



Health Worker Migration in the European Region:
Country Case Studies and Policy Implications

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Health Worker Migration
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Country Case Studies and
Policy Implications

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The document provides an analytical overview and highlights the key findings of the five country case studies on health worker migration in the European region - Estonia, Germany, Lithuania, Poland and the United Kingdom. It reports on the current level of reported staff shortages, assesses migratory flows of different categories of health workers and examines policies and policy responses. The country reports are based on the analysis and views of the country-based authors.

Country Reports:

Estonia	Pille Saar
Germany	Katja Borchardt
Lithuania	Liudvika Starkiene, Zilvinas Padaiga
Poland	Roman Danielewicz, Katarzyna Majcher, Ewelina Kowalska
United Kingdom	James Buchan

1. Introduction

This report presents an overview of the policy implications of the international migration of health workers in Europe, based on case studies conducted in five countries – Estonia, Germany, Lithuania, Poland and the United Kingdom – and draws on information from other WHO European Region countries, such as Israel and Latvia. International recruitment and migration of health workers has been a growing feature of the global health agenda since the late 1990s (see OECD, 2002; Stilwell et al., 2003, 2004 and Buchan et al., 2003, for example) and was one of the issues identified for further examination at the “Human resources for health” workshop organized by WHO Regional Office for Europe (2004) in May 2004.

Migration of skilled workers is on the increase across a range of sectors (Findlay & Lowell, 2002). In the health sector, medical doctors, nurses and other health workers have always taken the opportunity to move across national borders in pursuit of new opportunities and better career prospects (Mejia et al., 1979) but in the last few years this migration appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries. While the issue of international migration of health workers is sometimes presented as a one-way “brain drain”, the dynamics of international mobility, migration and recruitment are complex, comprising individual rights and choice, motivations and attitudes of health workers, the differing approaches of governments to managing, facilitating or attempting to limit out-flow or in-flow of health workers and the role of recruitment agencies.

This migration can have positive aspects: it can be a solution to the staff shortages in some countries, it can also assist source countries which have an oversupply of staff, and it can be a means by which individual health workers can improve their skills, career opportunities and standard of living. However, it can also create additional problems of shortages in the health systems of some countries that are already understaffed.

The effectiveness of health systems that lose scarce skilled workers may suffer, as highlighted in the May 2004 World Health Assembly resolution

(World Health Organization, 2004). The effect of health professionals' migration on health system performance has therefore become more significant in recent international health policy debate (Buchan, 2001; Chanda, 2002; Tjadens, 2002; Pang, Langsang and Haines, 2002; Stilwell et al., 2003; Buchan et al., 2003; Dumont and Meyer, 2004; Buchan & Dovlo, 2004). Much of the focus of this policy attention has been on the negative impact of emigration of health workers from sub-Saharan Africa.

European Union Accession

In Europe there has been an additional dynamic - the accession of ten more states to the EU in May 2004. An overview report completed before the 2004 accession of new member states (Krieger, 2004) reported the following key estimates: there were 13 million non-national citizens living in the 15 EU member states in 2000, but half were nationals of other EU countries; the net flow of immigrants in 2000 was 680 000 people, or 2.2 per 1000 population. The income gap between acceding countries in central and eastern Europe and existing member states was estimated at 60%, much higher than in the previous enlargement of the EU. The Council of Europe has also examined the issue of cross-border mobility of health professionals, and has developed draft recommendations (Council of Europe, 2005).

Some of the European countries summarized in the country reports, such as Germany and the UK, are reported to be recruiting staff from other countries. Others, such as Lithuania, are reporting emigration of health workers, or are concerned that this may increase as they are now part of a much larger free market for mobile health professionals.

Types of migration

The report focuses primarily on the cross-border migration of physicians and nurses, because these are the occupations for which there is greatest availability of data, and because they have been the focus of most policy attention. However, it must be noted that all types of health workers can migrate, but do not always do so as health workers. Immigrant doctors working as taxi drivers and immigrant nurses working as care assistants are found in many countries, but are not easily reflected in data on health professional migration.

