the beginning of this case study, there is also a structural issue related to the allocation of physicians to public hospitals. Consequently, in some areas, the challenge is more a maldistribution of physicians rather than an actual shortage; to improve the quality of health services, the Ministry of Planning, Economic Development and International Cooperation stated that the 2022/23 development plan allocates a total estimated investment of EGP 75 billion, combining public and private funding (MPED 2023).

Box 4: Factors driving the emigration of medical students from Egypt

A study was conducted from February to April 2019, with 711 fifth- and sixth-year medical students and 174 residents from two of the eight medical faculties in the Nile Delta Region. Most participants (89.4 per cent) expressed the desire to emigrate due to salaries being inadequate considering working hours and occupational hazards. In addition, physicians had to work extra time in private hospitals to add to their income, resulting in high workload and negatively impacting on work–life balance.

Professional reasons for physicians emigrating from Egypt included, among others, the inadequate length of training to be a skilled doctor, lack of surgical and medical supplies, and few research opportunities. Only 18.8 per cent of the participants reported that good opportunities and facilities for scientific research were available in Egypt and the majority (87.2 per cent) wanted to emigrate for better research opportunities. Participants were open to remaining in Egypt if its health sector showed significant signs of improvement.

Source: Kabbash et al. 2021.

As with medical doctors, Egypt is also experiencing a shortage of nurses, with the brain drain of the latter being an ongoing phenomenon that impacts the quality and quantity of the nursing workforce and affects the quality of care, especially in the context of an ageing population and increased need for health services. A recent study from Basiony and Ahmed (2023) showed that more than two thirds of the participating nurses from eleven hospitals in Egypt intended to migrate. The most significant push factors identified in the study were economic factors, work environment and professional opportunities, while salary, management support and career development were the top pull factors.

Brain gain

Brain gain can be beneficial to the country of origin: either directly, through brain circulation and virtual returns (for example, workers returning regularly or occasionally to offer medical services), or indirectly through the creation and development of professional networks. In this respect, an important role is played by the Egyptian health diaspora, especially in the United States and United Kingdom. In fact, among other things, they can assist fellow-national migrants in settling in the country of destination, provide supplies and medical equipment to their country of origin, raise funds, as well as send qualified professionals back to provide training or direct clinical care. One example of a network that can channel the transfer of skills to Egypt is the American Board-Certified Doctors for Egypt (ABCDE), a non-profit organization established in 2011. The organization has over 1,000 Egyptian volunteers who work as physicians, scientists and dentists in the United States. Its main mission is to share the knowledge gained during migration with doctors in Egypt. Another network is that of the Egyptian American Medical Association. Members deliver educational sessions and webinars for new medical graduates in Egypt and collaborate with several hospitals and medical institutions there (ABCDE, n.d.). In the United Kingdom, the British Egyptian Medical Association (BEMA) provides support to Egyptian health workers in the country, as well as to doctors and the healthcare system in Egypt (BEMA, n.d.).

Conclusions

One of the factors driving the emigration of health professionals from Egypt relates to employment terms and conditions, often in public establishments, which affect both women and men equally. The destinations of Egyptian doctors are primarily the Member States of the Cooperation Council for the Arab States of the Gulf (GCC) – especially Saudi Arabia – and, increasingly, those of the Organisation of Economic Co-operation and Development (OECD). The United States, the United Kingdom and Germany are the first among the latter. The gender distribution of doctors in Egypt is balanced at 50 per cent, while there are no sex-disaggregated figures for migrant doctors.

Globally, demand for doctors and other medical professions is growing. In fact, increasing demand is facilitating migration processes from which Egyptians are benefiting. Even if they are subject to further

tests, upgrading and licensing processes, and do not give automatic access to practising, the doctors' medical degrees that were acquired in Egypt are recognized in Member States of both the GCC and the OECD. Tests are carried out to ascertain the effective levels of the doctors' skills; the same applies to nurses.

Nurses face similar challenges to doctors in terms of push factors for migration, such as wage levels. In addition, estimates of their migration numbers and information on their destinations are limited. However, their migration should be carefully analysed, given the shortages in OECD countries and a growing demand for care services, as well as the simplified migration procedures for this professional category in some countries.

In the context of universal health insurance coverage as adopted by Egypt, health policy should ensure the provision of quality medical services to its population in both urban and rural areas. Central policy objectives may include the improvement of doctors' and nurses' terms and conditions of employment, of their working environment and of their opportunities for education and skill acquisition; equality of treatment and non-discrimination should also be guaranteed. Such policy measures would reduce the push factors for migration without affecting the right to freedom of movement. With the aim to both minimize the brain drain represented by doctors' and nurses' migration and maximize the gains accrued from their experiences, the following policy measures may be considered:

- the regular collection, processing, analysis and dissemination of data on the migration of Egyptian doctors and nurses, which is vital – collaboration agreements should be established with national statistical offices in countries of destination for access to the data they collect (broken down by sex, age, specialty and destination);
- the analysis and enhancement of both working conditions and wage levels of health professionals, in collaboration with workers, employers and their representatives, to address migration push factors and brain drain concerns;
- the improvement of opportunities to access education and training, so as to facilitate the advancement of young health professional careers;
- the establishment of specialized employment services for returning migrant doctors and nurses, with a view to matching their acquired skills with demand in public and private hospitals – these services could also match the former with hospitals that are in a position to host them for any period of time (thereby facilitating the transnational transfer of skills); and
- the development and maintenance of working relations with associations of Egyptian migrant health professionals in countries of destination, as well as the encouragement of health professionals to establish these associations where they do not exist.

Information on the migration of health professionals from Egypt remains scarce, particularly for lower-skilled workers; consequently, this case study has focused primarily on medical doctors and nurses, where data was available. Other health professions were not included, highlighting the need for further research.

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Germany

The German health system at a glance

One of the most important economic sectors in Germany is that of health. In 2022, approximately 12.8 per cent of the country's GDP was allocated towards it, amounting to a total of €498 billion (Destatis, n.d.-a). In fact, after Switzerland and Norway, Germany is the European country that spends the most on health per capita – an estimated €5,702 in 2020 (OECD, n.d.). This has increased at an annual real growth rate of 2.1 per cent from 2008 to 2012, and 2.5 per cent from 2013 to 2018.

In terms of employment, the health sector engages around 6 million individuals, with 75 per cent of these being women in 2022. Of these, approximately 16 per cent are under the age of 30; 69 per cent are between the ages of 30 and 59; and 15 per cent are over the age of 60 (Destatis, n.d.-b).

The health sector is widely recognized as a major contributor to employment and economic growth in Germany. In recent years, it has been navigating several developments, including growing demand for skilled professionals. To date, Germany is experiencing a shortage of labour in 352 occupations out of a total of 801, of which 11 occupations[11] are related to health and have faced a long-standing shortage of skills across the entire country (BMWK, n.d.; BA 2021). This shortage is present at all skill levels, ranging from vocational trainees to specialists with a master's certificate or higher qualification. The shortage of skilled workers can be attributed to several factors, one of which is the demographic shift towards an aging population. This shift has led to increased demand for health services, particularly in long-term care and for specialists in geriatrics.

According to projections undertaken by the United Nations Department of Economics and Social Affairs (UNDESA), the working age population of Germany will decline by 8.2 per cent by 2030, and an additional 8.0 percentage points by 2050. As such, the number of people aged between the ages of 15 and 64 will drop from 53.9 million in 2021 to 45.2 million by 2050, while those aged 65 years and over will increase from 18.1 to 24.0 million (UNDESA 2019). This increases the dependency ratio of the country and thereby places strain on the Federal Government to implement appropriate measures, without which Germany will experience a rise in the shortage of workers in the health sector. This shortage will be further exacerbated by the retirement of a large proportion of the health workforce over the coming decades. In fact, according to the World Health Organization's National Health Workforce portal, 38.5 per cent of medical doctors in Germany are between the ages of 55–64, and 6.4 per cent are over the age of 64 (WHO 2021).

Projections indicate that the German health sector may face a shortfall of approximately 400,000 full-time employees by 2030, including an estimated 330,000 positions in elderly care (PWC, n.d.). These figures are in line with labour market forecasts from the Federal Ministry of Labour and Social Affairs, as well as analyses conducted under the "QuBe – Qualifications and Occupations in the Future" project, a joint initiative of the Federal Institute for Vocational Education and Training (BIBB) and the Institute for Employment Research (IAB) of the Federal Employment Agency (Vogler-Ludwig, Düll, and Kriechel 2013).

To address labour market challenges, the German government has introduced a range of measures, including a comprehensive strategy to secure skilled labour. This approach focuses on increasing domestic labour force participation—particularly among women and older individuals—while also

[11] This includes occupations in the fields of elderly care; healthcare, nursing, emergency services and obstetrics; human medicine and dentistry; medical technology, orthopaedic technology and rehabilitation technology; pharmacy; medical laboratory; medical help and doctor's office help; veterinary medicine; psychology and non-medical psychotherapy; animal care; nutritional advice, health advice and wellness.

supporting the immigration of qualified professionals and recognising the potential of refugees through labour market integration.

As part of this strategy, the Skilled Immigration Act (FEG) was introduced in 2020 to facilitate the entry of skilled workers from non-EU countries. This policy direction supports the long-term sustainability of the German labour market. Estimates suggest that, in the absence of immigration, the workforce could shrink by up to one third by 2060—equivalent to approximately 16 million people (BMWK, n.d.).

To further strengthen the availability of skilled labour, Germany adopted a new national strategy in 2022 that outlines five key priorities: modernised training systems, targeted education and upskilling, increased labour market participation, improved working conditions, and a forward-looking migration policy that also addresses emigration (BMAS, n.d.).

Building on this, and in alignment with the requirements of EU Directive (EU) 2021/1883, a revised Skilled Immigration Act was passed, with initial provisions coming into effect in November 2023. The updated legislation expands access for university-educated professionals and facilitates migration in high-demand occupations—such as healthcare, childcare, and professional services—through mechanisms like the EU Blue Card.[12] Additionally, from March 2024, the Act introduces two new pathways for individuals undertaking qualification measures in Germany (GoG, n.d.).

In order to facilitate skilled worker immigration and to ensure that the qualifications match the German reference occupation, Germany has extensively improved the provision of information surrounding the recognition of foreign qualifications. As such, there has been a noteworthy trend of increasing applications, especially from countries outside of the EU. In fact, to date, most applications for recognition of foreign professional qualifications are submitted for regulated professions – primarily health and nursing staff, as well as doctors, engineers, and educators (Böse et al. 2021).

Germany's qualification and skills recognition processes

The regulatory framework

At the 2008 Education Summit in Dresden, the Federal Government and the Federal States agreed to introduce measures aimed at better utilizing previously untapped skills, including greater recognition of foreign professional and vocational qualifications. In the years that followed, however, the recognition process varied in practice and was influenced by factors such as an individual's country of origin. While the recognition of EU citizens was regulated under the Directive 2005/36/EC of the European Parliament and the European Council on the recognition of professional qualifications, focused on EU nationals having legal right to a recognition procedure. Since the Directive did not cover migrant workers, the Federal Government established the Assessment and Recognition of Foreign Professional Qualifications Act (in short the Recognition Act) on the 1 April 2012, which aims to both standardize the procedure and guarantee that individuals originating from outside the EU have the legal right to undertake it. This has been achieved by extending the original scope of the European Directive 2005/36/EC to also include unregulated professions as well as professional qualifications of individuals originating from countries outside of the EU. As such, the act ensures that any individual, regardless of their nationality or place of residence, is entitled to a recognition procedure – even if applying for it from abroad.

In 2021, a new EU Directive was adopted, Directive (EU) 2021/1883 of the European Parliament and of the Council of 20 October 2021, which aimed to facilitate the conditions of entry and residency of third-

[12] The German legislation is in line with the new Blue Card Directive of the EU – Directive (EU) 2021/1883 of 20 October 2021 on the conditions of entry and residence of third-country nationals for the purpose of highly qualified employment.

country nationals who intend to perform highly skilled work. Germany implemented the requirements of this directive through the new Skilled Immigration Act, which came into force in November 2023.

For the health sector, a distinction can be made in the recognition process by country of origin. The professional qualifications of doctors, dentists, veterinarians, pharmacists, midwives and nurses originating from within the EU can be automatically recognized (EC, n.d.), while other health professions are subject to the regular recognition procedure, in which an equivalency check is carried out and adaptation measures may be necessary. For individuals outside the EU, the regular recognition procedure is applied to all health professions.

When considering its content, the Recognition Act is composed of 61 Articles. The first consists of the Professional Qualifications Assessment Act (BQFG),[13] while the remaining articles (Articles 2 to 61) reflect amended sectoral laws. The latter directly regulate the recognition of regulated professions, including health professions, both for EU citizens and third-country nationals under the Federal Medical Code, the Nursing Act, as well as the Crafts and Trade Regulation Code, among others. Any provisions of the sectoral laws take precedence over the BQFG (BIBB n.d.-a).

All of these articles contribute towards the main aim of the Recognition Act, which is to attract skilled foreign workers with professional or vocational qualifications as well as to support their long-term integration in the country by assessing their qualification for "equivalence with the German reference occupation" (BIBB n.d.-a). Such recognition not only provides the applicant with the opportunity to work in jobs that match their qualifications, but also provides transparency to employers, allowing them to better assess the foreign qualifications. In total, the Act applies to more than 600 regulated and non-regulated professions that fall under federal jurisdiction, including those in the health sector (see box 5). Depending on the profession as well as the federal state, various competent bodies are responsible for the recognition process.

In the case of regulated health professions, the Recognition Act identifies the relevant competent body for professional recognition and training (namely, the chambers of physicians, dentists, nurses and pharmacists according to their respective fields of work). This is based on what is stipulated under the Vocational Training Act, as well as under the Federal Medical Code for healthcare professions. These chambers are present in each of the 16 federal states, and medical staff wanting to practise in health professions in Germany must become a member of the chamber of the federal state in which they wish to practise. In general, the respective chambers are responsible for professional recognition (namely, the issuance of licences to practise medicine), specialist examinations, and the assessment and arbitration of malpractice allegations. These activities are governed by the *Heilberufekammergesetz*, a medical professions law which varies by federal state.

[13] The aim of the BQFG is "to improve the use of professional qualifications [and training certificates] acquired abroad so that holders of such qualifications can find work commensurate with those qualifications on the German labour market" (Section 1). The legislation, as such, (i) contains standardized regulations for recognition, (ii) contains criteria for recognition, (iii) legally enforces the right to a recognition procedure, (iv) identifies the relevant competent body and (v) applies to 330 unregulated occupations in Germany's Dual System.

Box 5: Statistics in relation to the Recognition Act, Germany, 2019–20

As of December 2020, a total of 205,359 applications for recognition of a professional or vocational qualification have been reported within federal statistics since the implementation of the Act. In 2020, approximately 74 per cent of the total 31,536 applications were made for a medical healthcare profession. Of these, close to 82 per cent were for the reference occupations of general nurse, doctor and physiotherapist. While 53.8 per cent of the applications were awarded full equivalence in 2020, 8.7 per cent were awarded partial equivalence. Of the latter, 34.9 per cent required a compensation measure, thereby allowing foreign individuals in a regulated occupation to compensate for substantial differences between a foreign professional qualification and a German reference occupation. Such measures include either learning new skills, or undertaking an aptitude or knowledge test. The latter must be undertaken by, for example, health professions coming from a third country. Furthermore, in 2019, it was found that approximately 80 per cent of all applications were for medical health professions, of which the three most common – registered general nurse, doctor and physiotherapist – represented roughly 85 per cent of all medical profession applications.

Sources: BIBB 2020; BIBB 2021.

