A dynamic understanding of health worker migration

Prominence of Bilateral Agreements

The international migration of health workers is increasing. There has been a 60% rise in the number of migrant doctors and nurses working in OECD countries over the last decade. Future projections point to a continuing acceleration in the international migration of health workers, with an escalating mismatch between the supply of and economic demand for health workers.

The European Union and the Norwegian Agency for Development Cooperation, sought to advance understanding and management of health worker migration through targeted support to the implementation of the *WHO Global Code of Practice on the International Recruitment of Health Personnel*. Targeted support was provided at the global level and in five countries: India, Ireland, Nigeria, Uganda, and South Africa.

Implementation of the WHO Global Code provides a new and dynamic understanding of health worker migration, with substantial intra-regional, South-South and North to South movement to complement the better understood movement of health workers migrating from the global South to the global North. Temporary migration, including professional registration and employment in multiple jurisdictions, is also evidenced.

WHO Global Code of Practice on the International Recruitment of Health Personnel

The Code, adopted by the World Health Assembly in 2010, is a key global governance instrument. It is contributing to better understanding and management of health worker migration through improved data, information and cooperation. Member States and all relevant stakeholders are called upon to implement and report on the recommendations of the Code, with the WHO Director-General mandated to report on its implementation every three years.

The value and legitimacy of the Code is increasing. Seventy-four countries submitted complete national reports during the second round of reporting in 2015/2016: an increase in over 30% from the first round, with improvement in quality and the geographic diversity of reporting. Sixty-five agreements between countries were identified, with 22 countries taking into account ethical considerations as called for by the Code.

The third round of national reporting will take place in May 2018, with the WHO Director-General to report the findings to the 72nd World Health Assembly in May 2019.

Complex Patterns of Mobility: A blurring of "source" and "destination"

South to South movement

Nigeria, Cuba, and Democratic Republic of the Congo (DRC) are respectively the

1st, 3rd and 4th

largest sources of immigrant medical doctors who entered South Africa between 2011-2015.

More than

1/2

of emigrant nurses from Kerala (India) are estimated to reside in Gulf countries according to the Kerala Migration Survey.

In 2014 approximately

1/5th

of all new entrants licensed to practice in Nigeria were foreign medical graduates with an estimated half from Asia and one third from African countries.

Approximately

1/2

half of doctors in Trinidad and Tobago are foreign born and foreign trained; **with one third from India, and a quarter each from Jamaica and Nigeria.**

Globalization of medical education

- In the General Division of Ireland's Health Services Executive, **less than**

  1/2

  of European medical school graduates (excluding Ireland's) are EU passport holders.
- From 2010–2016, 38 **foreign nationals from 10 countries** (including Kenya, India, Iran, Mexico and Poland.) received their basic medical qualification in Uganda.

North to South movement

Almost

1/3rd of GP's

who registered in Uganda (2010–2015) were trained and held nationality in Europe or North America. Nationals from 74 countries registered in Uganda during the period.

UK was the

2nd **largest source** of immigrant medical doctors who entered South Africa (2011–2015).

Temporary migration

- Of doctors who received their basic medical qualification in South Africa and registered in Ireland, **only**

  1/5th

  reported practising only in Ireland.

Intra-regional movement

Over

1/2

of emigrant GPs from Uganda

(2010-2015) are estimated to have moved within Africa, primarily to Southern and Eastern Africa with Namibia and Kenya as leading destinations.

2/3rd

of Argentina's

foreign-trained doctors originate from Bolivia and Colombia.

Focus Countries: Results – highlights

Through targeted support, strong evidence has been generated on the stock and migration flow in surgical care, general medical practice and for the nursing and midwifery workforce in the five focus countries.

India

- Near doubling of doctors with MBBS: 37,192 in 2010/2011; 63,985 in 2017.
- From 2000-2015, colleges offering nursing degrees increased from 30 to 1,650. In Kerala, the number of seats available in nursing institutions increased from 124 in 2005 to 17,600 in 2016, with over 90% of seats in private institutions.
- According to the Kerala Migration Survey, more than 50% of emigrant nurses from Kerala (India) are estimated to reside in Gulf countries, with UAE, Australia, Saudi Arabia, Kuwait, United Kingdom and the United States of America the leading destinations in 2013.
- The Kerala Migration Survey estimates an external emigration rate of 19.4 % for medical doctors from Kerala (India), with Gulf countries a leading destination.
- Findings from a 2016 cohort study of Kerala medical doctors graduating in 2010 evidences substantially greater internal migration (20%) as compared to external migration (5%); related to improved postgraduate education opportunities in India.

