HEALTH WORKFORCE MIGRATION

DATA ISSUES AND POLICY ISSUES

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DES POLITIQUES MEILLEURES POUR UNE VIE MEILLEURE

Main data sources to monitor health workforce migration

1) OECD Health Database reporting data from OECD/Eurostat/ WHO-Europe Joint Questionnaire based mainly on national professional registries:
   - Provide data on number of foreign-trained health workers

2) EC Regulated Professional Database:
   - Provide data on number of health professionals seeking recognition of professional qualifications in another country (intention to migrate, but no migration yet)

3) OECD Database on Immigrants in OECD and non-OECD countries (based on population censuses and LFS):
   - Provide data on number of foreign-born health workers (updated every five years)

Annual OECD/Eurostat/WHO-Europe Joint Questionnaire on foreign-trained health workers

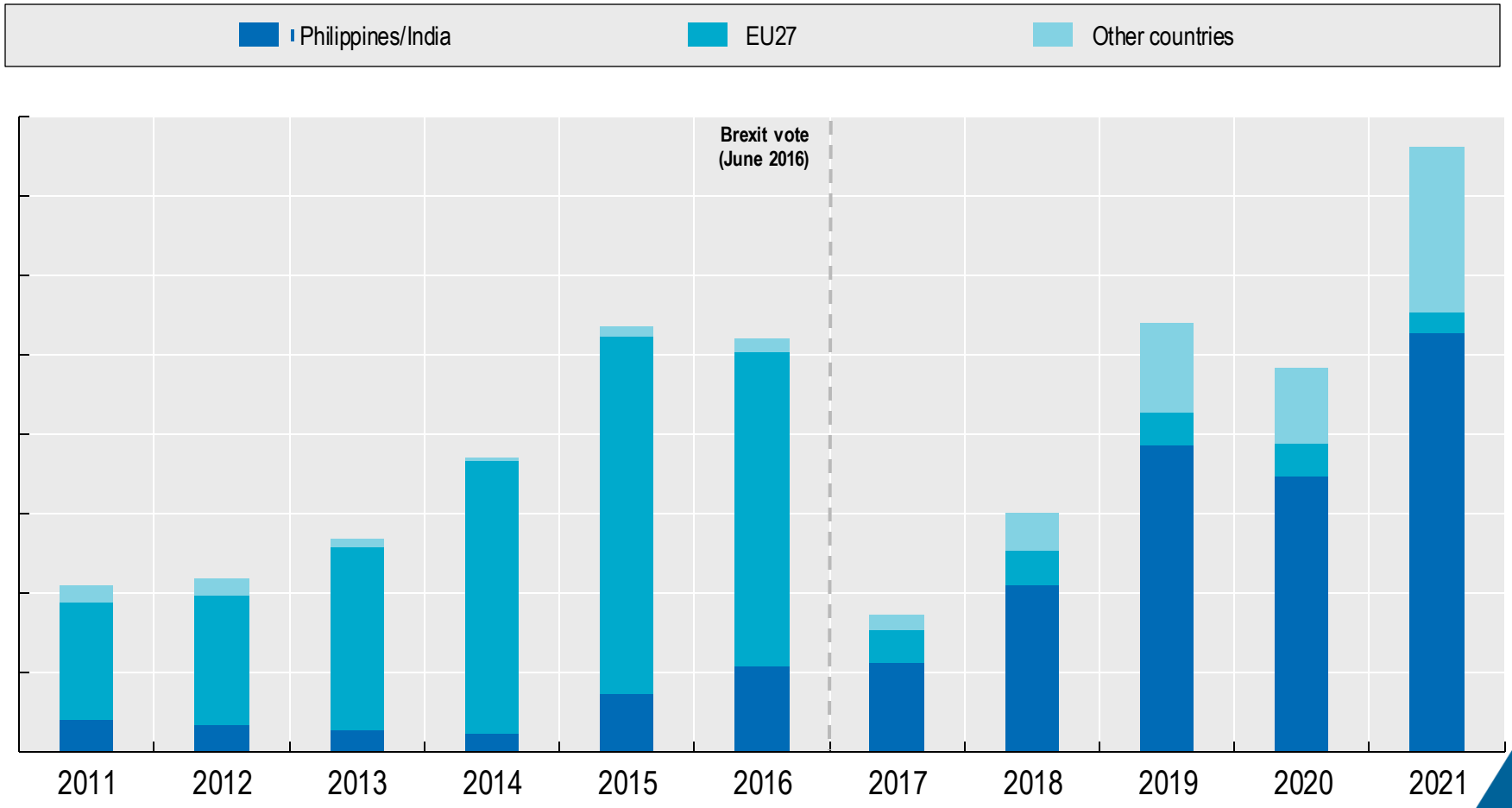
- Focus on place of training (where first diploma was obtained)
- Distinguish foreign-born from domestic-born international graduates (important in some countries where many students study abroad and come back)
- Collect data on total "stock" and annual "flows"
- Collect immigration data from destination countries by all countries of origin (not only European countries)
- Describe emigration patterns through aggregation of immigration data