Germany has complemented the Recognition Act with the Skilled Immigration Act (FEG), in force since 1 March 2020, and the new Skilled Immigration Act of November 2023, which offers further opportunities for the immigration of skilled workers – including health workers – from countries outside of the EU (GoG, n.d.), thereby facilitating their immigration in line with the needs of the German economy. This has been supported by the adaptation of certain requirements under the Residence Act – an Act that regulates the issuing of residence permits for various purposes, including for work, training and the recognition of foreign qualifications.

While the recognition of professional qualifications and the issuance of a residence permit are still mandatory and separate procedures, the new Skilled Immigration Act has led to the reorganization of the relationship between immigration and recognition at various levels. In summary, the immigration regulations for skilled workers who have completed qualified vocational education and training are now aligned to the regulations that apply to skilled workers who have undergone academic training. The relevant implications that the Skilled Immigration Act of 2020 has had for foreign individuals are described in box 6.

Box 6: The most significant changes resulting from the Skilled Immigration Act, Germany, March 2020

- The term "skilled worker" has been standardized under the Residence Act and is now applied to individuals who have obtained higher academic education or who hold a vocational education and training qualification.
- If an individual holds an already recognized qualification and a contract of employment, no priority review is required. A priority review is the process in which the immigration officials review whether or not the given employment position could be filled by the national workforce.
- Skilled workers with vocational training are now allowed to travel to Germany to look for employment on the precondition that their qualifications are recognized prior to entry, their livelihood is secured, and they can prove profession-specific German language skills of at least B1 level in the Common European Framework of Reference for Languages (CEFR). Previously, this was only possible for foreigners with an academic qualification.
- It is now possible for foreign skilled workers to enter the country before the start of the recognition process and take up employment in unregulated professions in parallel to the process. This regulation applies specifically to healthcare professions as well as to "other selected professional qualifications" (Paragraph 16d of the Residence Act).
- Individuals may now enter Germany for the purpose of achieving full equivalence via compensation/training measures. Possibilities of employment during this period are also supported. Yet, for an individual to make use of this, a formal recognition process should have been conducted prior to their arrival in Germany. Furthermore, the individual should prove their livelihood as well as provide a certificate of German language skills equivalent to the B1 CEFR level.
- Employers are now able to accelerate the immigration procedures of skilled workers from third countries by shortening the duration of recognition. To do so, they conclude an agreement with the responsible immigration authority in Germany. The total costs of €411 for the accelerated procedure are borne by the employer according to Section 81a of the Residence Act.

Source: BMAS 2020.

The Skilled Immigration Act was amended in November 2023 to make the process more accessible and attractive to skilled foreign workers. The changes particularly increase flexibility for qualified professionals seeking the EU Blue Card and expand eligibility to cover more occupations (see Box 7).

▶ Box 7: Changes introduced in 2023 to the "Skilled Immigration Act" of 2020

- **Increased flexibility for professionals:** The amended Act removed the previous restriction that limited skilled workers to jobs related to their specific qualification. Applicants with a vocational qualification or a university degree are no longer restricted to employment that directly matches their field of training — except in the case of regulated professions.
- **Right to a residence permit:** Skilled workers with a recognized vocational or academic qualification are entitled to a residence permit, whereas previously it was a discretionary decision.
- **Introduction of a job search opportunity card:** An opportunity card has been introduced that enables jobseekers to stay in Germany for one year to look for employment.

The Act also includes the following specific regulations for assistants in nursing from third countries and healthcare and nursing professions:

> *"**Access to the labour market for assistants in nursing from third countries:** The planned changes will add a provision for assistants in nursing from third countries, to the rules that govern access to the labour market for healthcare professionals. All third-country nationals with less than three years of regulated nursing training will be able to work in the healthcare sector. The prerequisite for this is that such individuals either have relevant vocational training in nursing in Germany or a foreign nursing qualification that is recognized in Germany.*
>
> ***Job seeking after training in healthcare and nursing professions:** Nursing and care assistants from third countries who have completed their training in Germany will now be able to apply for a residence permit for jobseekers. The residence permit will be issued for up to twelve months and can be extended by up to six months if the applicant's livelihood is further secured."*

Source: GoG, n.d.

The recognition process: information provision and the application procedure

Information provision and awareness raising for individuals

The Recognition in Germany portal

The "Recognition in Germany" portal, established in 2012, acts as the Federal Government's main platform for information regarding the recognition of foreign professional and vocational qualifications. It is aimed at individuals residing in Germany and abroad who are interested in seeking recognition for their qualifications. While recognition can be a complex topic, the portal is designed to be user-friendly, outlining information on the recognition process in a clear manner. Furthermore, the presence of 11 language options ensures that a wide variety of migrant workers have access to this information. In 2020, the portal was accessed by 300,000 visitors a month, of which around 55 per cent come from abroad, mostly from non-EU countries (BIBB 2020).

As part of the portal, the Federal Government has introduced the Recognition Finder, an essential source of guidance for individuals seeking recognition. This tool is available in German and English, and includes relevant information on professions and occupations governed by federal and federal state laws. While the tool has always been based on regulated professions (including those in the health sector), unregulated academic higher education qualifications have been added since 2017. An overview of the general process that the tool undertakes is shown in figure 1.

Make it in Germany

Make it in Germany is the key information portal of the Federal Government for skilled workers from abroad. The portal is accessible in various languages; it provides an overview of current trends in the German labour market and offers information for individuals interested in working in Germany, namely on topics related to working, studying and training in Germany, visas and residency.

The BQ-Portal

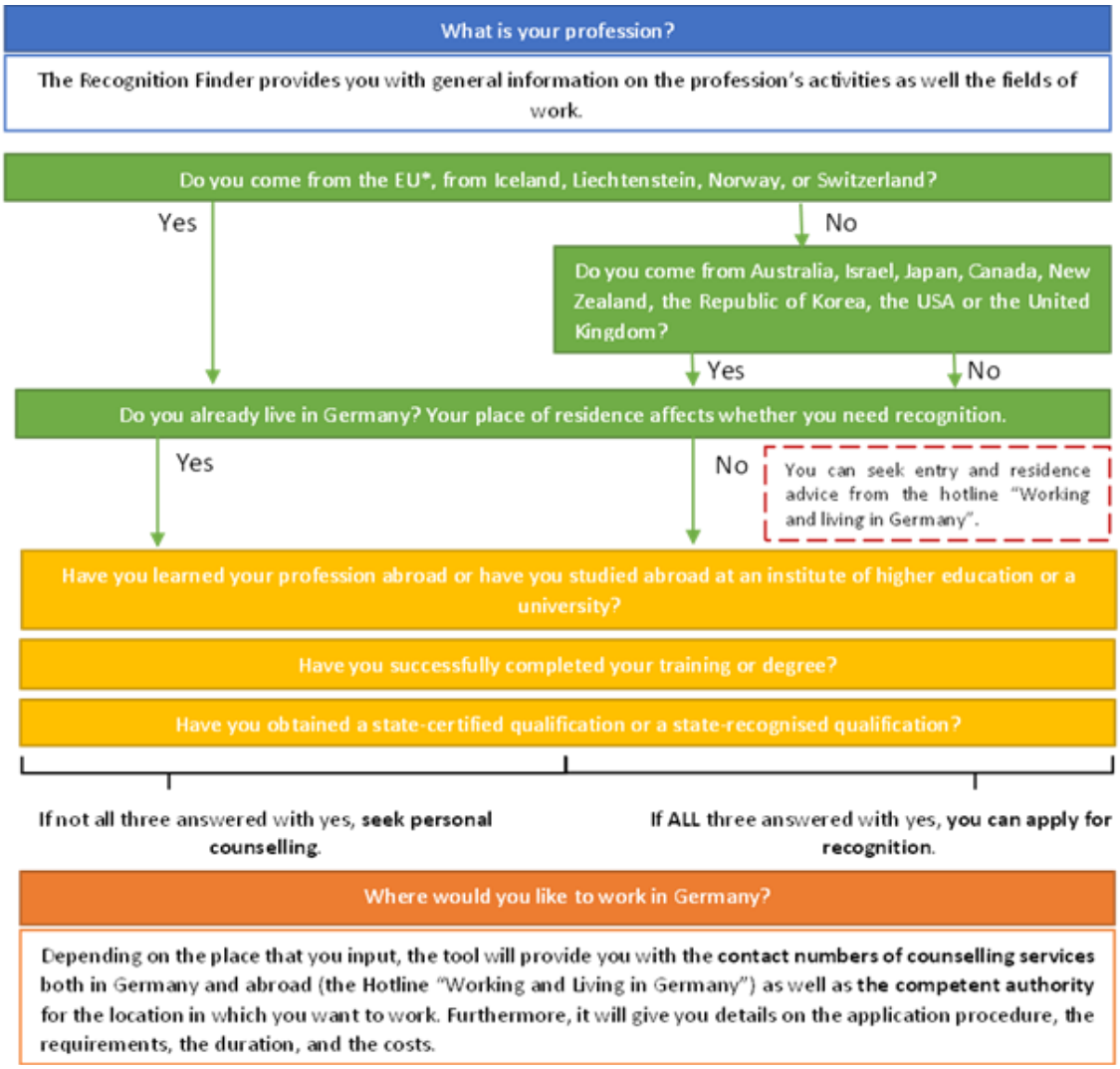
A third source of information on recognition, the BQ-Portal[14] is directed towards the competent bodies in the relevant chambers as well as towards employers. Not only does it assist with assessing and evaluating foreign vocational education and training (VET) systems as well as professional and vocational qualifications, but it also acts as a knowledge network and knowledge management system. This system has a public as well as an internal section: in the former, the competent bodies in the relevant chambers use the portal to upload relevant information on foreign vocational qualifications; in the latter, results of equivalence assessments are made available. As such, other chambers will be able to profit from the outcomes of previous assessments, thereby fostering a more uniform evaluation practice at a national level. By 2025, users of the portal were able to access 6,135 occupational profiles across 107 countries – thereby making equivalence procedures "more standardized, quicker and more transparent" (BMBF 2019; BQ-Portal, n.d.).

However, the portal largely provides information on what the federal law identifies as unregulated dual training qualifications.[15] As previously outlined, many professions in the health sector are uniformly regulated throughout Germany and are, as such, not in the focus of this portal. Yet there are also health professions that are largely unregulated by state law, which involve the care of the sick and the elderly (for example, geriatric care assistant or nursing assistant). Recognition in these instances is not a prerequisite but may be beneficial for facilitating employment. These health professions are featured in the BQ-Portal. In fact, nursing training programmes in Serbia and Ukraine were the second most frequently accessed information pages in 2019 (BMBF 2019). In 2024, the BQ-Portal was awarded the United Nations Public Service Award 2024 for Innovations in Public Institutions.

[14] BQ stands for the German term *Berufsqualifikation* (professional or vocational qualification).

[15] "Dual training qualifications" refers to a system that combines classroom training (theory), with on-the-job experience (practice).

▶ Figure 1: The process undertaken by the Recognition Finder tool, Germany



Source: Author's own work

The anabin database

The fourth information database is named anabin,[16] a German acronym for "Recognition and assessment of foreign educational qualifications". It is aimed at a number of stakeholders, including educational establishments, government authorities, employers as well as individuals interested in obtaining recognition. In contrast to the previous information platforms, the anabin database offers information that will allow for the assessment of (i) foreign higher education qualifications, (ii) vocational and school qualifications and (iii) foreign tertiary educational establishments – thereby facilitating the categorization of foreign educational qualifications in the German education system. Another difference is that it is only available in German, as its main users are German institutions; however, given that it is also geared towards providing information to workers, it may effectively discourage migrant workers from applying, given language barriers. In this respect, the Recognition in Germany portal and the BQ-Portal – both provided in multiple languages – offer facilitated access and understanding.

[16] In German, anabin (styled in lower case) stands for "Anerkennung und Bewertung ausländischer Bildungsnachweise".

In 2018, the anabin database was expanded with the aim of optimizing knowledge management between the Central Assessment Agency for Healthcare Professions (GfG),[17] which is a branch of the Central Office for Foreign Education (ZAB),[18] and the competent bodies in the health sector. By 2019, the database contained information and assessments for 180 education systems, 31,400 institutions of higher education and 29,000 higher education qualifications, as well as 31,700 sample assessments of individual educational biographies (BMBF 2019). Given that this database continuously evolves, more and more information and assessments on education systems and qualifications for health professions will become available.

To complement the existing information portals, a range of free multilingual guidance services are available to individuals seeking assistance with the recognition of their qualifications. These services encompass various stages of support, from initial orientation to aid in the actual application process (see box 8 below).

[17] In German, this agency is called: Gutachtenstelle für Gesundheitsberufe (GfG). It is intended to support the recognition of foreign qualifications in the health professions and to accelerate the process.

[18] In German, this office is called: Zentral Akademie für Berufe im Gesundheitswesen (ZAB). It is the central office for assessing foreign qualifications in Germany – including school, professional and university qualifications. The ZAB provides services for educational institutions, authorities and private individuals. The ZAB maintains the anabin database. One can apply for the recognition of educational certificates directly at the ZAB; it answers around 43,000 inquiries every year. Competent authorities undertaking the recognition process can ask the ZAB for support; this includes requests for an expert opinion on a specific case or for general information about a country in question and its education system. Furthermore, foreign recognition bodies can obtain information on the German educational system from the ZAB to facilitate the assessment and recognition of training abroad that has been completed in Germany. In addition, the ZAB is the national information point regarding the application of the EU directive on the recognition of professional qualifications (KMK, n.d.).

Box 8: Guidance services for individuals interested in seeking recognition, Germany

In addition to the information portals, free multilingual guidance services are also offered to individuals who seek support in the recognition of their qualifications; this support ranges from the initial orientation phase to assistance in the actual application for recognition. These services include:

- The Working and Living in Germany Hotline offers advice on aspects related to recognition. While Germans are the largest group seeking advice, the hotline has increasingly been used by individuals living abroad as well (mostly by Turkish, Indian, Syrian or Italian citizens).
- The Network "Integration through Qualification" (Network IQ) provides counselling with regard to professional and occupational recognition. The network clarifies questions around the prerequisites of a recognition procedure, supports the individual with necessary documentation and refers them to the appropriate competent body for applications. Of those receiving support in 2019, 95.2 per cent were resident in Germany – of which the majority were Syrian, followed by Germans, Russians and Iranians.
- Initial guidance is provided by chambers of crafts and trades, as well as by chambers of commerce and industry, in their respective area of expertise. They provide information on the recognition process and determine the reference occupation, as well as the documentation required for application.
- Information and guidance via the Central office for Foreign Education (ZAB) is largely demanded for certificate assessment (60 per cent), with the remaining questions centred on the relevant procedures to be undertaken, as well as other topics related to recognition legislation. In 2018, roughly 10 per cent of all enquiries were submitted from abroad.
- Other relevant advisory stakeholders on the recognition procedure include, among others, migrant organizations, welfare associations, institutions managed by religious communities, the *Stark im Beruf* (Strong in Work) programme, as well as regional stakeholders (for example, the Advanced Training Centres of Bavarian Trade and Industry [bfz] or the Continuing Training Guidance Agencies in North Rhine-Westphalia).

Source: BMBF 2019.

The general application procedure

In order to submit an application for the recognition of foreign qualifications, an applicant must: (i) wish to work in Germany, (ii) possess a state or state-recognized professional qualification in their country of origin, and (iii) provide a final certificate as evidence of their professional qualification.

If these three prerequisites are fulfilled, the applicant is to contact the competent authority for their profession. For the health sector, the competent bodies are identified under the 2005 Vocational Training Act (Berufbildungsgesetz) and are composed of the chambers of physicians, dentists, physiotherapists, nurses and pharmacists, according to their respective fields. If a chamber does not exist for a specific profession, then the competent authority will be determined by the federal state. The information portals that are outlined earlier in this subsection clearly provide applicants with the necessary information. In fact, for individuals applying from outside the EU, the information portals point to a toll-free counselling hotline (namely, the Working and Living in Germany Hotline), as well as offering information on the visa application process and entry into Germany.