Ireland

- The pattern of migration of medical doctors has been characterized as one of "brain gain, brain waste, and brain drain".
  - Brain gain: in 2015, there were approximately 20,000 doctors on Ireland's medical register – international medical graduates (IMGs) constituted 38%, with the Eastern Mediterranean Region the leading source.
  - Brain waste: in 2015, almost 77% of non-consultant hospital doctors (e.g. non-specialists) not in training posts were IMGs, compared with 23% for Irish medical graduates.
  - Brain drain: exit rates from the general division of Ireland's medical register, an estimated two thirds of which are IMGs, are three to four times higher than from the specialist division.
- The number of nurses and midwives registered as inactive due to working abroad increased by approximately 60% between 2007–2014.
- Data evidences practice in multiple jurisdictions for IMGs registered in Ireland. As example, approximately 20% of those who qualified in South Africa and registered in Ireland reported only working in Ireland.

Nigeria

- From 2010–2016, an average of 600 GPs were estimate to emigrate annually from Nigeria; nearly 50% of emigration was to Europe, followed by North America and Africa.
- In 2014, approximately 17% of all new entrants licensed to practice in Nigeria were foreign medical graduates. Analysis of the applications for temporary registration in Nigeria – a proxy for source of migration of foreign medical doctors entering the country – shows that 50% were from Asia, 29% from other African countries, 14% from Europe and 4% from America.
- In 2016, letters of verification, a proxy for intention to emigrate, were processed for 13% of the nurses and midwives registered that year. The top destinations for emigrant nurses and midwives were the United States of America, Canada, United Kingdom, United Arab Emirates, Australia, and Ghana.

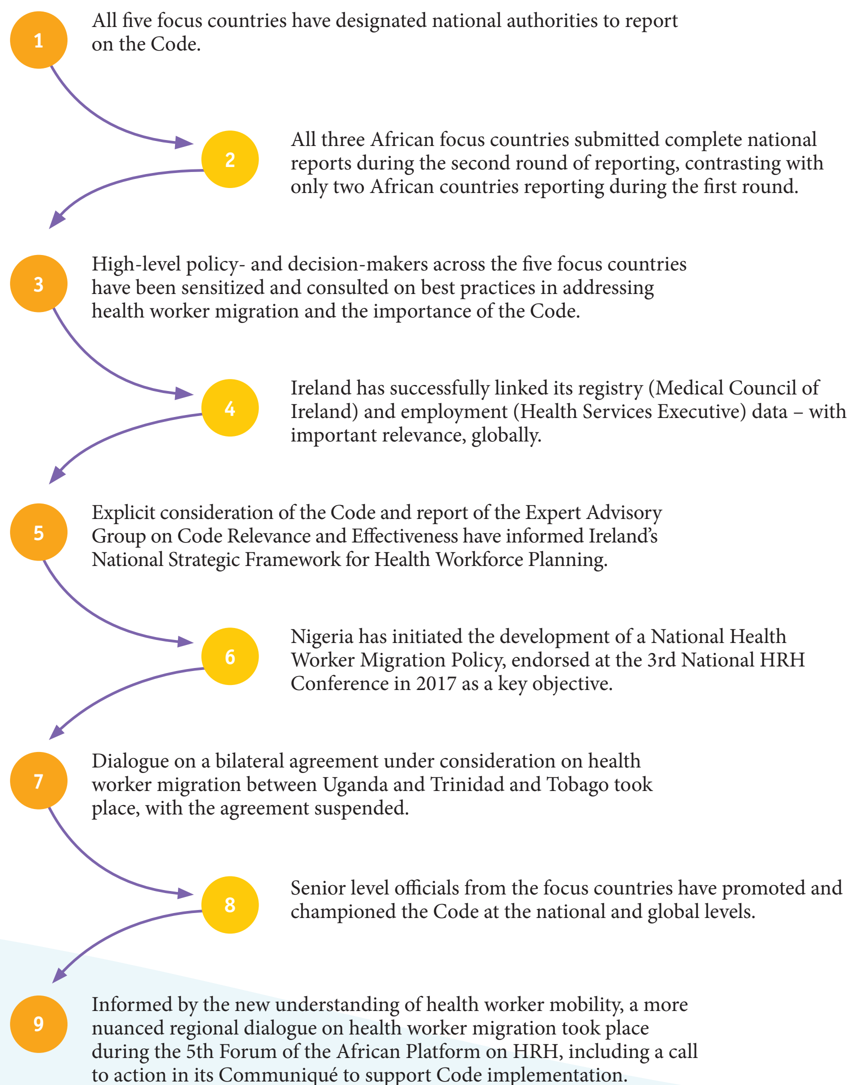
Uganda

- Between 2010–2016, 2915 GPs entered the Ugandan labour market: 38% of registered GPs were foreign nationals, mainly from North America (19%) and Europe (12%).
- Data indicates that 5% and 2% of nationally-trained and foreign-trained GPs, respectively, were unemployed in the period.

