

The ILO Decent Work Across Borders

Mobility of health professionals between the Philippines and selected EU member states: A Policy Dialogue



Executive Summary

Assessment of the Impact of Migration of Health Professionals on the Labour Market and Health Sector Performance in Destination Countries

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The study represents a desk review of the impact of the migration of health professionals on the labour market and performance and quality of health services in major countries of destination, particularly the UK. It focuses on two categories health professionals: doctors and nurses.

The study discusses the impact of immigration of health professionals on the destination country in relation to three major aspects: the labour market in terms of employment and wages, performance of the health system, and the quality of care. Several factors determine the actual impact of medical migration on destination countries. These are: a) skill composition of incoming workers; b) occupational distribution of migrant and native workers; c) number of immigrant health workers; d) distribution of migrant workers between public and private sectors; e) migration status of workers - permanent, temporary, or circular, and f) recruitment practices. The analysis presented in the report is based on an extensive literature survey, and consultations with key resource persons.

Impact of immigration of health professionals on the labour market

The study first reviewed general studies of immigration on the labour market in destination countries. Econometric techniques are usually adopted in such assessments. Two generally accepted methods of testing the effects of immigration on employment and wages are: 'area analysis' and 'factor-proportions analysis'. The "area approach, or spatial correlation approach" uses cross-sectional data to determine how wages and employment of native workers in different regional or local labour markets are affected by differences in the share of immigrants in the local labour supply. The "factor proportions" approach posits a national labour market, and generally uses time series data to simulate the relationship of changes in national wages or employment of a particular skill group to changes in the share of immigrants in that group. The different skill groups serve as the different "areas." It compares the actual supplies of workers in particular skill groups to those that would prevail in the absence of immigration (the counter-factual situation). It is argued that changed factor proportions due to immigration will lead to different wage and employment outcomes for native skilled and low-skilled workers.

The employment impact of immigration on native workers has continued to be the subject of debate in both United States and Europe. The issue is whether the employment of foreign workers leads to displacement of native workers in the profession. Many studies on Europe and the USA surveying the literature on the employment impact of migration on native employment have pointed to small negative employment effects. This in effect means that immigrants do not displace natives in employment in any significant way.

As regards the impact on wages and earnings, the popular view is that migrant workers compete with national workers, depressing their wages and worsening income distribution. Yet most research does not support this view of immigration's negative impacts on wages. The general finding of a wide range of studies is that any negative effect of immigration on wages is small, if it exists at all.

In regard to the specific impact of immigration of health workers on employment and wages in the health sector, there are hardly any studies in Europe including the UK. While there have been some important studies of health professions in Europe in recent years – Health professional mobility in the European Union Project (PROMeTHEUS), Mobility of Health professionals project, (MoHProf) and the Nurse forecasting project (RN4CAST), all funded by the European Commission - these have not addressed wage and employment impacts of medical migration. In discussing the labour market impact, the study recognizes that the health labour market is highly regulated in many countries because of market failures, which reduces the scope for isolating the impact. This especially applies to the UK situation where the National Health Service (NHS) – is the main public sector employer.

The study first reviewed trends in the UK health immigration for understanding the labour market impact of medical immigration. The period 1997-2004 represented a period of high recruitment of health workers from different world regions, particularly India and the Philippines. Since 2006, there has been a marked shift in the new inflows in favour of European Union (EU)/European Economic Area (EEA) health workers given the EU/EEA free mobility directive. Changes in the shortage occupation list of the British Home Office have removed a number of health worker categories including General Nursing leading to a large reduction of inflows from non-EU countries. New rules have also made the role of the UK as a centre of postgraduate medical training less accessible to students from developing countries. Frequent changes in UK immigration policies, sometimes with retrospective effect, have caused difficulties for health sector workforce planning and individual immigrant health professionals such as those who immigrated under old rules: e.g. the Highly Skilled Migrant Programme. There is also limited circular migration of health professionals between European countries and developing origin countries as advocated by the European Commission, and the only programme resembling a circular migration initiative is the UK Medical training Initiative of the Academy of Royal Colleges of Medicine. The bilateral agreements for admission of health workers signed with India and the Philippines have become defunct under new immigration rules although not formally abrogated.