Once the relevant competent authority has been identified, the applicant is to submit several documents, either by postal service or via an online application.[19] While these can be occupation specific, there are several documents that are mandatory for all applications, irrespective of whether they are regulated or not. These include: (i) an identification document, (ii) a table listing the completed training courses and work history, (iii) the training certificates acquired abroad, (iv) proof of relevant professional experience or other certificates of competence if they are necessary for establishing equivalence, (v) a statement indicating that no previous application for establishment of equivalence has been filed and (vi) documents explaining the applicant's intention to work in an occupation that is equivalent to their professional qualifications. The latter documents may include an entry visa, a proof of contact with potential employers, or a business plan. Furthermore, in the case of regulated professions, the applicant must also submit a document certifying their entitlement to practise the profession in the country of training. All documents submitted must be in the German language; if this is not the case, the applicant should use publicly appointed translators to do so. The fees of this process are borne by the applicants.

Once all documentation has been submitted, the competent authority begins the recognition process for the desired profession. Through this process, it is determined whether or not the applicant's foreign professional qualifications for the desired profession correspond to those of Germany. To do so, specified formal criteria are used, and any formal professional experience as well as other relevant formal qualifications are taken into consideration. According to the Professional Qualifications Assessment Act (BQFG), once full documentation has been received by the competent authority, the decision regarding equivalence should not take more than three months.[20] The potential outcomes for professions that require recognition and for those that do not are summarized in table 2.

In the instance in which equivalence is not established between the applicant's qualifications and those of the desired profession, the competent authority is to provide a written explanation of the reasons – termed either as a recognition notice, notice of equivalence, or notification of a deficit. This should include a description of the applicant's existing professional qualifications, as well as a description of the differences present between these qualifications and those acquired through German training. In addition, it is important that the explanation include information on potential legal remedies of which the applicant can make use.

The total average costs of the recognition procedure are approximately €600, yet this may vary on a case-by-case basis depending on the total amount of work required. However, legal provisions have been made by Germany for the profession-specific regulation of these costs. The applicable costs will be determined by the competent authority, after which the applicant is informed. In addition to the costs for the procedure, additional costs may arise, such as for translations, compensatory measures, refresher training, travel, as well as certifications. To provide disadvantaged individuals with the opportunity to recognize their skills, the Federal Government has established programmes of financial assistance for which they can apply; this assistance is provided by the Federal Employment Agency, the Federal Government, as well as the Federal States of Hamburg and Berlin (BIBB, n.d.-c).

[19] As stipulated in the German Professional Qualifications Assessment Act (BQFG), the online application is only provided as an option for EU citizens who have obtained their professional qualifications in the EU, the European Economic Area or in Switzerland. It is generally possible to do so for all regulated professions in Germany, including those in the health sector.

[20] This period may only be extended once, by a reasonable period and with justifiable circumstances.

Table 2: Potential outcomes of the recognition process, Germany

Professions requiring licensing (regulated/licensed professions)	Professions not requiring licensing
Recognition The applicant's professional qualification is equivalent to the German reference occupation, and they meet the other requirements for authorization to practise (such as personal aptitude or language skills).	**Recognition** The applicant's professional qualification is equivalent to the German reference occupation.
No recognition The applicant's professional qualification is not equivalent to the German reference occupation and substantial differences exist between them; in many cases they may still be able to receive recognition with a compensation measure. Following successful participation in the compensation measure, the applicant submits the certificate to the competent authority; they then receive a positive recognition notice. Usually, the applicant does not need to submit a new application for recognition.	**Partial recognition** Part of the applicant's professional qualification is equivalent to the German reference occupation, yet there are substantial differences in another part. If the applicant successfully completes a refresher training course, they can receive full recognition. This requires submitting a follow-up application for recognition – which consists of the acquired training certificate along with the other required documents – to the relevant competent authority.
No recognition The applicant's professional qualification is equivalent to the German reference occupation, yet they do not meet the other requirements for authorization to practise (such as personal aptitude or language skills).	**No recognition** There exist major differences between the applicant's professional qualification and the German reference occupation.

Source: BIBB, n.d.-b

Improving the recognition process: progress and challenges

Major developments to enhancing the process

Germany has made progress in recent years regarding the effectiveness of its process of recognizing skills and qualifications, in the health sector as well as overall. The implementation of the Recognition Act has provided individuals – especially those originating from countries outside the EU or those wishing to be employed in unregulated occupations – with the legal right to have their qualifications recognized for the purposes of employment in Germany. In fact, of the applications handled since 2012, 46 per cent were made by individuals who had no legal entitlement to a recognition procedure until the Recognition Act came into force (BIBB 2017); of those who did have the right, an increase in applications can be attributed to legal innovations that allowed for the consideration of professional experience, as well as to technical innovations that expanded the information and advisory structures of the recognition procedure. Evidence shows that thanks to these developments in the recognition process resulting from Recognition Act, the chances that a migrant worker will engage in a profession for which they have acquired qualifications have increased four-fold (BIBB 2017) – thereby positively influencing labour market integration, reducing skills-mismatch as well as reducing the overrepresentation of migrant workers in fixed-term contracts, marginal employment, shift work and part-time work. Furthermore, the improved recognition process has resulted in migrant workers being employed more

frequently, for a longer period of time and for higher wages, as well as working in professions that more closely resemble their qualifications. In addition, migrant workers have witnessed an opening up of new opportunities, both in the realm of employment as well as that of training opportunities (BIBB 2017).

The implementation of the Recognition Act has also led to the establishment of a number of agencies to support the process of recognition in the health sector. The first is the Central Assessment Agency for Healthcare Professions (GfG), a branch of the Central Office for Foreign Education (ZAB) established on 1 September 2016 in Bonn. This has allowed for the pooling of competencies and has had a positive impact, both in terms of procedural standardization and in terms of creating greater transparency for the way in which recognition procedures are implemented in the health sector. It has involved the introduction of two projects. The first is an optimization concept that focuses on further increasing the efficiency of the recognition process as well as shortening processing periods; as part of this, the GfG aims to develop a uniform basis for evaluating health professions across national borders and to support the competent accreditation bodies in the federal states in carrying out the procedures with equivalency reports.[21] As a consequence, 16 new positions were created for this task – one in each federal state. The second project is Konzertierte Aktion Pflege (Concerted Care Action), where the Federal Government, together with the federal states, is drawing up proposals for the standardization and digitalization of applications for recognition of professional nursing qualifications from countries outside of the European Union (BMG, n.d.).

The second agency is the German Agency for International Healthcare Professionals (DeFa),[22] established in 2019 in public ownership, with the aim of more efficiently organizing the administrative procedures of application, both within Germany and abroad. This includes receiving the required application documents from a respective applicant and ensuring that these are pre-checked and prepared in a way that facilitates the approval of equivalence by the competent authorities – thereby reducing bottlenecks and potential delays. In addition to this, DeFa also ensures fair recruitment and undertakes spot checks with each of its contractual partners (namely, agencies and employers), to ensure that ethical standards are maintained (DeFa, n.d.).

In addition to the advantages brought about by the Recognition Act, the introduction of the Skilled Immigration Act has extended the scope of applicants to include individuals who have completed vocational training. These applicants are, from 2020 onwards, considered to be highly skilled individuals. In line with this, the law has allowed for the establishment of special categories of visas for some health professionals. For example, trained nurses – in cooperation with local employment agencies and with the appropriate approval from the Federal Employment Agency – can enter Germany without prior recognition of their skills. The skills process can then be commenced from within Germany. Based on the key informant interviews conducted for the present study, this practice has been identified as effective, given that it offers to foreign workers the opportunity to gain further work experience in Germany, thereby facilitating the process of recognition once they apply for it.

Enhancing the Recognition Framework

Progress has been made in the recognition of foreign workers' skills and qualifications in Germany, and several areas have been identified where further developments could be considered, as outlined below.

Legislation

The Recognition Act and the Skilled Immigration Act provide a valuable legislative framework for the recognition of foreign qualifications in Germany. While the Recognition Act was designed to promote

[21] This information is based on the qualitative research undertaken.

[22] In German: Deutsche Fachkräfteagentur für Gesundheits- und Pflegeberufe.

greater consistency across the country, some differences in implementation and outcomes continue to be observed among and within the federal states (Sommer 2021; Lietz, Javier Alafont Montiel, and Müller 2015; Kovacheva and Grewe 2015). For instance, applicants holding a two-year specialist nursing qualification may receive recognition in some states but not in others. Exploring ways to further align recognition practices across all 16 federal states could contribute to enhanced transparency, while supporting more consistent opportunities for applicants and helping to ease administrative processes, particularly for those who relocate during the procedure.[23]

There continues to be potential for further refinement in the implementation of the Skilled Immigration Act (Duell and Vetter 2020). While the Act represents a significant step toward facilitating labour migration, its objective of simplifying the recognition process has not yet been fully realized. Strengthening coordination between immigration authorities and the relevant recognition bodies may help support more streamlined procedures. In addition, capacity constraints at immigration offices and foreign missions—such as extended visa processing times, limited appointment availability, and administratively complex procedures for applicants from non-EU countries—continue to pose challenges to the Act's overall effectiveness (OECD 2020).

Bilateral agreements, such as those established under the Triple Win Programme, have played a constructive role in helping to address labour needs in Germany. At the same time, continued efforts may be needed to respond to ongoing shortages in certain sectors (Kovacheva and Grewe 2015; Angenendt, Bither, and Ziebarth 2015). International recruitment supports staffing strategies; however, current recruitment levels remain modest in relation to projected future demand. For example, the German nursing sector is anticipated to experience a shortfall of between 100,000 and 200,000 nurses by 2025, with this gap potentially increasing to 520,000 by 2030. As a result, an estimated 9 per cent of nursing vacancies may remain unfilled—rising to a projected 12 per cent by 2030 (Reiff, Gade, and Böhlich 2020; Bonin, Braeseke, and Ganserer 2015; Prognos AG 2012).

Human and financial resources

There may be value in further supporting procedural efficiency by strengthening the human and financial resources available to competent authorities and consulting institutions. These bodies carry out their responsibilities with care and professionalism, though limited staffing and funding can sometimes make it more difficult to consistently meet procedural timelines. Enhancing capacity where needed could help facilitate smoother processing. Additionally, continued efforts to improve transparency and coordination across federal states—while respecting diverse legislative frameworks, data protection requirements, and infrastructure needs—could contribute to a more cohesive and accessible recognition system nationwide.

Costs and financing assistance

While the recognition process does involve certain costs, these can vary depending on an applicant's individual circumstances. In some cases, particularly for candidates from non-EU countries, the total expenses may be higher. For these individuals, covering such costs can be especially challenging, as their income levels may vary (Lietz, Javier Alafont Montiel, and Müller 2015). However, support mechanisms are in place to help alleviate these financial burdens. Expanding awareness of existing funding opportunities and simplifying access to them could further strengthen the system's

[23] An example of progress can be found in the State of Bavaria: its seven administrative districts and the responsible Ministry have established a uniform application form for health professions, as of January 2021.

inclusiveness. For example, financial assistance is available for compensatory measures, provided they are offered by training providers certified under the Accreditation and Admissions Ordinance (AZAV). [24]

Further enhancing accessibility and support in the recognition process

In addition to financial considerations, applicants often seek additional guidance in identifying the appropriate authority responsible for content-related equivalence assessments. While the Recognition Act clearly designates the bodies tasked with determining equivalence, it does not yet specify those responsible for implementing compensatory measures (BIBB 2021). This presents an opportunity to strengthen support systems for applicants, who are often left to organize these measures independently based on the notice of equivalence. Enhancing coordination and expanding the availability of preparatory courses, aptitude tests, and knowledge tests would greatly benefit applicants navigating this stage.

Private sector involvement

The role of the private sector in the recognition process for migrant workers, including those in the health sector, is gradually evolving. Recent initiatives indicate increasing interest and suggest potential for deeper collaboration. Bilateral programmes such as the Triple Win Programme illustrate how collaboration between public and private actors can effectively connect applicants with specific employers, such as hospitals. In cases where full equivalence of qualifications is not initially established, private sector actors may also support migrant workers by providing vocational training opportunities or employment pathways that facilitate integration into the workforce.

A recent pilot initiative led by the Federal Ministry of Health under the Konzertierte Aktion Pflege (Concerted Care Action) aims to consolidate nurse recruitment through private healthcare providers via a single-channel approach (BMG, n.d.). The project seeks to establish a seal of quality for skilled worker recruitment in the private care sector. In collaboration with federal states, the initiative also focuses on improving recognition procedures for foreign qualifications and supporting complementary measures, such as qualification programmes abroad and the acquisition of German language skills. These efforts are intended to help streamline future recognition processes for foreign-trained nursing professionals.

Recognizing the skills of migrant women

Migrant women bring valuable skills, perspectives, and potential to the German labour market. Many arrive through family reunification and initially focus on caregiving responsibilities. In these cases, authorities often provide important support in areas like health, language, and parenting. Building on this foundation, there is great potential to further support these women by actively recognizing their professional qualifications and aspirations.

Many migrant women hold academic degrees or vocational training, even if they have limited formal work experience. While this can create some gaps compared to German reference occupations (BIBB 2020), it also creates an opportunity for tailored support—such as language training, practical experience programs, and access to compensatory measures. With the right resources, these women can successfully transition into skilled professions, contributing meaningfully to the workforce. By

[24] In German: Akkreditierungs- und Zulassungsverordnung Arbeitsförderung (AZAV). In order for a foreign institution to be accredited, it needs to submit an application with the expert body that is the AZAV. This includes the provision of supplementary documentation. Once submitted, the documents are examined by a lead auditor, who provides feedback to the institution regarding points for improvements. The lead auditor then schedules an on-site assessment of the institution – if the latter has various sites, one or more is randomly picked. Following the on-site assessment, the institution again receives points for improvement, if applicable. Finally, the auditor submits a report to the AZAV, which checks whether or not all the requirements are met; if so, the institution receives an approval certificate for a period of five years. Once this certificate has been approved, annual monitoring is undertaken by the lead auditor of AZAV (AZAV, n.d.).

expanding affordable training, flexible childcare, and clear guidance, their talents—especially those from outside the EU—can be more fully realized (Kluß and Farrokhzad 2021; Duell and Vetter 2020; Kovacheva and Grewe 2015; Leuven and Oosterbeek 2011; Büchel and Battu 2003).

At the same time, addressing structural barriers such as discrimination can further support equal access to opportunities. While challenges exist, many migrant women succeed in entering the workforce, particularly in health and care sectors. These fields, though demanding, highlight their strong engagement and resilience. In fact, women—both migrants and nationals—are notably present in regulated professions, showing high levels of commitment to formal training and qualification (Kluß and Farrokhzad 2021).

For women who migrate independently for employment, supporting family reunification can strengthen retention in the workforce. Many are unable to bring their children due to financial constraints, but with supportive policies and access to resources, they can more easily balance work and family life (Kniejska 2016; Abizadeh et al. 2013; Orozco 2010; Yeates 2005).

Conclusions

Over the past decade, Germany has taken significant steps to improve the recognition of foreign professional qualifications. The implementation of the Recognition Act, along with the establishment of specialised agencies, has contributed to greater consistency, transparency, and accessibility—particularly in the health sector. These developments reflect a sustained commitment to enhancing pathways for skilled international professionals. In light of evolving healthcare needs, there may be value in exploring greater flexibility and inclusivity within Germany's legislative framework. As the demand for qualified health professionals continues to grow, fostering a welcoming and supportive environment for international workers becomes increasingly important.

Periodic reviews of bilateral agreements—guided by the lived experiences of migrant workers—can help ensure that policies remain relevant and responsive to practical challenges. Retention outcomes may also be enhanced by facilitating family reunification, particularly for non-EU nationals, and by strengthening access to childcare, financial assistance, and clear, accessible information on labour rights.