South Africa

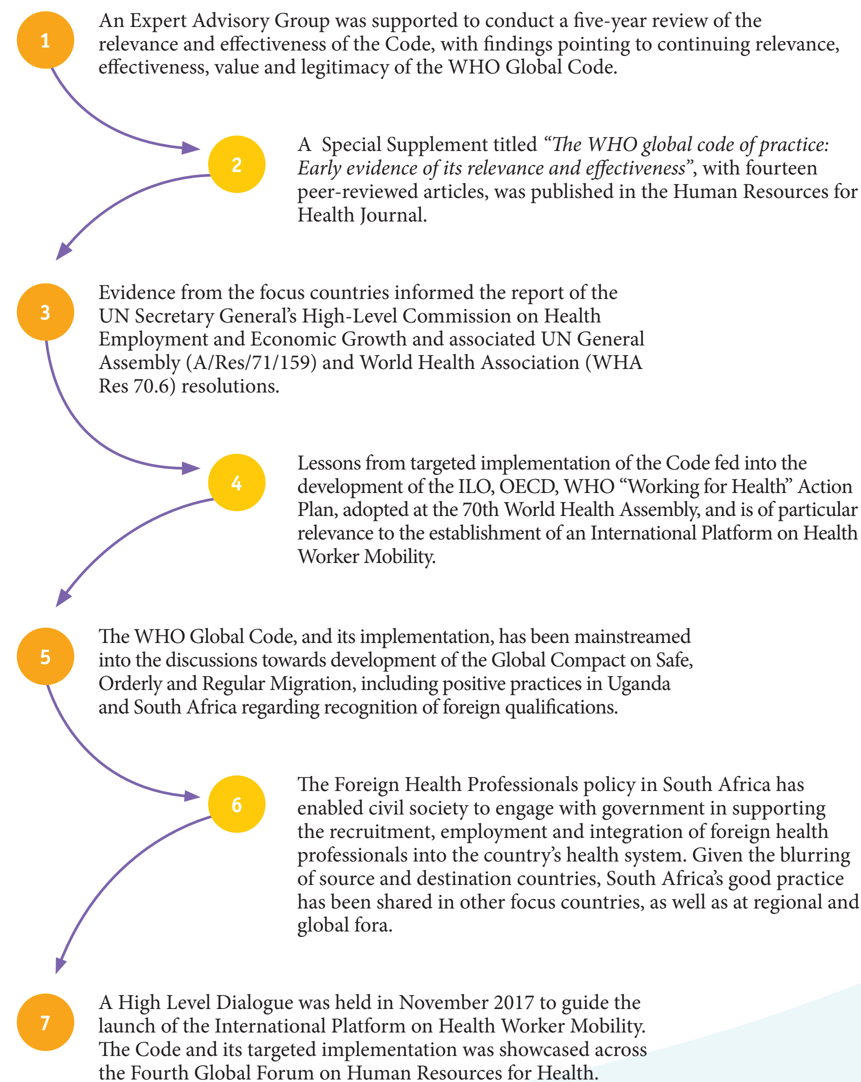
- Each year the government processes applications for medical doctor registration from over 60 countries, with Nigeria the leading source. The United Kingdom is the second largest source, followed by Cuba and the Democratic Republic of the Congo.
- Second round of national reporting on the Code evidences that migrants constituted more than 10% of South Africa's total medical workforce; further confirmed by the Health Professions Council data.
- Enabled by the Foreign Health Professionals policy, Africa Health Placements has placed approximately 3000 migrant doctors, mostly from the United Kingdom, into South Africa's health system. Some 430 refugee doctors from the Democratic Republic of the Congo have also been successfully integrated.

Policy achievements
National level



1. All five focus countries have designated national authorities to report on the Code.
2. All three African focus countries submitted complete national reports during the second round of reporting, contrasting with only two African countries reporting during the first round.
3. High-level policy- and decision-makers across the five focus countries have been sensitized and consulted on best practices in addressing health worker migration and the importance of the Code.
4. Ireland has successfully linked its registry (Medical Council of Ireland) and employment (Health Services Executive) data – with important relevance, globally.
5. Explicit consideration of the Code and report of the Expert Advisory Group on Code Relevance and Effectiveness have informed Ireland's National Strategic Framework for Health Workforce Planning.
6. Nigeria has initiated the development of a National Health Worker Migration Policy, endorsed at the 3rd National HRH Conference in 2017 as a key objective.
7. Dialogue on a bilateral agreement under consideration on health worker migration between Uganda and Trinidad and Tobago took place, with the agreement suspended.
8. Senior level officials from the focus countries have promoted and championed the Code at the national and global levels.
9. Informed by the new understanding of health worker mobility, a more nuanced regional dialogue on health worker migration took place during the 5th Forum of the African Platform on HRH, including a call to action in its Communiqué to support Code implementation.