Example of results from joint data collection: Stock of foreign-trained nurses in United Kingdom

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total number of nurses	634672	638189	644473	650743	650638	647678	652651	660213	675803
- Domestically-trained nurses	552418	553642	555303	553850	547734	546722	550016	553453	561571
- Foreign-trained nurses	74334	77090	82060	90157	96687	95194	97222	101510	108782
Of which: native-born but foreign-trained									
- Unknown place of training	7920	7457	7110	6736	6217	5762	5413	5250	5450
% of foreign-trained nurses	**11.7**	**12.1**	**12.7**	**13.9**	**14.9**	**14.7**	**14.9**	**15.4**	**16.1**
Philippines	22572	22581	22581	23248	24483	25806	28320	30653	33582
India	16398	16459	16502	16892	17213	17578	18801	21029	24860
Romania	2254	2606	3739	5997	8115	7725	7542	7407	7421
Portugal	1748	2888	4015	4878	5319	4913	4672	4534	4397
Spain	1729	3324	5054	6567	7309	6153	5172	4473	3842
Nigeria	2859	2797	2772	2759	2726	2717	2888	3190	3698
Italy	340	498	1395	3314	4702	4192	3817	3575	3470
South Africa	3842	3599	3441	3337	3209	3090	3051	3007	2968
Zimbabwe	2285	2239	2221	2197	2166	2195	2298	2383	2564
Poland	2019	2109	2334	2596	2869	2723	2619	2554	2481
Ireland	1482	1665	1765	1858	1811	1733	1693	1661	1630
Ghana	1385	1377	1346	1333	1314	1304	1340	1424	1529
Australia	1963	1753	1568	1441	1288	1168	1124	1220	1284
Pakistan	1097	1081	1068	1053	1034	1030	1012	1009	1001
Zambia	860	851	838	831	815	807	810	826	833
Bulgaria	715	743	781	843	883	852	831	821	810
Nepal	546	565	579	603	611	649	688	722	775
Greece	140	210	346	526	759	745	744	749	764
Jamaica	424	419	417	411	410	390	419	586	704
Kenya	644	630	623	610	593	584	594	625	659

Source: OECD Health Statistics (based on national data submission to OECD/Eurostat/WHO-Europe Joint Questionnaire)

Example of results from joint data collaction: Inflow of foreign-trained nurses in United Kingdom



Source: Analysis of data from OECD Health Statistics (based on national data submission to OECD/Eurostat/WHO-Europe Joint Questionnaire

Example of results to monitor emigration by using immigration data: Annual outflows of nurses from Romania