A recognition process that is consistent and efficiently administered can ease the entry of international professionals into the healthcare system. Simplified procedures, supported by adequate financial and human resources for the relevant authorities, could contribute to reduced waiting times and improved applicant experiences.

Migrant women often navigate additional challenges, including caregiving responsibilities, limited language proficiency, and financial constraints. Targeted qualification programmes—combined with financial support and access to childcare—can promote broader participation in the health workforce. Expanding access to maternity protections, parental leave, and flexible, no-cost language learning opportunities, particularly through digital platforms, may further support integration.

Inclusive recruitment approaches that consider pathways for women without formal qualifications can also create opportunities for meaningful engagement in the health sector. Such measures not only contribute to workforce development but also foster social inclusion.

Coordinated efforts between public institutions and private sector stakeholders are key to supporting integration. Investments in digital infrastructure may enhance cooperation, streamline communication, and improve overall transparency.

Professional associations are well-positioned to offer guidance to migrant workers when equipped with timely, targeted information. Employers can complement these efforts by establishing internal support structures to assist with orientation and workplace integration. Active engagement with migrant organisations, alongside well-considered incentives, can further strengthen the sustainability and inclusiveness of these initiatives.

International cooperation remains essential to ensuring smooth migration pathways. Enhancing information flows with countries of origin—particularly around recognition procedures and visa requirements—can help reduce administrative delays and financial burdens for prospective migrants.

Targeted outreach in non-EU countries could also highlight the recognition of vocational qualifications in Germany, especially in fields such as elder and home care, while promoting awareness of recognised training institutions. Improving access to language instruction abroad—ideally supported through public or partnership funding—can further ease the transition process.

Finally, expanding structured migration initiatives such as the Triple Win programme to include additional partner countries could offer more predictable and mutually beneficial pathways for skilled healthcare professionals seeking to contribute to the German health system.

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Italy

The Italian health system at a glance

Article 32 of the Italian Constitution considers health to be a fundamental right of the individual and in the interest of the community. The implementation of this principle is jointly the responsibility of the State, especially the Ministry of Health, and of the regions. The prevention, care and rehabilitation services are mainly provided by the National Health Service (SSN). Most of the services are directly run by the SSN and partially by private health entities, through specific financial and technical agreements. There are 191,000 beds available in hospitals, of which 23.3 per cent are offered by the private accredited structures. The SSN is mainly financed by taxes and, for specific services, by income-based contributions (so-called "tickets"). It is important to note that additional medical services are provided by private initiatives that are not included in the SSN but rather financed by patients who pay as well as by voluntary insurance.

Estimates show that health expenditure represented 9.4 per cent of Italian GDP in 2021; other EU countries invested more in this area by comparison, such as Spain (10.7 per cent), Denmark (10.8 per cent) and France (12.3 per cent) (OECD, n.d.-a).

According to the Ministry of Health, there are currently 30 recognized health professions (MoH, n.d.-a); the exercise of each requires registration with its respective professional association. There are professional associations for surgeons and dentists; veterinarians; pharmacists; psychologists; chemists and physicists; biologists; nurses; midwives; as well as for technical health professions. There are also the auxiliary health professions and healthcare operators for which there is no obligation to register as a professional.[25]

There are no detailed data on the number of migrant health workers present in Italy. According to the Association of Foreign Doctors in Italy (AMSI), there were around 77,500 foreign citizens in Italy with medical qualifications in 2023; this number includes 22,000 doctors, 5,000 dentists, 38,000 nurses, 5,000 physiotherapists, 5,000 pharmacists, 1,000 psychologists, and 1,500 podiatrists, radiology technicians, biologists, chemists and physicists (Consulcesi 2023). There is a lack of data with regard to the nationality of these health workers – specifically, the number of EU citizens among them who are subject to different rules than those applicable to health workers migrating from non-EU countries.

According to data from the Ministry of Health, 72.5 per cent of SSN staff were medical personnel in 2021. Most of them are nurses (59.2 per cent), followed by doctors and dentists (22.9 per cent). The gender distribution is significant: women workers represent 69.1 per cent of the medical personnel, with a striking majority among nurses (77.8 per cent) (MoH 2021). There is no split data on the number of foreign-born health staff in the SSN. Research conducted by UECOOP (2018), using data from the OECD, highlighted that there were 22,232 foreign-born nurses – equivalent to 5 per cent of the total nurses operating in Italy; half were migrants from Eastern countries such as Romanians (11,204), Poles (2,374) and Albanians (1,032), while among the other most represented communities were Indians (1,399) and Peruvians (1,080). Migrants from African countries numbered just 433, less than 2 per cent of the total number.

The identification of any future skill requirements for health professions is vital to the successful planning of resources to insert into the education system each year. Based on the results of the EU's Joint Action on Health Workforce Planning and Forecasting (2013–2016), the Ministry of Health has adopted a forecasting method that can identify the number of health professionals necessary to maintain the entire health system in a medium- to long-term perspective (see box 9).

[25] For a detailed list, please see: Riconoscimento qualifiche professioni sanitarie (salute.gov.it)

▶ Box 9: Italian Ministry of Health's workforce forecasting method

The process is conducted every year (by the end of April) and involves the collaboration of the Ministry of Health; the Ministry of Education with academic institutions; regions and autonomous provinces; professional orders as well as health workers' associations.

The forecast model is a quantitative model of the "stock and flows" type, in which the quantities expected in a future period of 20 years are determined by the difference between the quantities currently present in the system (stock) and the flows that are expected to be "inbound and outbound" in future years (flows). The forecast is annually updated. The main variables of the model are:

- the current and future population (as it varies, over the 20 years of projection considered, in number, age structure and composition by gender);
- the demand for professionals per 100,000 inhabitants (indicating the quantitative level needed to guarantee the care, assistance and prevention services);
- the stock of active professionals (namely, the number of health professionals estimated to be active in the labour market);
- the inflows (estimated on the basis of the number of students in training, correlated with the academic success rate and with the actual average duration of studies, as well as the professionals who can be activated); and
- the outflows (namely, the number of retirements estimated with consideration of political scenarios and life expectancy), using data from the Italian National Institute of Statistics.

It should be noted that the forecasting model does not separately consider the impact of health labour migration in terms of existing stock and as part of the inflows.

Source: Author's own work, based on data from the Ministry of Health.

The Italian migration system, established in 1990 by Law No. 39/1990 (known as "the Martelli law"), is demand-driven, as it is based on the yearly labour market needs that can be addressed by migrant workers (quotas). The Ministry of the Interior and the Ministry of Labour and Social Policies collaborate on the definition of the annual labour migration quotas. The entry quota system applies to all occupational profiles, including health professions – the only exception being professional nurses, who can always enter Italy provided they are recruited by public or private health services (Article 27 of Legislative Decree No. 286/1998). During the crisis generated by the COVID-19 pandemic, the Government established a derogation for foreign health staff to practise in Italy and be contracted until the end of 2022,[26] but they had to have a permit of stay that was valid for employment[27] – this provision clearly did not apply to professional nurses, who have been excluded from immigration quotas since 1998.

As the programming and management of health services are a shared competence of the State and the regions (along with the two autonomous Provinces of Trento and Bolzano), it is interesting to examine how it is organized in one of the decentralized institutions (see the case study of the Piedmont Region in box 10).

[26] This temporary authorization did not imply the recognition of medical qualifications as determined by the Ministry of Health.
[27] See Article 13 of Legislative Decree No. 18/2020.

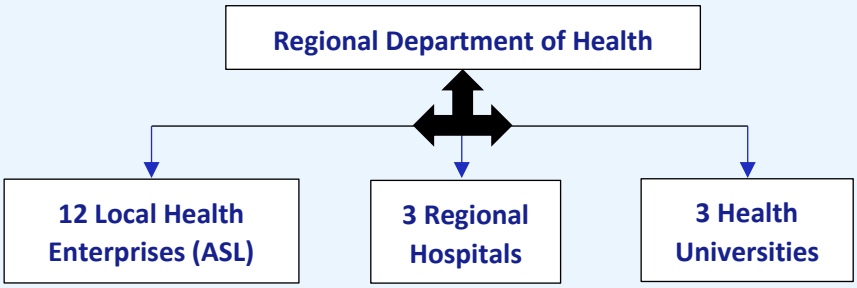
Box 10: Case study: The Health System in the Piedmont Region, Italy

Piedmont is one of the 20 regions dividing Italy in terms of the management of public services.

It has an area of 25,402 km² (8.4 per cent of the country) and a resident population of 4,273,210 (7.2 per cent of the national population); foreign-born residents make up 9.5 per cent of the population.

The demographic indicators of the Region are in line with those at the national level. In particular, the median age, estimated at 47.5 in 2021, confirms the general trend of an aging population and the related increase in demand for health and social services. The fertility rate is 1.24 per woman (in line with the Italian average). The natality index is 6.5 per thousand, while the mortality index is almost double: 12.3 per thousand (ISTAT, n.d.-a).

As already mentioned, the health system is a shared responsibility of the national government and of the regions. The Ministry of Health is responsible for setting and ensuring the minimum standards (Essential Assistance Levels, LEA) for healthcare services and benefits nationwide. The regions autonomously plan and manage the health services in their own territory. The structure of the health system of the Piedmont Region is shown in the following flow chart.

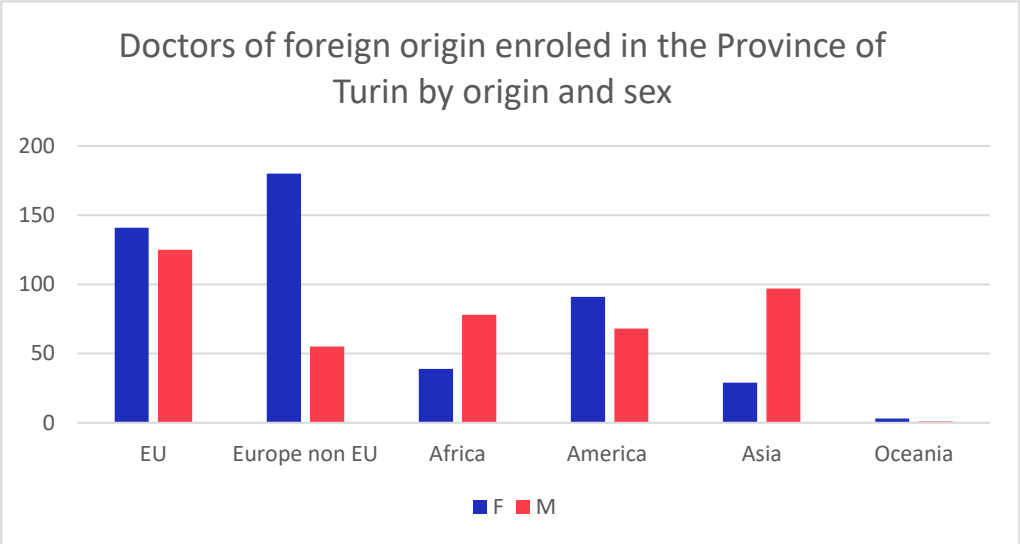


The annual budget of the health system in Piedmont is €8 billion.

The number of workers in the sector was 60,148 in October 2021, of which 9,163 were doctors (48 per cent being women) and 23,663 nurses (85 per cent women). According to data provided by the Health Department of Piedmont Region, staff of foreign origin number 3,139 – of which 2,582 are women and 557 men. Many doctors of foreign origin – both men and women – are in managerial positions;[1] a significant number come from EU countries (20 from Germany, 18 from France, 19 from Romania and 17 from Greece), but also non-EU origin countries (27 from Albania, 24 from Iran, 23 from Switzerland and 10 from the United States). These data are particularly relevant in the context of integration. While EU citizens benefit from free movement and the right to work, access to managerial positions within the Italian public sector generally requires Italian citizenship, which may present additional barriers for foreign-born workers.[2]

There is an average of 3.5 doctors and 4.8 nurses per 1,000 inhabitants. The rate of doctors is below the national average (3.9), but in line with the EU average (IRES 2019).

Many doctors operating in the Region were born abroad.[3] According to data provided by the Provincial Register of Practitioners of Turin, there are 907 foreign doctors enrolled. As detailed in the following graph, the majority come from EU countries, followed by other European countries and Asia. Women doctors are a majority when coming from EU and other European countries, as well as from America, while most doctors coming from Africa and Asia are men. This gender distribution could be attributed, among other factors, to socio-cultural influences and access to educational opportunities.



Notes: [1] Managerial positions might involve being responsible for big organizations such as hospitals and Local Health Agencies (ASL), or directing departments, services or units. They include pharmacists, clinical engineers, purchasing managers, technical department managers, information systems managers, human resources managers, risk managers and so on. [2] Migrants can apply for Italian citizenship after ten years of regular residence in the country; the duration is decreased to five years in the case of foreign nationals being granted the status of stateless persons or refugees and to four years for EU citizens. [3] There is no information on the share of foreign-born doctors who studied in Italy or those who studied abroad and had to undergo the recognition procedures.

Source: Provincial Register of Practitioners Turin.

The working conditions of medical staff

Many regions in Italy are facing shortages of doctors, nurses and midwives. This is largely due to structural challenges, as the education system struggles to meet the growing demand for healthcare services and replace retiring personnel. Additionally, the medical profession is becoming less attractive, further exacerbating the issue.

To assess whether working conditions influence the career choices of medical professionals, ANAAO-ASSOMED conducted a survey in November 2023, involving 1,117 medical doctors, 47.9 per cent of whom were women (ANAAO-ASSOMED 2023). The findings revealed that 96.5 per cent of respondents believe they are subjected to an excessive workload, with 71 per cent required to work beyond their contractual obligations. Among them, 31 per cent reported working up to 150 additional hours per year, 21 per cent between 150 and 250 extra hours, and 19 per cent exceeding 250 additional hours annually.

Furthermore, 72 per cent of respondents have considered leaving their current job in the National Health Service (SSN), either to move abroad, transition to general medicine, or shift to the private sector. These findings highlight the significant impact of working conditions on the retention and career decisions of medical professionals in Italy.

Many Italian regions are struggling to ensure the minimum level of healthcare services, particularly in emergency care, leading to long waiting times before patients receive medical attention. These challenges may have contributed to a growing lack of trust among patients and their families, sometimes escalating into physical aggression against doctors and nurses.

To address acute domestic workforce shortages, national and regional authorities have implemented various strategies, including:

- recalling retired doctors to fill workforce gaps;
- extending the retirement age for medical doctors to 72 years;
- employing "medici a gettone" (on-call doctors), who can be contracted in cases of necessity and urgency (these doctors are typically registered with cooperatives and adhere to specific Ministry of Health Guidelines); and recruiting foreign-trained health professionals.

How to become a medical doctor in Italy

According to data from the Italian National Institute of Statistics (ISTAT, n.d.-b), there were 242,721 doctors in 2021, with a rate of 4.1 per 1000 inhabitants (the average rate is 3.5 at EU level). The training process for the profession of doctor is quite complex – the university course lasts six years. Until 2024, access to university in Italy was restricted by an annually fixed quota, with admission determined through an entry test organized by the Italian Ministry of University and Research (MUR). However, this system has recently been reformed. Starting from the 2025/26 academic year, the fixed quota system has been formally abolished. Instead of a pre-admission test, students can now enrol freely in university programmes. However, they should successfully complete the first semester by passing exams and acquiring enough credits to continue their studies. This new system, known as the "filter semester", acts as a selection phase within the first months of study rather than before admission. The reform may face delays due to the need to establish standardized evaluation methods across all universities.[28]

After obtaining their degree, graduates need to register with the Professional Practitioners Order (Ordine dei Medici Chirurghi) in their province of residence. They can then follow one of two paths: a training course in general medicine (which last three years and leads to the profession of general practitioner, namely family doctor), or a medical specialization school (lasting four or five years depending on the specialty). Every year the MUR launches several scholarships for which the doctors can compete; the winners are employed in the medical structures until the end of the scholarship. EU citizens can access the medical specialty schools under the same conditions and with the same requirements as Italian citizens. Non-EU citizens and holders of a residence card, or a residence permit for employment or self-employment, whether for family reasons, for political asylum, for humanitarian asylum or for religious reasons, are all allowed in the competition on equal terms with the Italians.