Policy achievements
Global level



1. An Expert Advisory Group was supported to conduct a five-year review of the relevance and effectiveness of the Code, with findings pointing to continuing relevance, effectiveness, value and legitimacy of the WHO Global Code.
2. A Special Supplement titled *"The WHO global code of practice: Early evidence of its relevance and effectiveness"*, with fourteen peer-reviewed articles, was published in the Human Resources for Health Journal.
3. Evidence from the focus countries informed the report of the UN Secretary General's High-Level Commission on Health Employment and Economic Growth and associated UN General Assembly (A/Res/71/159) and World Health Association (WHA Res 70.6) resolutions.
4. Lessons from targeted implementation of the Code fed into the development of the ILO, OECD, WHO "Working for Health" Action Plan, adopted at the 70th World Health Assembly, and is of particular relevance to the establishment of an International Platform on Health Worker Mobility.
5. The WHO Global Code, and its implementation, has been mainstreamed into the discussions towards development of the Global Compact on Safe, Orderly and Regular Migration, including positive practices in Uganda and South Africa regarding recognition of foreign qualifications.
6. The Foreign Health Professionals policy in South Africa has enabled civil society to engage with government in supporting the recruitment, employment and integration of foreign health professionals into the country's health system. Given the blurring of source and destination countries, South Africa's good practice has been shared in other focus countries, as well as at regional and global fora.
7. A High Level Dialogue was held in November 2017 to guide the launch of the International Platform on Health Worker Mobility. The Code and its targeted implementation was showcased across the Fourth Global Forum on Human Resources for Health.

Innovations in methodology

- Research protocol for capturing "stock and flow" of health workers developed.
- Variety of methods used to estimate emigration: certificates of good standing and letters of verification (Uganda, Nigeria); age specific exit rates analysis of professional council registers (Ireland); migration surveys (Kerala, India); and social media (Kerala, India).
- Across countries, capturing immigration data is easier and more reliable than emigration data.
- The Code reporting mechanism is a key mechanism to share immigration data and advance understanding of international health worker migration patterns: Argentina, Austria, Belize, Brazil, Cambodia, Canada, Kiribati, Latvia, Maldives, Namibia, Portugal, Singapore, South Africa, Switzerland, Trinidad and Tobago, and Uganda provided immigration data during the second round.

> *"Better evidence is fundamental to understanding the dynamic nature of health worker migration and maximizing benefits from it."*
>
> Jim Campbell, Director, Health Workforce Department, WHO.

Key Lessons

1. All countries are source and destination, albeit to varying degrees.
2. Policies for the integration of foreign health professionals (e.g. South Africa) are relevant across all countries.
3. Strategic linkages must and can be made across the health labour market: production, licensing and registration, employment, and migration.
4. Improved reporting and sharing of immigration data through the WHO Global Code (e.g. 3rd round) will provide a more complete global picture of health worker mobility.
5. Targeted support to implementation of the Code in low-income and middle-income countries is fundamental.

> *"The project has evidenced the value of targeted support to implementation of the WHO global Code, particularly in low-income countries."*
>
> Dr Francis Omaswa, Director, African Centre for Global Health and Social Transformation, Uganda.

International Platform on Health Worker Mobility

As an immediate action, the High Level Commission on Health Employment and Economic Growth called on ILO, OECD, and WHO to work with relevant partners to establish an international platform on health worker mobility to advance dialogue, knowledge and cooperation in the area. The WHA Resolution 70.6 adopted the ILO, OECD, and WHO Five Year Action plan, with a specific call for the establishment of the international platform.

The platform will seek to facilitate robust policy dialogue and action on health labour mobility through strengthened monitoring, country support, knowledge generation and sharing, and through strengthened support to the WHO Global Code and relevant ILO Conventions and Recommendations.

Senior level policy-makers convened on the margins of the 4th Global Forum on Human Resources for Health, to share perspectives and guide the launch of the platform.

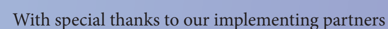
The International Platform on Health Worker Mobility will serve as a key mechanism to strengthen the Code and its implementation, building on progress achieved in the five focus countries.

With special thanks to our implementing partners

- The Royal College of Surgeons (Ireland)
- The African Centre for Global Health and Social Transformation (Uganda and Nigeria)
- The African Institute of Health and Leadership Development in South Africa (South Africa)

Funding provided by the European Union (DCI-MIGR/2013/282-931)

Case studies can be consulted at: http://www.who.int/workforcealliance/brain-drain-brain-gain/en/



WHO/HIS/HWF/BrainDrain/EC/2017.1