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Belgium	7	24	54	50	57	87	123	269	194	180	163	94	96	159	100	74
Canada	55	42	37	34	59	47	34	41	34	14	22	17	5	10	0	8
Denmark			5	5	9	3	7	3	5	2	6	11				
Finland							1				2	2	1		1	1
France			1	6	8	30	27	15	7	6	8	4	6	7	10	2
Germany								**72**	**207**	**465**	**798**	**804**	**795**	**696**	**738**	**777**
Hungary									19	21	24	26	24	43	18	20
Ireland				17	4	7	13	6	25	22	37	155	224	107	11	
Israel	1	2	3	2	2		1		1					3		1
Italy	**1424**	**1781**	**2225**	**1337**	**1269**	**1122**	**1045**	**720**	**541**	**521**	**340**	**423**	**190**	**182**	**266**	**335**
New Zealand															1	
Norway	2	2	9	9	4	8	6	13	27	26	26	26	32	23	27	44
Spain	85	255	364	118	4	10	22	14	5	1	3			5	60	54
Sweden	0	0	0	0	1	1	2	4	9	7	4	16	4	10	10	7
Switzerland	33	41	20	30	51	45	38	36	29	24	31	33	30	34	45	31
Türkiye	1	0	0	0	0	0	1	0	0	0	0					
United Kingdom	**37**	**84**	**237**	**370**	**211**	**308**	**660**	**465**	**458**	**1215**	**2344**	**2411**	**120**	**127**	**115**	**147**
United States	74	53	48	36	37	25	27	15	11	16	12					
TOTAL	**1719**	**2284**	**3003**	**2014**	**1716**	**1693**	**2007**	**1673**	**1572**	**2520**	**3820**	**4022**	**1527**	**1406**	**1402**	**1501**
Number of countries reporting data	11	11	13	14	14	13	15	14	16	15	16	13	12	13	14	13

Sources: National data submission to OECD/Eurostat/WHO-Europe Joint Questionnaire

Strengths and limitations
EC Regulated Professional Database

Strengths

- Request for recognition of professional qualifications provide data on intention to migrate
- Data easy to collect and compare in Europe
- Information on place of education/training available

Limitations

- Does not provide data on health workers who have actually migrated (many other steps in the process before people actually migrate, if they migrate)
- Does not provide data on destination countries
- Does not cover "popular" destination countries outside Europe where doctors and nurses may seek recognition of professional qualifications (e.g. USA, Australia, Canada)