With their medical qualifications acquired, doctors may wish to move abroad to practise their profession. In order to benefit fully from freedom of movement within EU and the European Free Trade Association (EFTA) countries (namely Norway, Iceland, Liechtenstein and Switzerland),[29] they may request from the Ministry of Health a certificate of conformity and of good standing that can be presented to the authorities of the country in which they intend to work.

The EU Directive 2005/36/EC on the recognition of professional qualifications[30] includes, among others: nurses, midwives, doctors (basic medical training, general practitioners and specialists), dental practitioners, pharmacists and veterinary surgeons. To facilitate the recognition of regulated professions, the European Union has introduced the European Professional Card (EPC) which allows nurses responsible for general care, pharmacists and physiotherapists to apply online for recognition

[28] The Government has been delegated by law (Disegno di legge S. 915) to reform the access system to health professions. The new mechanisms have been designed and put in place by the Italian Ministry of University and Research (MUR) (MUR 2024).

[29] Citizens of EU member states can move freely within the Union without "any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment" (Article 45 of the Treaty on the Functioning of the European Union).

[30] The Directive was amended by Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013.

of their qualifications in other EU countries – this electronic procedure may be extended to other professions in the future.

An Italian citizen who has gained their qualification abroad is required to first acquire recognition of it from the Ministry of Health before they can register with the National Register of Practitioners or Nurses and practise the profession. The procedure of recognition is expected to be completed within four months, but delays are possible as the Ministry of Health needs to convene the Conference of Services, which involves other Ministries, regions/provinces and professional registers.

An EU citizen who graduated in an EU country can reside and work in Italy; however, in order to exercise their profession in Italy, their degree needs to be recognized by the Italian Ministry of Health,[31] which regulates medical professions such as surgeons and physicians, psychologists, pharmacists, veterinarians, nurses and midwifes, rehabilitation, technical and auxiliary health professions (MoH, n.d.-b).

In order to be added to the National Register of Practitioners and to practise medicine in Italy, a doctor is required to first pass an examination on the Italian language and on the standards and policies which regulate the practice of medical professions in Italy. The same procedure applies to EU/EFTA citizens whose medical qualification was obtained outside the EU/EFTA – a specific procedure is envisaged in case the said qualification has already been formally recognized by one of the EU/EFTA Member States.

An interesting opportunity is offered to EU/EFTA citizens whose profession is surgeon, specialist doctor, pharmacist, veterinary surgeon, dentist, specialist dentist, nurse or midwife: they can provide occasional professional services in Italy, without settling permanently and without being added to the Italian Register for their profession. They must be in possession of a qualification obtained in one of the EU/EFTA countries and are required to communicate in advance to the Ministry of Health the date, venue and motivation of the service they are offering, as well as have professional indemnity insurance coverage.

It is also worth mentioning that all EU citizens who have their qualifications recognized in Italy can participate in the competitions aimed at recruiting health staff for the public health system.

The research found that every year, numerous doctors leave Italy to work abroad; yet the data relating to Health Workforce Migration extrapolated from OECD Statistics (OECD, n.d.-b) does not seem to support the hypothesis that the phenomenon of doctors emigrating abroad can be considered a notable brain drain. It may be more pertinent to speak of "physiological" movements of medical personnel, also linked to professional choices and personal motivations. It is estimated that an average 1,100 doctors emigrate annually.

How to become a nurse in Italy

A three-year degree in Nursing or Paediatric Nursing at the Faculty of Medicine and Surgery is necessary to exercise the health profession of Nurse and Paediatric Nurse. The access to these university courses is limited and the number of places available is defined each year by the Italian Ministry of University and Research (MUR). Therefore, to enroll, aspiring students need to pass an entrance exam.

After obtaining their qualification, a graduate nurse is required to join one of the Provincial Nursing Professions Orders (FNOPI, n.d.). They are given the opportunity to continue their studies to specialize

[31] The EU Directive 2005/36/EC sets the principle of free circulation and the establishment of many regulated professions, but each Member State is directed to check the equivalence of the studies, as stated in Article 21: "Each Member State shall recognize evidence of formal qualifications as doctor giving access to the professional activities of doctor with basic training and specialized doctor, as nurse responsible for general care, as dental practitioner, as specialized dental practitioner, as veterinary surgeon, as pharmacist and as architect ..."

in certain areas (geriatrics or psychiatry, for instance) and eventually enroll in a PhD programme that can provide the skills for executive functions. Each year, some universities offer a competitive admission process for a three-year PhD programme in Nursing Sciences, designed to equip candidates with the skills required for executive roles (for example, the Universities of Rome Tor Vergata, of L'Aquila or of Florence[32]).

If an Italian citizen has acquired their nursing degree abroad, it is necessary to apply to the Italian Ministry of Health for recognition of said qualification, before registering with the competent Provincial Nursing Professions Order.

As with the other medical professions, EU citizens who have attained their nursing degree abroad can practise their profession in Italy. After applying to the Ministry of Health to have their professional qualification recognized and an equivalence decree issued, the nurse is required to take an exam to assess their knowledge of the Italian language before finally registering with the competent Provincial Nursing Professions Order.

If an Italian citizen would like to practise nursing in another EU/EFTA country, the Ministry of Health can issue a certificate of professional integrity (good standing). This document confirms that the registered nurse is eligible and compliant with the regulatory standards of the nursing profession. For countries outside the EU/EFTA, the certificate can be issued by the specific Professional Order (MoH, n.d.-c).

The recognition process for doctors and nurses

The recognition process varies according to the place in which the medical degree has been obtained; the various possible options are outlined below.

a) Qualification in Italy

A medical degree conferred in Italy does not require recognition. After the degree, the doctor can enroll in the National Register of Practitioners.

It is important to note that foreign-born citizens, instead of applying for the recognition of their qualification through the Ministry of Health, can decide to ask an Italian university for the declaration of equivalence. As was indicated during the interviews conducted for the present study, the Didactical Committee of the contacted university may decide to offer prescriptions for earning additional credits in specific learning areas, if these are deemed necessary to reach equivalence. Once these are integrated, the applicant is entitled to a full Italian qualification. Since universities are autonomous and their inner workings not public, there are no statistics on this approach.

b) Qualification in an EU country

Pursuant to the EU Directive 2005/36/EC and the subsequent EU Directive 2013/55/EU, as applied in Italy through Legislative Decree 9 November 2007, No. 206, amended with Legislative Decree 28 January 2016, No. 15, the qualification needs to be recognized by the Italian Ministry of Health. Before registering with the relevant professional order, the applicant is required to prove they have adequate Italian language skills.

c) Qualification in a country outside the EU

The applicant needs to have a valid residence permit and their qualification must be recognized by the Italian Ministry of Health, according to the procedure detailed in box 11. There are two ways to have the

[32] The full list of available PhD courses can be found on the website of the Italian Ministry of University and Research (MUR).

foreign degree recognized and thereby become eligible to register with the relevant professional order, both described below.

- An Italian university assesses the equivalence of the foreign qualification to that issued in Italy, and may request the integration of additional modules before certifying equivalence. The result is the issue of an Italian degree, requiring no further recognition process. This procedure is not always easy, as equivalence could be totally refused, or when additional courses are requested, it may prove impossible to find a placement in the universities due to the annual fixed number for the Health Faculties.
- The Ministry of Health considers the qualification and, in consultation with other relevant institutions (such as ministries and professional orders), decides one of the following:
  - The degree is recognized: the applicant should register at the professional order within two years, otherwise it will lose validity.
  - The recognition requires that certain compensatory measures be prescribed, in order to first integrate missing competences; these may consist of an adaptation internship or an examination.
  - The application is rejected: the applicant cannot register with the Italian professional order and cannot practise in the country. Normally the rejection is final, unless the reasons for it are overcome.

If the degree conferred in a country outside the EU has already been recognized by an EU country, the degree holder should apply to the Ministry of Health for recognition of the qualification with the same procedure established for EU qualifications (Legislative Decree 9 November 2007, No. 206).

Egyptian doctors are a special and unique case: based on a bilateral agreement signed on 14 April 1951 and still operational, they are allowed to register directly at the Italian professional order without the recognition of their qualification by the Ministry of Health – the only condition is that the applicant has a regular residence permit, unless they hold Italian or EU citizenship (FNOMCEO 2021). They need to register to the professional order to practise and should demonstrate language proficiency and knowledge of the professional rules.

The research has shown that Italy has a consolidated and detailed system for the recognition of qualifications held by foreign-born citizens in the field of health. The procedure is demanding, time consuming and potentially expensive. In fact, while the direct costs are modest – a mere €16 state stamp – the indirect costs may well add up to more than expected. All the documents to be presented to the Ministry of Health need to be translated into Italian, and the translation validated, either by the Italian consular services in the origin country or in Italy by the courts. In addition, if the applicant turns to the services of a private agency for help with the recognition process, the costs could be very high, as these businesses operate in the free market and without a price ceiling.

To support migrant workers in the process of having their skills and qualifications recognized, an interesting project has been implemented in Turin since 2008 (see box 12).

Box 11: The "Extra-Titoli" project in Turin, Italy

This project offers services to residents in the Piedmont Region who have migrated from EU and non-EU countries with qualifications and skills acquired in their respective countries of origin, including in the field of medicine. Initiated in 2008, with the support of the Municipality of Turin and financial contribution from the European Social Fund, the project offers the following services:

- the recognition in Italy of academic or professional qualifications;
- the continuation of studies through recognition of training credits; and
- support for labour market integration.

Source: City of Turin 2011.

Non-EU migrant health workers: Procedures and challenges

For all foreign health workers, the first requirement is compliance with Italian immigration laws, namely that they are in possession of a valid residence permit. It should be noted that the immigration of professional nurses is not subject to the limits of the annual quota (due to shortages), as these workers can be contracted directly for work in public and private care institutions (Article 27 r–bis of Legislative Decree 25 July 1998, No. 286). After five years of continuous residence in Italy they are entitled to apply for the EU residence permit; this allows them to be employed or self-employed in any other EU Member State (Article 14 of the EU Council Directive 2003/109/EC of 25 November 2003).

According to the existing norms, health workers who are not citizens of a Member State or in possession of an EU residence permit are not entitled to take part in the recruitment procedures for public institutions.

Pursuant to the European Directive 2011/98/EU, the Legislative Decree 4 March 2014, No. 40 has introduced the single work permit that allows foreign nationals to reside and work in the country while enjoying the same rights as native workers (in terms of working conditions, education and vocational training, social security and so on).

Migrants become eligible to apply for citizenship after ten years of regular residence in the country. This period is reduced to five years in the case of stateless persons or refugees, and to four years for EU citizens.[33]

The other formal requirements for foreign health workers to practise in Italy are:

- the recognition of their professional qualifications;
- the assessment of their Italian language proficiency;
- the assessment of their knowledge of rules and procedures related to the profession in Italy; and
- their enrolment in the competent professional order.

The impact of the COVID-19 pandemic on the Italian health system

The crisis generated by the COVID-19 pandemic had a serious impact on Italy's national health system. The increased demand for healthcare, especially in public hospitals, prompted urgent measures from the Government that resulted in important changes in the consolidated modalities for the exercise of health professions in the country. Some measures were long lasting and immediately operational;

[33] The acquisition of Italian citizenship is regulated under Law 5 February 1992 No. 91 and implementing regulations No. 572/93 and No. 362/94.

others were aimed at addressing future needs; others still were adopted on a temporary basis for the duration of the crisis. The three categories are detailed below.

- **New simplified rules for the access to health professions**

  The old procedure envisaged that after their medical degree, a candidate to the profession had to take a formal state-managed examination and attend a practical training with a final assessment, before registering with the professional orders. Due to the severe shortage of doctors, the Legislative Decree 17 March 2020, No. 18 (known as the "Cura Italia" law) abolishes the formal exam and the practical training. In reality, there was a reshuffle of the university medical courses with the incorporation of practical training into the six-year course and a double exam at the end. This modification brought about structural changes that have continued after the pandemic.

- **Increasing number of posts for the specialization of doctors**

  Every year the Italian Ministry of University and Research (MUR) opens a competition for scholarships for the specialization of doctors. The number was considered insufficient to meet the needs of the health system. To address this situation, for the academic year 2020/21, the number of scholarships was increased to 17,400 from 14,455 in the previous year and 8,935 in the year 2018/19. The trend is still continuing: for the academic year 2021/22, the number of scholarships issued was 14,378, and for 2022/23 they numbered 14,579. The impact of this decision will be observable after the three-year duration of the medical specialty courses.

- **Emergency temporary measures**

  An additional extraordinary measure was the authorization given to the regions (including the autonomous Provinces of Trento and Bolzano) to allow the temporary exercise of health professions by migrant workers regularly present in Italy and with a residence permit valid for employment. These workers could be recruited for services linked to the COVID-19 pandemic based on their professional qualification obtained abroad; the temporary authorization meant that no formal recognition was needed.

  It is important to underline the fact that this procedure did and does not imply the recognition of the qualification or a declaration of equivalence, each of which are subject to specific procedures under the competence of the Ministry of Health and the universities respectively.

  Professionals interested in participating are requested to apply to the region or province concerned, presenting a certified copy of the certificate of registration in the professional order of the country of origin and other prescribed documents. All documents drawn up in a foreign language need to be accompanied by a translation into Italian – the translation must be certified as conforming to the original text from the Italian consular authority in the country where the document was issued, or must be sworn or certified by an Italian court. If there is no professional order of reference in the country of origin, the applicant should present, together with the application, a copy of the declaration of value,[34] issued by the Italian consular services present in the country where the qualification was issued.

[34] The declaration of value must certify: (a) that the qualification was issued by a competent authority in the country of achievement; (b) the requirements for access to the course (basic schooling); (c) that the qualification is for the exercise of the profession in the country where it was issued; (d) the duration of the degree course; (e) the authenticity of the signature affixed to the qualification paper and the regularity of it; and (f) the professional activities that the qualification allows to exercise in the country of achievement.

Once the requirements are considered by the competent authority (whether regional or provincial) to be met, the applicant is authorized to exercise their profession until at least the end of 2025.[35]

According to data from the Piedmont Region, many of the requests for the temporary authorization are made by nurses. In the first nine months of 2021 there were 103 applications; the majority were from Romania, followed by Albania, Brazil, India, Philippines and Morocco.[36]

The gender dimension of health labour migration in Italy

There are many aspects that a consideration of the gender dimension can involve; in the case of Italy, the analysis has been focused on leadership and the gender pay gap, both detailed below.

Leadership

Globally, women represent 70 per cent of the global health workforce but occupy only 25 per cent of senior positions (WHO 2019). In Italy, the situation is evolving, with increasing numbers of women in managerial positions, but still limited representation in the professional orders and sector associations.

- **Managerial positions**

  A survey conducted in February 2021 by the Federation of Italian Health Enterprises and Hospitals (FIASO) reveals that women represent 18.2 per cent of CEOs in the ASL (Local Health Enterprises) and Hospitals. This percentage, though limited, nevertheless shows progress from the 8.5 per cent recorded in 2008 (*Quotidiano Sanità* 2021). The presence of women in other managerial positions appears to be greater, even if it does not reflect the dimension of the workforce. For example: women represent 35.1 per cent of the directors of administrative services in the health sector, yet they make up 72.1 per cent of the workforce in these services. A similar situation is observed in health services, where 32.2 per cent of directors are women, compared to 68.7% of the workforce (MoH 2019).