Rutten's 2004 study of health worker immigration impact in the UK – undertaken in the period of high recruitment - is the only work specifically covering the economic impact. It analyses the macro-economic impacts of migration of skilled medical personnel from a receiving country's (UK) perspective. The methodology employed is general equilibrium analysis which can cover economy wide effects of immigration of health workers into the UK National Health Service. The hypothesis is that an increase in the size of the health sector reduces the supply of skilled workers available to other sectors, and thereby the output of these sectors. But the strengthened health sector simultaneously helps increase the effective supplies of labour by improving the health of all workers. The final impact depends on the factor bias (changes in the ratio of skilled to unskilled labour) and the scale effect of effective labour supply impacts. The main finding of the model is that admitting foreign doctors and nurses into the United Kingdom would generate higher overall welfare gains than a generic increase in the National Health Service budget. Given the possible medical brain drain from developing origin countries, the study concludes that in the long-term, "the only sustainable policy which addresses the root cause of the shortage of medical personnel is to increase the number of medical school places in the UK".

Given the absence of other specific studies on the UK or European countries on the theme, the paper reviewed the USA literature which was richer in this area. There has been no change in the policy of overseas recruitment of health workers in the USA although the global financial and economic crisis probably slowed down new recruitments. One study considered pertained to physician immigration while others focussed on nurse immigration. These studies have also used the area and factor proportions approaches cited above, and used large datasets covering different states. Health professionals from India and the Philippines formed a large share in these samples. Both time series and cross section data have been used in estimations. All studies concur in one finding: the impact is either absent or not significant in most cases where an impact is found. They also did not find any evidence to suggest that health worker migration led to movement of native health workers from areas of high concentration of immigrant health workers. These findings are similar to those of general studies of immigration on the labour market, suggesting that even for immigrant health professionals, the impacts are not that strong. The studies also agree that these findings have limited validity for formulation of long run immigration policies in the health sector, mostly because of ethical considerations regarding brain drain from developing origin countries.

Impact on health sector performance

The second area of investigation was the impact of immigrant health professionals on the performance of health systems. In addressing this, the framework provided by the World Health Report 2000 of the World Health Organization on the goals and functions of a national health system was used. The focus is on four vital functions of '*service provision, resource generation, financing and stewardship*' to achieve the overall goals of the health system: *good health, responsiveness to the expectations of the population, and fairness of financial contribution*.

Migrant health workers have contributed considerably to expansion of the delivery of services since they are often brought in to address particular shortages, and they favourably influence the geographical distribution, skill mix and size of the health workforce. Immigrant health workers are also used to address less popular specialities and under-served regions of the country. The resource function refers to "the manpower, skills and knowledge required by a health system". In developed destination countries such as Australia, United States and the UK, immigration of health professionals is a strategy for expanding health staff resources.

Given that immigrant health professionals enter destination countries in search of higher wages, mobility has obvious implications for the financing function of the health system. In the NHS there is little correlation between recruiting migrant workers and the reduction in associated labour costs given that same wages and benefits are provided to immigrant professionals. Spain is an important destination country where foreign health workers inflows from Latin America have served to keep salary levels in the public sector fiscally sustainable. Recently a case has been made for relaxation of immigration rules in the UK to bring in more overseas doctors to keep costs down, which cannot be upheld in terms of international norms. But the UK has saved considerably by bringing in health workers trained at public expense of other countries, mostly developing countries. The British Medical Association estimated that the NHS has saved up to £250,000 for each doctor trained elsewhere. Inflow of foreign trained nurses also has saved the UK considerable amounts in training costs. Other major destination countries such as Australia, Canada and the USA also continue to make substantial savings in recruiting overseas trained doctors and nurses, often at the expense of developing countries. There has been considerable discussion of the ethical dimensions of these recruitments, and whether and how destination countries should compensate origin countries adversely affected.