Strengths and limitations
OECD/Eurostat/WHO-Europe Joint Questionnaire

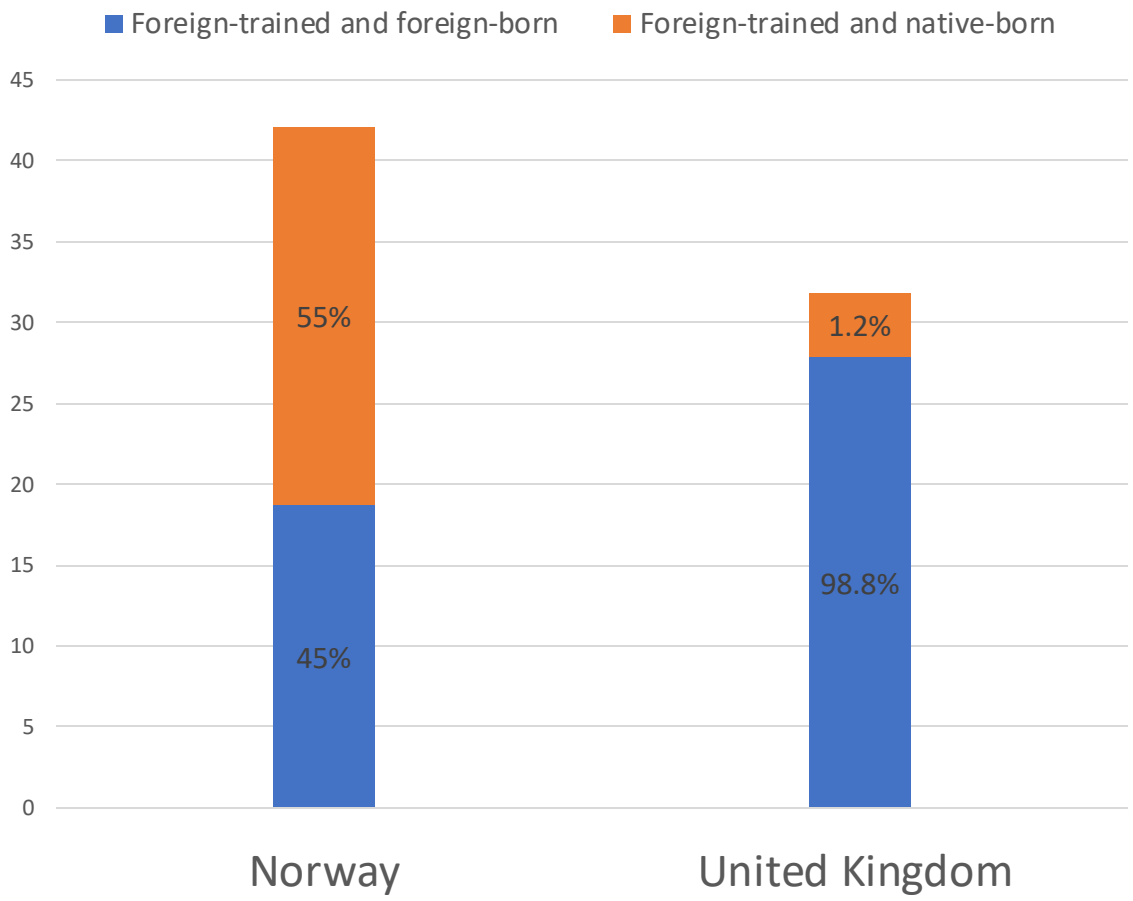
Strengths

- Data on actual migration based on place of training (the most relevant variable to monitor "brain drain")
- National data sources (professional registries) often provide data on both stocks and flows of immigration of health workers
- Data covers all countries of origin (not only European countries)
- Aggregation of immigration data from destination countries is the most feasible way to monitor emigration on a regular basis

Limitations

- Data on immigration not available/submitted by all destination countries (but key requirement is to get data from main destination countries, not all countries required)
- Foreign-trained health workers are not always immigrants ("foreign-trained but native-born" doctors do not reflect "brain drain" but internationalisation of medical education)

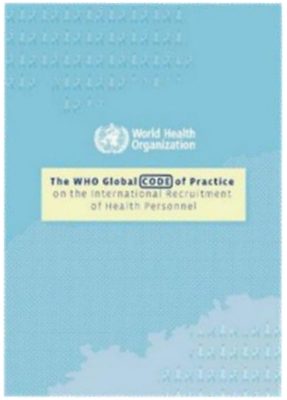
Share of foreign-trained doctors Examples of Norway and United Kingdom



Note: Data refer to 2021
Sources: National data submission to OECD/Eurostat/WHO-Europe Joint Questionnaire

POSSIBLE POLICY RESPONSES TO MITIGATE NEGATIVE CONSEQUENCES OF HEALTH WORKFORCE MIGRATION ON COUNTRIES OF ORIGIN

Avoid active recruitment of health workers in countries with the most severe shortages



- Key principle of WHO Global Code of Practice on International Recruitment of Health Personnel is to avoid active recruitment in countries with most severe shortages
- WHO recently updated the list of 47 countries worldwide requiring health workforce support and safeguards discouraging active international recruitment
- Most of these countries are in Africa

Region	Africa	Eastern Mediterranean	Western Pacific	South East Asia	Americas
Countries	33	6	5	2 (Bangladesh, Nepal)	1 (Haiti)

https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_10

Promote mutually beneficial bilateral agreements

- Aim of bilateral agreements is to maximise benefits and address any trade-offs between interest of health workers, countries of origin and destination countries
- New WHO/OECD report will review 37 bilateral agreements on health workforce mobility (coming out soon)
- Findings show mixed results:
  - Ministry of Health should play a critical role, but often not engaged
  - Power dynamics, capacity, 'push' and 'pull' factors often place destination countries with an advantage in negotiation and implementation of agreements
  - Evidence on health system benefits in countries of origin not identified
  - Respect for health worker rights and well-being incorporated in increasing number of agreements
  - Scarcity of data on agreement implementation, evaluation and impact

Addressing both "pull" and "push" factors

- Shared responsibility of destination countries and countries of origin to mitigate the factors contributing to emigration flows from countries of origin with low supply of health workers

"Pull" factors in destination countries:

- Increase domestic education/training capacity to reduce reliance on international recruitment
- Improve working conditions to increase retention rates (particularly for nurses, but also doctors)

"Push" factors in origin countries

- Address the various reasons/factors pushing health workers to migrate
- Improve working conditions (including health workers safety)
- Increase pay rates of health workers where possible to reduce the pay gaps