- **Representation**

  Two women out of 19 are members of the Governing Body of the National Federation of Medical Orders (FNOMCEO, n.d.). At the provincial level, there are 11 women elected as chairpersons of the Medical Orders (out of a total of 106) (FNOMCEO 2020). The role of women is greater in the National Federation of Orders for Nursing Professions (FNOPI): for the period 2021–24: the Chairperson, the National Secretary and one member of the National Council (15 members) are women (FNOPI 2021). For the period 2021–25, not a single member of the Governing Body of the National Order of Pharmacists (FOFI) is a woman (FOFI, n.d.).

  One woman is present on the ten-member Board of Directors of ENPAM, the largest pension institution in the medical world (ENPAM 2020). Things are no different within the sector unions. No woman is present on the executive board of the Italian Federation of General Practitioners (FIMMG), the largest union of family doctors (FIMMG, n.d.). As for the National Association of Primary Hospitals (ANPO), one woman is present on its board, one woman on its six-member executive committee and two on its 24-member council (ANPO, n.d.).

[35] The extension of the period to the end of 2025 was introduced by Article 15 of the Law-Decree 30 March 2023, No. 34.

[36] Data collected through interviews with Piedmont Region's officers.

Gender pay gap

In Italy, a 2018 survey carried out among graduates, including in health faculties, shows that the net average monthly salary is approximately €1,387 for men and €1,283 for women (+8.1 per cent in favour of the former) (AlmaLaurea, n.d.). However, this difference is much smaller than that found for the totality of first-level graduates: men earn 18.0 per cent more than women (€1,334 and €1,131, respectively).

Compared to the previous survey, in real terms, the salaries of graduates in 2018 in the health professions were increasing for both men (+5.1 per cent) and women (+3.0 per cent), however the gap between the two is expanding.

Another key factor affecting wages is part-time work, which in the health sector is more common among women (28.6 per cent) than among men (23.6 per cent). In some areas there is a striking difference: for example, in Trento Province in 2017, 40 per cent of women worked part-time compared to just 7 per cent of men (Autonomous Province of Trento 2020).

The above data are based on information available from official sources and do not include the effective level of wages in the private sector; press reports mention cases of €7 per hour of work, in contrast to the minimum contractual wage of €18 per hour (*ANSA* 2019). No specific studies have been conducted so far in this area.

Other challenges

During the COVID-19 pandemic, women health workers faced an increased burden both at work and at home. The closure of schools and childcare services impacted their caregiving responsibilities, while they also made significant contributions despite the heightened risks posed by the virus.

In the earliest phase of the pandemic, health professionals were highly infected by the disease: more than 28,000 workers became contagious in the period February–April 2020, of which 45.7 per cent were nurses and physiotherapists and 14.2 per cent doctors. A large majority of those infected at work were women (71.1 per cent). Among nurses and other health technicians, more than three out of four complaints were from female workers. On the other hand, just 12.6 per cent of cases concerned foreign workers, among whom the percentage of women was 80 per cent (INAIL 2020).

It should be noted that there is a dearth of reliable, detailed data on the conditions of women migrant health workers, especially on challenges met in their social and work environment.

Conclusions

The process of recognition of skills and qualifications in the Italian health sector is well-established in terms of its regulations and procedures. The implementation of the latter presents several critical areas that deserve further attention and that are detailed below.

- **Duration of the qualification recognition process**. The normally envisaged duration for qualification recognition is four months, as indicated by the Italian Ministry of Health. Before adopting a decision, the Ministry of Health consults the Conferenza dei Servizi advisory body, which encompasses relevant stakeholders (professional orders; other Ministries like the Ministry of Education, Higher Education and Research; and the regions including the autonomous Provinces of Trento and Bolzano) in the area of qualification to be recognized. The stakeholders change depending on the subject. This is done periodically, but not frequently. The advisory body is only convened once a minimum number of applicants is reached. Since migrant health workers need the recognition to

register in the professional association and to start practising, any delay could be an additional burden for them. For this reason, it would be important to maintain the schedule of three months.

- **Results of the qualification recognition process**. There could be three outcomes of the recognition process: acceptance, rejection and compensatory measures to fill in identified qualification gaps vis-à-vis the Italian Higher Education System. While these measures have been designed to facilitate the migrant health workers' labour market integration in Italy, the additional training can be of long duration and expensive.
- **Alternative process of skills and qualification recognition**. There is an option to establish the equivalency of qualifications through a university. When rejecting an applicant, the university could explain that additional training needs to be undertaken to reach the necessary qualification level. In this context, it should be mentioned that the medical studies carried out in the origin country can be used as credits to obtain the Italian medical qualifications.
- **Language proficiency and knowledge of the professional regulation tests**. Once the recognition process is completed, and in order to be eligible to register with the respective professional order, migrant health workers are expected to demonstrate proficiency in the Italian language and knowledge of the professional and legal rules that guide their activities. The tests are free of charge and organized by the professional order. Nevertheless, the process requires time and resources; support measures to help migrant health workers better prepare for the test should be made available.
- **Direct and indirect costs**. Direct costs are limited to the payment of a small fee. However, indirect costs can have a significant impact; for example, compensatory measures to reach the necessary qualification level and language skills may come at a very high cost. Migrant health workers may have difficulties during the recognition procedures, and in some cases they may request the assistance of private service agencies that can handle such issues – and since there is no regulation or ceiling of their fees, the costs could be high. Possible solutions could include regulating the fees, offering financial assistance, and/or offering more services to migrant workers in this context.
- **Skills and qualification recognition of EU nationals**. The EU Directive 2005/36/CE facilitated the recognition process by allowing EU citizens to get their medical qualifications recognized by the Ministry of Health through a simplified procedure. It consists of a comparison with the Italian qualification requirements and there is no need to translate any credentials into Italian. EU citizens can participate in public competitions in the health sectors, including for executive positions.
- **Temporary authorizations that are due to expire**. The demand for health services as a result of the COVID-19 pandemic has led to the adoption of extraordinary measures to address the shortage of health staff. The contribution of migrant health workers has been extremely valuable. Based on Article 13 of Legislative Decree 17 March 2020, No. 18, thousands of non-EU citizens who hold work permits were hired with a temporary contract until the end of 2022. Due to their key contributions and the high labour demands that remain in the health sector, there could be value in transforming the temporary authorization to a permanent one.
- **The gender dimension**. Women migrant health workers account for an important share of the health workforce. The process of skills and qualification recognition is gender-neutral per se, but challenges could be encountered by women when it comes to

accessing it and covering its costs. There are no precise figures on the number of women who have accessed the recognition process in the health sector, whether it be via the Ministry of Health or via academic institutions. There are data on the gender pay gap in the health sector, though they are not disaggregated by migrant status. The extent to which this gap can be attributed to difficulties requires further research. In this regard, it is important to collect data, disaggregated by migrant status and at the sectoral level, in order to better understand labour market outcomes, including for women migrant workers.

The present study has identified two key areas for conducting further research, in particular:

- the employment of migrant health workers in the private health sector, and the implementation of skills and qualifications in terms of labour market outcomes; and
- their conditions of work, including the implementation of skills and qualification recognition, matching and development – especially for women migrant health workers.

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The Philippines

The Philippine healthcare system at a glance

The Philippines is a founding member of the World Health Organization (WHO). In 2019, through the approval of the Act No. 11223, the Philippines adopted the target of Universal Health Care (UHC). The law states that all Filipino citizens, including Overseas Filipino Workers (OFWs), shall be automatically enrolled in the National Health Insurance Programme. It also prescribes other complementary reforms in the health system (WHO 2023).

The responsible institution for the health sector is the Department of Health; it oversees the formulation, planning, implementation and coordination of national health policies and programmes, while assisting and collaborating with local communities, agencies and interested groups, including international organizations in activities related to health (DoH, n.d.).

Providing health services for all citizens of the Philippines is the scope of the National Health Insurance Programme, which is managed by the Philippine Health Insurance Corporation (PhilHealth), a tax-exempt, government-owned and controlled corporation attached to the Department of Health. The Agency establishes standards, rules and regulations necessary to ensure the quality of care. It formulates and implements guidelines on portability of benefits, cost containment and quality assurance, healthcare provider arrangements and a referral system (PhilHealth, n.d.).

The Human Resources for Health Network (HRHN) plays an important coordinating role in the field of health. It is a multi-sectoral organization composed of government agencies and non-government organizations, which aims to address the various issues and challenges confronting Filipino health workers in the country and abroad. It develops and recommends policies and programmes for both national and international health labour markets, addressing education and training, employment, recruitment and reintegration of health workers (PSI and ILO 2015).

The density of physicians (per 10,000 population), including generalists and specialist medical practitioners, was 7.9 in 2021 (WHO, n.d.-a). The density of nursing and midwifery personnel (per 10,000 population) reached 47.5 in the same year (WHO, n.d.-b).

In 2023, there were 159,283 registered physicians, but only 95,039 (or 59.70 per cent) of them were active; of the 951,105 registered nurses, only 509,297 (or 53.55 per cent) were active; and while 182,300 midwives were registered, only 64,475 (or 38.1 per cent) of them were practising (*GMA News Online* 2023). While doctors were employed equally in public and private institutions, 61 per cent of nurses and 91 per cent of midwives worked in public health services (WHO 2018).

In 2022, the country's total health expenditure amounted to 1.20 trillion Philippine pesos, a decline of -1.4 per cent from the 1.22 trillion peso expenditure in 2021. Total health expenditure as a share of GDP, at current prices, was 5.5 per cent in 2022 (PSA 2023a). Despite having achieved universal healthcare, the Philippines is still experiencing unequal access to health services. As such, the standard of public healthcare is generally less effective in the rural areas, where 55.6 per cent of the Filipino population lives (WHO 2018). 25 per cent of all barangays[37] do not have any health workers (HHRDB 2020).

The Philippines' healthcare system is a mix of public and private sectors, with a significant reliance on private healthcare providers. Almost 65 per cent of the hospitals are privately owned: in 2015, of the 1,195 hospitals, 772 were private and 423 public (PSA 2020). Public hospitals often prioritize preventive

[37] The *barangay* is the smallest political unit in the Philippines; each municipality or city is made up of barangays. The primary requisite for the creation of a barangay is a population of at least 2,000 (or of 5,000 for highly urbanized cities).

and primary care along with public health education, while private hospitals often specialize in treating cardiovascular diseases, cancer, pulmonology and orthopedics.

According to the 2022 Occupational Wages Survey, the average monthly wage amounted to 51,251 Philippine pesos (US$881.88) for generalist doctors, 57,476 pesos (US$989.01) for specialist doctors, 20,715 pesos (US$355.78) for nursing professionals and 15,886 pesos (US$272.84) for midwifery professionals (PSA 2023b). These wages appear to be low, considering the cost of living – for example, the cost of living in Metropolitan Manila is estimated to be 50,798 pesos (about US$874) per month (Alibudbud 2022). According to recent WHO and ILO research (2022) women in the health sector in the Philippines are overall paid 4.1 per cent less than men.

According to the Medical Tourism Association, the Philippines is emerging as an important medical and wellness tourism destination in Asia, visited annually by 80,000 to 250,000 medical tourists (*Medical Tourism Magazine* 2023). The access to medical care is facilitated by the presence of 63 private hospitals near the international airports, with almost no waiting time for appointments and treatment. Twenty-three Philippine health facilities are internationally accredited and recognized by the International Society for Quality in Health Care. International patients are attracted by the competitive cost of the medical treatments and the lack of language barriers (as Filipino healthcare workers are English-speaking[38]).

Medical education for doctors in the Philippines

There are two phases of medical education: pre-med and medical studies. These phases apply to both Filipino and foreign nationals aspiring to pursue medical education (Centre of Educational Measurement, n.d.).

Pre-med training: Before applying to any medical school, a candidate need to earn a bachelor's degree, possibly with credits in certain subjects. The duration of the Bachelor of Science programme typically ranges from 10 to 18 months, depending on the university.

National Medical Admission Test (NMAT): Passing this test is a prerequisite for admission to any medical college in the Philippines. The exam is conducted twice a year by the Commission on Higher Education (CHED) and the Centre of Educational Measurement.

Certificate of Eligibility for Admission to a Medical Course (CEMed): In addition to passing the NMAT, prospective students, including foreign students, should obtain this certificate from the regional offices of the CHED; they are required to submit an application form accompanied by a transcript of records, a copy of their diploma or certificate of graduation, their NMAT results, their birth certificate and a certificate of good moral character.

Acceptance in medical school: The CEMed does not automatically ensure that the applicant will be admitted to a medical school, which depends on each university's admissions criteria – including, for example, passing an interview.

Following the above steps, the students can pursue a medical degree and obtain a licence to practise.

Doctor of Medicine

The Doctor of Medicine (MD) graduate programme is intended for individuals interested in pursuing a career in medicine. This term derives from the United States' education system that is followed by the Philippines. The total duration of the MD course is typically four to five years, followed by a one year of

[38] As prescribed by the "Updated Policies, Standards and Guidelines for Medical Education", CHED Memorandum Order (CMO) No. 10, series of 2006.

internship. During the course, students learn both in a classroom setting and through practical clinical experience. Upon completion, graduates are eligible to take the licensure exam to practise medicine.

Licensure examination

After earning the MD, it is necessary to pass the Physician Licensure Exam (PLE). This exam is given twice a year (usually in March and September) and is administered by the Board of Medicine, under the supervision of the Professional Regulation Commission (PRC). The PLE, also commonly referred to as the Philippine Medical Board, allows one to work as a general practitioner. The examination aims to assess a medical student's skills and knowledge of the practice of medicine.

Post Graduation Residency Programme

However, if medical graduates wish to proceed further with their studies and gain a specialty, they need to experience medical residency, preceded by one year training in general medicine, pediatrics or surgery. Residency Training Programmes in the Philippines are similar to the postgraduate studies in the United States. They can take between two to six years of training in accredited hospitals.

Nursing and midwifery education in the Philippines

Students who wish to pursue a degree in nursing are encouraged to take the Science, Technology, Engineering and Mathematics (STEM) strand under the Academic Track in Senior High School.[39] The strand can provide the basics of applied mathematics and sciences that will be useful in college training.

College Admissions Test

Prospective nursing students need to pass the entrance examinations specific to their chosen institutions – for example, the University of the Philippines requires a College Admission Test (UPCAT). The UPCAT is a five-hour examination, consisting of four areas: Language Proficiency, Reading Comprehension, Science, and Mathematics; it is administered in English and Filipino (University of the Philippines, n.d.).

Bachelor of Science in Nursing

As prescribed by Section 13 of the Philippine Nursing Act of 2002 (Republic Act No. 9173), in order to become a nurse, an applicant must have "a bachelor's degree in nursing from a college or university that complies with the standards of nursing education duly recognized by the proper government agency". It is a four-year degree programme that teaches students the necessary skills and knowledge for healthcare. It includes four main components: health promotion, disease prevention, risk reduction and health restoration.

On-the-job training or internship

During the fourth year of the programme, students are required to attend an on-the-job training in different hospital settings and community clinics. Their work performance is evaluated by immediate managers. The number of hours required by each university may differ.

Licensure examination

To become a registered nurse in the Philippines, a graduate of the Bachelor of Science in Nursing is required to pass the Nurse Licensure Examination. It is conducted by the Board of Nursing, under the supervision of the Professional Regulation Commission (PRC).

[39] Each student in Senior High School can choose among three tracks: Academic; Technical–Vocational–Livelihood; and Sports and Arts. The Academic track includes three strands: Business, Accountancy, Management (BAM); Humanities, Education, Social Sciences (HESS); and Science, Technology, Engineering and Mathematics (STEM) (*Official Gazette*, n.d.).