Impact on quality of care

The third aspect of the impact is the quality of care. Three approaches have generally been used in the literature to assess the impact on quality of care by international medical professionals.

- a. Fitness to practice procedures based on complaints from patients, public bodies, hospital trusts or peers which is popular in the UK;
- b. Educational measures of quality: equivalence or shortfalls in qualifications obtained abroad; language competencies; and failure rates in competitive qualifying examinations;
- c. Comparison of clinical outcomes for patients cared by native and immigrant health professionals.

A number of studies have found that doctors qualified outside the UK are more likely to be associated with higher impact adverse decisions at each stage of the fitness to practice process. According to one UK study, during 1999-2001, higher proportions of overseas qualifiers than UK qualifiers were referred to the Preliminary Proceedings Committee by screeners, a ratio of 2:3. Other studies also point to the fact that a larger proportion of complaints about overseas qualified doctors were sent to a fitness to practise panel following investigation. Similar patterns of complaints have been reported from Canada. Yet there has also been concern about the

effect of racism and discrimination regarding complaints procedures in the health systems at many levels.

There is no consistency regarding the comparative quality of native medical graduates and International medical graduates (IMGs), based on their performance at examinations. Non-US medical graduates have generally fared worse than US graduates in the US Medical Licensing Examination. Similar concerns have been raised in the UK by the General Medical Council which found some evidence that “doctors in postgraduate training who gained their primary medical qualification overseas are proportionally more likely to experience challenges in progressing through training”.

In regard to the patient outcome criterion, a US study carried out a test of quality of International Medical Graduates by looking at mortality rates of patients cared for, and it found no significant mortality difference when comparing all international medical graduates with all U.S. medical school graduates.

In the assessment of performance and quality of care, it is important to keep in mind that immigrant health professionals face a number of special problems in the work place as well as general living conditions in destination countries. There is evidence that they often work under more difficult conditions (e.g. late or night shifts, home care), and their conditions of work may be inferior in some cases to those of native workers. There is also documented evidence of racism and discrimination in the workplace by fellow workers and patients. A study focusing on the experience of doctors who have qualified outside the UK in working within the ethical regulatory framework of ‘Good Medical Practice’ found that the main information, training, and support available to Non-UK qualified doctors wishing to work in the UK had little emphasis on ethical and professional standards. These factors may cause overseas health professionals to perform below their potential.

Policy implications

There is not much evidence that migration of health professionals has had any significant adverse labour market impacts while their positive contributions to the performance of health systems have been well documented. Individual migrants also have improved their welfare by migrating to developed destinations. Still studies have shown that immigrant health professionals have not had equal opportunities for career progression. There is, however, continuing concern about brain drain of health workers from origin countries. While the UK had shown some concern on this development impact till recently, other major destination countries (Australia, Canada, New Zealand, and the USA) have rarely considered adverse impacts on source countries in their health worker admission policies. While circular migration involving short term temporary migration back and forth between origin and destination countries has been advocated to address this situation, it has not been seriously considered by any country as an option to minimise brain drain while ensuring migrant rights and welfare. In terms of above analysis the following policy options stand out.

- The need for better data generation on inflows and outflows and to capture the impact of health worker immigration in both origin and destination countries.
- Documenting the contributions of immigrant health workers to national health systems
- Careful review of immigration policy changes on immigrant health workers including those already present in the country from traditional source countries.
- Addressing issues of lack of proper orientation of foreign medical workers on ethical and regulatory frameworks on good medical practise in countries of destination by

providing specific information and educational resources prior to registration, accompanied by in practice support.

- Review impediments on equal access and opportunities for immigrant health professionals for career advancement, and adopt corrective policies and measures.
- Take remedial measures to compensate for the adverse impacts of recruitment from developing origin countries: ensure access to advanced/specialised medical training in destination countries; investing in training of medical personnel in origin countries; provision for regular exchange programmes; and promote two-way circular migration of health professions between origin and destination countries through bilateral agreements, among others.