Midwifery education

The pathway to become a midwife is similar to that for becoming a nurse, requiring a four-year specialized Bachelor of Science programme. To register as a midwife, a graduate of a Bachelor of Science in Midwifery needs to pass the Midwifery Licensure Examination. It is conducted by the Board of Midwifery, under the supervision of the PRC.

Medical degrees obtained abroad

If Filipino citizens obtain a medical degree abroad and wish to practice in the Philippines, they are required take the Physician Licensure Examination managed by the PRC. To access the exam, the candidates need to present the following documents:

- a diploma of a medical degree or equivalent;
- an original or authenticated copy of the description of the course for the licensure examination, issued by the institution of higher learning where the applicant has graduated;
- a Certificate of Equivalency issued by the Commission on Higher Education (CHED), stating that the courses taken by the applicant are equivalent to the Doctor of Medicine course offered in Philippine Schools of Medicine; and
- a Certificate of Post Graduate Internship, issued by a hospital accredited by the Association of Philippine Medical Colleges (APMC) or a Certificate of Equivalency issued by CHED.

Migration of medical staff: modalities and challenges

Based on data from the Philippine Overseas Employment Administration (POEA) and the Commission on Filipinos Overseas (CFO), from 1990 to 2017, a total of 350,361 doctors, nurses and midwives have left the country to work abroad. Of this total, 95 per cent were nurses, 3 per cent physicians and 2 per cent midwives (HRH2030 2020). In 2021, the Department of Health estimated that 316,000 licensed nurses (51 per cent of all licensed nurses in the country) had migrated abroad (MPI 2024).

The situation was particularly challenging during the COVID-19 pandemic, when 13,000 medical personnel were shown to have migrated abroad, creating a gap in the country's healthcare services. To address the issue, the Philippine Government adopted a deployment ban of healthcare workers for 2020 and a deployment cap of 5,000, subsequently raised to 7,000 in 2021 (Cura 2023).

The main destination countries include mainly those with whom the Philippines has a bilateral labour migration agreement (see figure 2). In 2021, Filipino nurses accounted for 27 per cent of the 546,000 foreign-born registered nurses in the United States (MPI 2024).

Push factors for migration include salary levels, working conditions, career prospects and access to the latest healthcare technologies (HRH2030 2020). Pull factors include the prospect of better social, economic, and professional opportunities abroad and the presence of relatives in the destination country.

Migration policies in the country serve multiple objectives. The Department of Health implements policies focused on retaining health workers, while the Department of Migrant Workers (DMW), along with its agency, the POEA, and the Commission on Filipinos Overseas (CFO), work to protect migrant health workers abroad.

Concerning skills development before migration, the POEA organizes pre-employment orientation seminars, while the Technical Education and Skills Development Authority (TESDA) – the national

Technical and Vocational Education and Training (TVET) authority – organizes training courses for working abroad (Tesda Online Program, n.d.).

There are different migration channels and governance mechanisms for migrant workers, including in the health sector.

Support from the Filipino diaspora

Networks of relatives and friends in the countries of destination can provide information on vacancies and procedures for qualification recognition and logistics, as appropriate. Associations of Filipinos working abroad may conduct seminars, workshops, conferences and information dissemination activities in support of the Filipino health workers overseas.

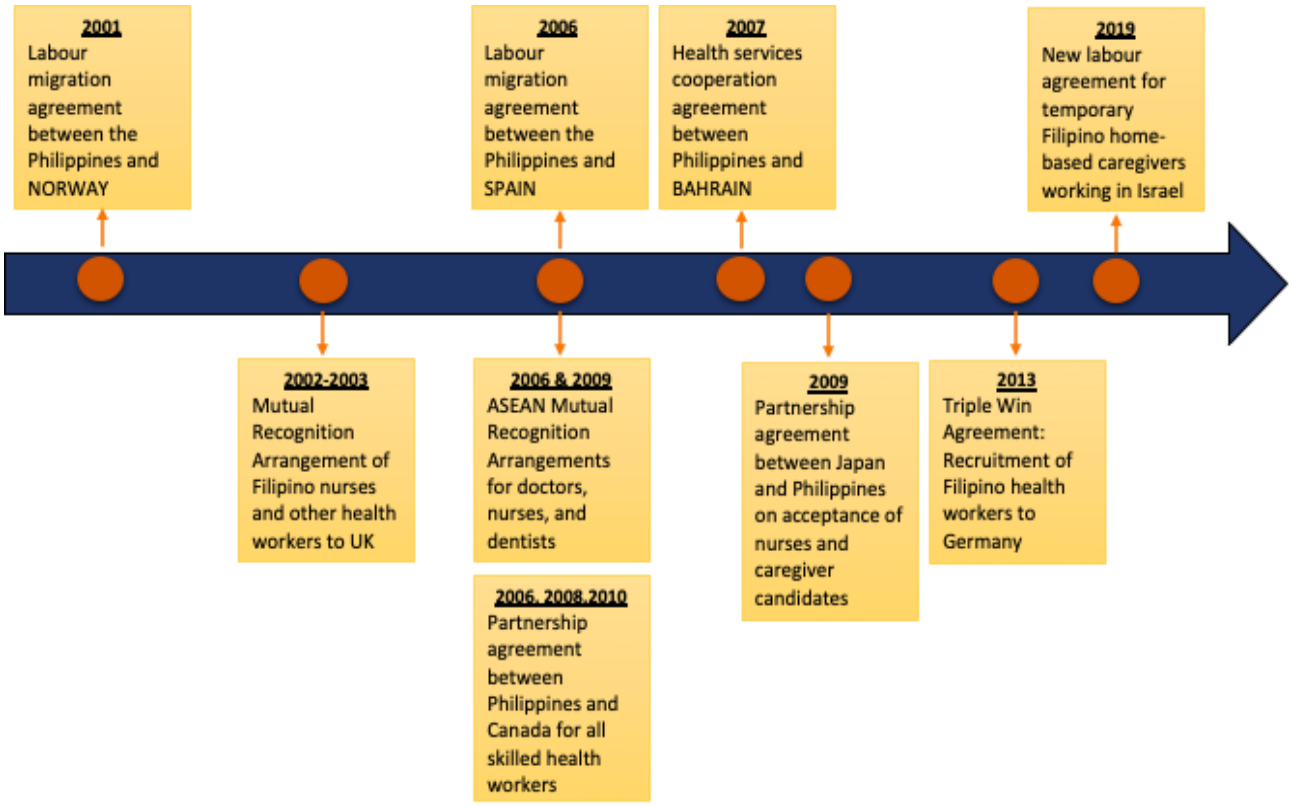
The following is a non-exhaustive list of such associations:

- Philippine Nurses Association of America (PNAA)
- Association of Filipino Physicians in America (AFPA)
- Filipino UK Healthcare Workers Association
- Filipino Nurses Association Germany e.V.
- Philippine Nurses Association – Saudi Arabia (PNA-SA)
- Philippine Nurses Association of Canada (PNAC)
- Filipino Canadian Medical Association (FCMA)

Bilateral labour migration agreements (BLMAs)

BLMAs play an important role in protecting migrant workers' rights and ensuring favourable working conditions (Yeates and Pillinger 2018). Accordingly, the Philippine Government has stipulated bilateral and multilateral agreements with the main migration destination countries (see figure 2).

Figure 5: Timeline of labour migration governance arrangements between the Philippines and specific destination countries



Sources: Yeates and Pillinger 2018; POEA, n.d.-a.

It is challenging to assess the effectiveness of the labour migration agreements; there are no fully functioning monitoring mechanisms, and in some cases they were never fully implemented (for example, Norway and Spain). The agreement with the United Kingdom was implemented during a period of limited labour demand. The Philippines–Japan Economic Partnership Agreement (PJEPA) opened employment opportunities for Filipino workers in Japan (see box 13).

▶ Box 12: Philippines–Japan Economic Partnership Agreement

According to Japan's Ministry of Health, Labour and Welfare (MHLW), the country is facing a significant shortage of nurses, with estimates ranging from 60,000 to 270,000 by 2025.[40] To mitigate this, the Japanese Government launched economic partnership agreements, opening the doors to foreign nurses. Agreements were signed with the Philippines (the PJEPA, in 2006), Indonesia (in 2007) and Viet Nam (in 2008). The scope of the agreements did not include migration per se; their focus was on training and then retaining the trainees as workers in Japan. The Japanese health enterprises in charge of training the applicants and benefitting from the agreements were charged with all expenses, including the costs of Japanese language learning.

The economic partnership agreements proved to have a limited impact: as of January 2019, only 136 foreign registered nurses remained in Japan out of the 1,300 candidates who entered since 2008. The main challenges appear to have been the language and differences in working methods.

Source: Hirano, Tsubota and Ohno (2020); Kaneda and Yamashiro (2023).

To determine the effectiveness of BLMAs, monitoring and evaluation mechanisms are necessary. Some agreements – those with Norway (2001), Spain (2006) and Bahrain (2007), for example – experienced challenges in their implementation. In other cases, destination countries recruit the workers without having a specific agreement (Saudi Arabia, for example) (ILO 2014).

The agreement with Germany on Sustainable Recruitment of Nurses (the Triple Win Programme) offers a good example of a working migration arrangement including involvement of the social partners and a strong focus on skills (see box 14).

[40] Ministry of Health, Labor and Welfare. Nursing-related policies [in Japanese]. 2023. Available nline: https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000079675.html. Reported by Y. Kaneda and A. Yamashiro in *Addressing nursing shortages in Japan: toward quality and quantity enhancement.* https://jphe.amegroups.org/article/view/9401/html

Box 13: Migration of Filipino nurses to Germany

To address the shortage of nurses for its health services, Germany has concluded bilateral agreements with countries that have a surplus of qualified nurses who cannot be absorbed by the local labour market.

In the Philippines, the project is implemented based on the agreement between the German Federal Employment Agency (BA) and the Philippine Overseas Employment Administration (POEA). The agreement covers the procedures, selection and placement of nursing professionals.

The first step is the identification of suitable candidates through a screening implemented in collaboration with the POEA. Preselected candidates are interviewed via Skype by employers for their institutions.

Before leaving the Philippines, the selected nurses undergo a German language preparation up to B1 level in the Common European Framework of Reference for Languages (CEFR) certificate, and a 4-day professional orientation course that includes information on processes and requirements for getting their qualifications recognized in Germany. They are individually assisted with the preparation and submission of documents for qualification recognition to the relevant German authorities before departure. Nurses receive the labour market entry visa before departure.

The German employers cover the costs of language and occupational training, travel and qualification recognition. The agreement between the Philippines and Germany includes the participation of trade unions in the implementing and monitoring of the agreement.

Sources: ILO 2020; UNNM 2022.

Another instrument of international migration cooperation is a Mutual Recognition Arrangement (MRA). It allows the negotiating countries to consider the skills and qualifications issued by one country as being valid in the others. An example of a regional MRA is the one signed by the Philippines with ASEAN countries (see box 15).[41]

Box 14: ASEAN MRA with the Philippines

The Philippines have signed an MRA with the ASEAN Member States for the mutual recognition of eight professional categories, including the health sector: namely nurses, medical and dental practitioners. The recognition is not automatic, as professionals must have the skills and experiences that are required by national committees, established for each profession, in each country. The recognition is not sufficient for implementing effective mobility per se, due to the need to comply with work permit and other technical and administrative requirements. In the Philippines, the authority in charge for the application of the MRA is the Professional Regulation Commission (PRC), that has also defined the roadmaps for the implementation of the MRA on the three above-mentioned health worker occupations.

Source: PRC 2023.

Private employment agencies

When it is not foreseen by a BLMA, migrant workers can try to find work abroad through the services of one of the authorized private recruitment agencies listed on the website of the Philippine Department of Migrant Workers (DMW, n.d.). The POEA is the licensing authority for private recruitment agencies (see box 16).

[41] ASEAN Member States: Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam.

Box 15: Private recruitment agencies in the Philippines

As a regulatory body for overseas employment, the Philippine Overseas Employment Administration (POEA) issues licences to private recruitment agencies in order to supervise their recruitment activities. The POEA approves the individual employment contracts proposed by the agencies, prevents malpractices and prosecutes those who violate recruitment standards. The POEA implements emigration policies, campaigns against trafficking, provides pre-departure information, addresses labour rights and violations abroad, and assists its nationals in destination countries. The POEA's governing board is chaired by the Secretary of Labor and Employment and consists of the agency administrator, along with representatives from the land-based, sea-based and private sectors.

Source: ITC-ILO, n.d.; POEA, n.d.-b.

Return and reintegration

As many healthcare workers are abroad on temporary assignments, they may return to the Philippines once their contracts end. However, it is possible that they may re-migrate (circular migration). These returnees likely do not require immediate labour market reintegration support. It is worth considering whether the decision to re-migrate is influenced, at least in part, by the availability and attractiveness of reintegration services. Additionally, factors such as recruitment fees and debts may also play a role in their choice to seek employment abroad again. In case of permanent return, the country offers services, aimed at facilitating reintegration, including labour market reintegration. These reintegration services are a mandate of the National Reintegration Centre for Overseas Filipino Workers (NRCO) of the Department of Migrant Workers (DMW), created by the Republic Act No. 10022 of 2010. The agency can provide, among other things, counselling and psychosocial services, assistance to find employment or to start a business. It also provides returnees, who have been irregular migrants, with livelihood starter kits and educational scholarship programmes for children (Lorenzo et al. 2014). However, there is a need to develop institutionalized reintegration programmes specifically tailored for returning healthcare workers. Such programmes could provide opportunities for them to effectively utilize the skills and experience they have gained abroad, contributing to the development of their home country.

There are many other institutions and agencies that offer programmes and initiatives for the reintegration of returnees (ADB 2023). However, it seems that their use is somewhat limited, due to their scarce accessibility from remote areas and lack of awareness.

The gender dimension of health labour migration in the Philippines

Women are increasingly entering traditionally male-dominated healthcare professions. In 1990, men constituted the majority of physicians (51.5 per cent) and physiotherapists (58.2 per cent). However, by 2015, women had become the dominant group, representing 56.9 per cent of physicians and 61.9 per cent of physiotherapists (Abrigo and Ortiz 2019).

This shift is particularly significant in the context of labour migration. Women healthcare workers, especially nurses, make up a substantial portion of migration flows from the Philippines, with many seeking employment in Asian and Gulf countries.[42] The primary factors influencing migration among healthcare professionals include: (i) job satisfaction and career growth opportunities; (ii) limited

[42] Saudi Arabia was the leading destination, accounting for 20.0 per cent of all migrant workers in 2023, followed by the United Arab Emirates at 13.6 per cent (PSA 2024).

employment prospects within their chosen healthcare field in the Philippines; (iii) challenging living conditions; and (iv) the rising cost of living (Bourgeault et al. 2021).

The Philippines is a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The provisions of the CEDAW have been transposed in the Republic Act 9710 on the Magna Carta of Women: a comprehensive women's human rights law that seeks to eliminate discrimination through the recognition, protection, fulfilment and promotion of the rights of Filipino women (PCW, n.d.). The country also adheres to the International Covenant on Economic, Social, and Cultural Rights (ICESCR).

Conclusions

The Philippines has a performant health education system, modelled after the US system. The skills and qualifications of its health workers are highly appreciated abroad, and this contributes to increased migration outflows. The quality of the health system in the Philippines is also well appreciated globally, as witnessed by growing flows of medical tourism. This is due to its competitive prices and the fact that almost all medical staff speak English.

The migration of health workers is mainly due to the level of remuneration and the working conditions present in remote rural areas. Retention policies should focus on improving these. Attention should be paid to enhancing health workers' quality of employment, especially in geographically isolated and disadvantaged areas.

The national migration policy needs to balance preventing possible duality in promoting retention of health workers in the national system, with the need for increasing the level of remittances and their developmental impact. An important step in this direction could be the adoption of the "one-country team" approach in migration policies, towards which the national policy makers are currently working.

The adoption of appropriate policy measures regarding healthcare workers needs to be supported by detailed data that are currently not always available. The existing platform on the Health Human Resource Development Bureau (HHRDB, Philippines Department of Health) website might be used for integrating the Human Resources for Health Statistics with migration data to create a sector labour market and migration information system. This could be an important tool to support evidence-based policy making.

Developing effective bilateral labour migration agreements could represent an important arrangement for facilitating the recognition of skills and qualifications. A good potential for skills recognition is offered by the ASEAN MRA, which needs to become more effective and linked to free mobility within the region.

No specific reintegration programmes are envisaged for migrant health worker returnees, who could greatly benefit from such programmes. Many health migrant workers hold temporary contracts, and they are frequently engaged in circular migration. Reintegration programmes could be strengthened to attract more migrant health workers to return and use their skills and knowledge gained abroad to improve the healthcare delivery services.

Diaspora organizations play an important role in assisting migrant health workers in destination countries. Some of them, especially in the United States, are very active in providing support to the health system in the Philippines.

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Conclusions

It is vital that labour migration governance play a central role in ensuring the adequate and timely recognition of the skills and qualifications of migrant health workers, as well as the effective protection of their rights. The scope of the present compendium has been to analyse the processes of skills and qualification recognition for migrant health workers, with particular attention being paid to women migrant workers. The research has focused on two destination countries (Italy and Germany) and two origin countries (the Philippines and Egypt). It should be noted that the division of origin and destination countries is increasingly blurred, so countries are increasingly origin, transit and destination sites at the same time. This poses new challenges for labour migration policies, including at the sectoral level, such as with healthcare. The research does not cover specific migration corridors but rather makes reference to the agreements/recognition arrangements that a country has with multiple migration corridors. Below are the key concluding insights from each country's case study.

In Germany, the anticipation of a significant healthcare worker shortfall, particularly in elderly care, has spurred legislative efforts, such as the Recognition Act of 2012 and the Skilled Immigration Act of 2023. These measures aim to streamline the recognition of foreign qualifications and facilitate the entry of skilled non-EU workers across over 600 regulated and unregulated professions (including the health sector), with the goal of enhancing integration and workforce replenishment. However, persistent challenges include navigating complex legislative frameworks, resource constraints, financial limitations and language proficiency requirements.

Italy's healthcare system, grounded in a constitutional mandate that recognizes health as a fundamental right, shares responsibilities between the State and the regions. Despite ongoing efforts to integrate foreign qualifications, challenges persist in the recognition process for migrant health workers. These include the long duration of the process of recognition and its associated costs. The COVID-19 pandemic highlighted the system's adaptability through temporary authorizations for migrant healthcare professionals. The entrenched gender disparities in leadership roles and the pay gap remain a challenge.

Egypt's healthcare system is currently undergoing substantial reforms, with the ambitious objective of achieving universal health insurance by 2027. However, the system remains fragmented, with governance divided among multiple entities, resulting in disparities in health service access and resource allocation across different regions. Despite ongoing efforts to enhance conditions, health professionals, particularly doctors and nurses, continue to confront challenges such as low wages, unequal distribution of resources and inadequate working environments. These factors contribute significantly to a pronounced emigration of skilled workers who seek better opportunities abroad, posing a challenge for Egypt's health service delivery. The Egyptian health diaspora actively contributes to supporting healthcare initiatives in their home country through remittances, knowledge exchange and professional networks. Organizations like the Egyptian American Medical Association and the British Egyptian Medical Association are examples of such collaboration.

The Philippines has made significant strides with the enactment of the Universal Health Care (UHC) Act No. 11223 in 2019, aiming to achieve comprehensive coverage and equitable access to healthcare services for all Filipinos, including Filipino migrant workers. Spearheaded by the Department of Health and implemented through the Philippine Health Insurance Corporation (PhilHealth), the UHC mandates automatic enrolment in the National Health Insurance Programme. There is a predominant role of private healthcare providers. In rural areas, there are still disparities in accessibility and in healthcare workforce distribution. The Philippine Government has established bilateral and multilateral agreements with key migration destination countries to support safe and orderly migration processes

for Filipino health professionals, particularly doctors and nurses. In addition, efforts to retain healthcare professionals and mitigate migration impacts through deployment regulations and reintegration programmes are ongoing.

In this context, to promote effective labour market integration, both in countries of destination, and upon an eventual return home, policies for migrant health workers should promote both fair recruitment and the development, matching and recognition of skills and qualifications. The ILO labour standards, Recommendations and frameworks provide key guidance in this direction. There is also a need to ensure that health sector considerations are central to the design of any labour migration governance arrangements, from both public health and economic perspectives. In this regard, it is important to identify good practices when implementing bilateral labour migration agreements (BLMAs), to prepare guidance and capacity-building tools that specifically target the health sector, and for policymakers to draw on international labour standards and human rights instruments.

Labour migration governance needs to take into account the existing arrangements for recognizing qualifications and certificates at the national and regional levels. A policy concern that has been increasingly raised is whether or not regulatory bodies – such as a national qualification council, a ministry of health, or a ministry of higher education – are flexible enough to adequately address the growing need to recognize foreign qualifications, especially in the context of continuously increasing demand for health workers and rapid technological and medical advancements. For migrant health workers, the recognition process may be lengthy due to the administrative barriers and costs involved, which may lead them to find employment in occupations outside of their training profile – which, in turn may result in deskilling or informal employment. The present study found this difficult to quantify.

As the length of the recognition process depends on the level of equivalence of the qualifications to be recognized and the type of additional training required, which clearly impacts the costs involved, a possible solution could be offered by the negotiation of BLMAs, including skills clauses or referring to existing process. Regarding recognition of higher education qualifications, the process can be facilitated by the existing regional conventions (ENIC-NARIC, n.d.) and by the Global Convention on the Recognition of Qualifications concerning Higher Education.

In this context, it is also important to consider lessons that can be learnt from existing supranational arrangements for professional recognition (for example, Directive 2013/55/EU on the recognition of professional qualifications, or health-related mutual recognition agreements within the Association of Southeast Asian Nations, ASEAN) and their potential application in other regions. In the case of the EU, skills recognition and mobility are linked for EU citizens since education systems are harmonized through the Bologna Process. For third country nationals, each EU Member State applies its own rules and modalities, which might be time-consuming and expensive. In the case of the ASEAN, recognition and admission processes remain two separate areas. Within regional economic communities, it is important to coordinate labour migration and recognition processes. The increasing importance of coherence, linked to growing international labour migration, calls for greater efforts to harmonize and coordinate policies related to sectors, employment, education/training and labour migration (ILO, n.d.). In the specific context of the health sector, the World Health Organization (WHO) regards policy coherence as a key driver of health equity. This can be achieved through "the systematic promotion of mutually reinforcing policies across government departments to create synergies towards achieving agreed objectives" (Boniol et al. 2019).

Given the high demand for health personnel, recognition rules should be transparent and implemented in a cost-effective way, benefiting all those involved. Policy coherence is shaped by diverse political, economic and social factors, and differs depending on whether it is adopted by origin or destination countries. Origin countries focus on establishing safe migration channels for their nationals and strive to enhance the protection of their rights in destination countries. In contrast, destination countries prioritize addressing skills gaps in their labour markets by employing migrant workers. It is therefore

crucial for both origin and destination countries to ensure effective coherence between labour migration, employment and other national policies to promote decent work for all (ILO 2017; ILO 2021).

The role and potential impact of digitalization for improving access and lowering the cost of skill and qualification recognition for migrant health workers should also be considered. When digital management platforms store important information, such as work contracts and medical certificates, they create a record of documents – a digital trail. This can be useful if disputes arise about contract conditions, payments or other issues between a migrant worker and an employer or recruitment agency always ensuring safeguarding personal data on platforms through robust data security measures. The potential value of such platforms could also be assessed for facilitating skill recognition and certification. For instance, the International Trade Union Confederation (ITUC) launched the "Recruitment Advisor" in 2018, an initiative to monitor recruitment agencies. The web platform was developed by the ITUC with support from the ILO Fair Recruitment Initiative, with more than 10,000 in Hong Kong (China), Indonesia, Malaysia, Nepal, the Philippines, Qatar, Saudi Arabia, Singapore and other countries (Recruitment Advisor, n.d.). The experiences gained by users of the recruitment agencies are shared with those who are looking for a job abroad. The platform can thus contribute to the protection of migrant workers from abusive employment practices.

In countries where regular data collection remains limited, qualitative methods can be used to forecast skill demands. This approach would support the development of up-to-date education and training programmes tailored to evolving labour market needs. Furthermore, Labour Market Monitoring and Information Systems (LMMIS) play a crucial role in designing, implementing and monitoring bilateral or multilateral labour migration agreements to address healthcare workforce shortages. In the short term, a national-level monitoring system could be established – integrated into the broader LMMIS, where available – to analyse and plan for national healthcare system needs, identify gaps and assess international demand for healthcare professionals. However, it is important to note that LMMIS and skills anticipation systems generally focus on forecasting future labour needs rather than skills recognition. Italy is currently the only country in this report with a system that identifies future workforce demands and requires employers to report how many of these vacancies could be filled by migrant workers. However, the reliability of these reports can vary, as employers are required to submit monthly forms, and the accuracy of the data may be influenced by various factors.

In the medium to long term, improving labour migration governance in the health sector and strengthening the link between migration and development require coherent labour migration and health policies. These policies should also address the labour market reintegration of returning migrant health workers. As highlighted earlier in this document, the Philippines has implemented initiatives to support the reintegration of migrant workers; however, there is no specific policy targeting this group. Similarly, Egypt does not have dedicated reintegration measures for returning health workers. A notable initiative is the Egyptian German Centre for Jobs, Migration, and Reintegration, established in 2022. The Centre provides reintegration support through funding, housing assistance and family support for return migrant workers. While the Centre was initially developed in collaboration with Germany specifically, its services are available to all Egyptian returnees, regardless of the country from which they are returning (MOIC, n.d.).

Policymakers in origin countries should establish a system – if one is not already in place – for recognizing qualifications and validating prior learning, particularly in the health sector. Since on-the-job training is the most common form of skill development for migrant workers abroad, a structured approach to recognizing these competencies is essential. In this context, public employment services can play a crucial role by facilitating the recognition of skills and qualifications gained abroad. Given their position as intermediaries between employers and workers, they are particularly well-suited to support medium-skilled health professionals in obtaining formal recognition of their qualifications from the relevant institutions. To highlight the importance of qualification recognition, Germany's Triple Win

Programme serves as a valuable example. This initiative supports the migration and integration of health professionals by ensuring their skills are formally recognized. Additionally, Germany provides accessible online information in multiple languages, helping potential applicants understand the recognition process and requirements before migrating.

Research by the WHO and the ILO (based on data from 54 countries) indicates that, on average, women in the healthcare sector earn approximately 20 per cent less than their male counterparts (WHO and ILO 2022). This disparity can be attributed to the overrepresentation of women in lower-paid occupations, while men are disproportionately represented in higher-paid roles, such as physicians, where the gender pay gap tends to be more pronounced. Factors such as age, education and gender segregation across occupational categories also contribute to the gender pay gap in the healthcare sector. Moreover, the gender pay gap in this sector is wider than in other economic sectors, likely due to the so-called "motherhood gap": workers in highly feminized sectors generally earn lower wages on average compared to those in less feminized sectors (WHO and ILO 2022).

There is a critical need to strengthen social dialogue and the involvement of social partners, including workers, to ensure policies and procedures on health worker migration are devised and implemented in a manner that reflects the needs and realities of health workplaces, respecting the rights and conditions of workers.

Areas for further research

In conclusion, the modalities of qualification and skill requirements for migrant health workers vary significantly between countries, being context-specific and differing in availability and accessibility depending on the country in question. The skills recognition process tends to be costly. To address this, efforts should focus on simplifying and streamlining the recognition procedures by reducing bureaucratic hurdles, enhancing efficiency in documentation requirements and promoting mutual recognition agreements between countries of origin and destination. Given that the financial burden is primarily shouldered by migrant health workers, targeted support mechanisms should be considered, such as subsidies, grants, employer-sponsored recognition programmes, or public-private partnerships to ease the financial strain. Based on the existing information presented in this compendium and the gaps in available data, it was not feasible to accurately assess whether there are gender-specific differences in the recognition requirements. An area for further research is the gender dimension of health labour migration. There is a need for additional quantitative and qualitative research, in both origin and destination countries, in the following areas:

- ✓ Social dialogue is central to designing, implementing, monitoring and evaluating coherent policies that protect the rights of migrant health workers and ensure decent working conditions. It enables participation of social partners and key actors, fosters policy coherence, strengthens enforcement and helps embed migrant rights into labour, health and migration policy frameworks. Research is needed to examine the mechanisms, barriers, effectiveness, and outcomes of social dialogue in the specific context of migrant health workers, to improve their protection.
- ✓ Access to skill and qualification recognition processes, career progression opportunities, and working conditions, including addressing the gender pay gap, is critical for migrant health workers. To better understand labour market outcomes – particularly for women migrant workers – it is essential to collect occupation-specific data.
- ✓ A greater number of countries should be analysed to assess the challenges faced by migrant health workers in recognition processes and the implications for their integration into health systems, enabling more detailed policy conclusions to be drawn.

- ✓ The risks of brain drain, and potential policy responses should be evaluated using up-to-date statistical information and evidence, striking a balance between the importance of remittances for origin countries and the need to address labour market shortages in destination countries. One possible solution to reconcile these competing interests is "brain sharing", facilitated by circular migration for those who are interested. Implementing such an approach would require coordinated policies on admission, skills development, labour market integration and reintegration.
- ✓ The availability of health services and adherence to minimum standards are significantly affected by the uneven distribution of health personnel, particularly in rural areas, where shortages remain a persistent challenge. The policy debate in many origin countries revolves around the challenge between addressing poverty and ensuring access to quality health services for all, highlighting a central issue in health migration policy.
- ✓ Coordinated solutions can be negotiated between origin and destination countries through bilateral labour migration agreements. These agreements can help ensure fair recruitment practices while addressing workforce shortages. Destination countries should commit to refraining from recruiting healthcare professionals from countries facing critical shortages, particularly when these shortages cannot be quickly addressed due to the time and costs required for medical education and training. At the same time, origin countries can benefit from evidence-based approaches to establish national indicators that ensure uniform healthcare service coverage. Such policy approaches can help distinguish between genuine shortages and apparent shortages caused by the uneven distribution of healthcare resources on the territory, allowing for more effective workforce planning.
- ✓ Analysing the availability and accessibility of upskilling services for migrant workers is crucial. Key questions to address include the existence of such services, the financial burden on individuals, the availability of relevant courses and the level of employer support. These factors are vital for understanding and addressing the challenges faced by migrant workers and warrant further exploration.
- ✓ There is insufficient evidence-informed analysis of temporary labour migration schemes for health professionals, regarding protection and skills recognition. Since skill and qualification recognition presents a major obstacle to the integration of migrant health workers into the labour market of both origin and destination countries, it is vital that existing processes be evaluated, and that viable funding mechanisms be identified.
- ✓ It is essential to evaluate the use of digital tools in facilitating access to skills and qualification recognition processes within the health sector and enhancing skills matching for various health occupations.
- ✓ Health worker migration involves a diverse range of professionals, yet research and policy discussions tend to focus predominantly on medical doctors and nurses. There is a need to also expand the scope of research and policy attention to other health-related occupations, such as midwives and physical therapists, to better understand their migration patterns, challenges in skills and qualification recognition, and integration into foreign health systems.
- ✓ Future research should also broaden the geographical focus of case studies to include a wider range of origin and destination countries. Additionally, adopting a migration corridor approach could provide valuable insights into specific migration dynamics, recruitment mechanisms and recognition processes.

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