Emigration may be temporary or permanent, voluntary or forced, stimulated by positive incentives in the destination country and/or negative incentives in the country of origin. These different types of migration were summarized by Stilwell et al. (2003).

Table 1: Typology of migrants

- **Permanent settlers** are legally admitted immigrants who are expected to settle in the country, including those admitted to reunite families.
- **Documented labour migrants** include both temporary contract workers and professional transients:
 - Temporary migrant workers* are skilled, semi-skilled or untrained workers who remain in the receiving country for finite periods as set out in an individual work contract or service contract made with an agency.
 - Temporary professional transients* are professional or skilled workers who move from one country to another, often with international firms.
- **Undocumented labour migrants** are those who do not have a legal status in the receiving country because of illegal entry or overstay.
- **Asylum seekers** are those who appeal for refugee status because they fear persecution in their country of origin.
- **Recognized refugees** are those deemed at risk of persecution if they return to their own country. Decisions on asylum status and refugee status are based on the United Nations Convention Relating to the Status of Refugees, 1951
- **Externally displaced persons** are those not recognized as refugees but who have valid reasons for fleeing their country of origin (such as famine or war).

There is little international standardization of migration-related documentation, making it difficult to compare levels of general migration between countries (Auriol & Sexton, 2001). There is also often a lack of specific data on health professionals (Diallo, 2004). It is therefore not possible to develop a detailed pan-European or international picture of the movement trends of doctors, nurses and other health workers, or to assess the balance between temporary and permanent migrants.

The motives of migration

The motives for migrating are often characterized as “push and pull” factors. Table 2 below summarizes some of the possible main push and pull factors related to health workers. To a certain extent, they present a mirror image – on the issues of relative pay, career prospects, working conditions and environment available in the source and destination countries. Where the gap (or perceived gap) is significant, the pull of the destination country will be felt.

However, there are other factors that may also act as significant push factors in specific countries at specific times, such as concerns about personal security in areas of conflict, and economic instability. Other pull factors, such as the opportunity to travel or to assist in aid work, may also be important.

Table 2: Main push and pull factors in migration and international recruitment of health workers

Push factors	Pull factors
Low pay (absolute and/or relative)	Higher pay
Poor working conditions	Opportunities for remittances
Lack of resources	Better working conditions
Limited career opportunities	Career opportunities
Limited educational opportunities	Better resourced health systems
	Provision of post-basic education
Impact of HIV/AIDS	Political stability
Unstable/dangerous work environment	Travel opportunities
Economic instability	Aid work

Adapted from Buchan, Parkin, Sochalski, 2003

People are motivated to move for different reasons, and the mix of migrant health workers may differ among countries and times. Migration is not just a one-way flow from origin to destination - health workers may leave one country to work in a second, and then either return to their home country, or move on to a third. They may even live in one country and cross a national border on a regular basis to work in another. Improvements in travel and communication, combined with availability of employment can encourage this circulation - for example Filipino nurses working in Ireland have been actively recruited to Australia (Marino, 2002).

Other factors, such as geographical proximity, and shared language, customs and educational curricula and professional qualifications may affect the choice of a destination country. Post colonial ties (including similar educational curricula and language) may also be a factor in some EU countries. As noted above, there is relatively free mobility of some types of health professionals within the EU as well as traditional links between countries; for example, health professionals move freely among the Scandinavian countries, and doctors and nurses move between Ireland and the UK, France and Belgium, and Germany and Austria (Buchan et al., 2003; Simoens & Hurst, 2006).

There are also issues of professional and cultural adaptation to be considered. Doctors and nurses moving from one country to another may speak the language and have the recognized qualification, but it is likely there will be a period of adapting to clinical procedures and the broader organizational culture, since countries may have differing standards, qualifications and linguistic requirements. This issue is under-researched (but see Yi & Jezewski, 2000; Daniel, Chamberlain & Gordon, 2001; Simmgen, 2004; Borow et al., 2004; Buchan et al., 2005; Blitz, 2005).

This overview paper assesses the implications of health worker migration among countries in Europe, drawing from the country case studies. Internal migration of health workers is also a major factor in some countries, often compounding existing problems of uneven geographical distribution.

There are two further sections to this report. First, current health worker migration in Europe (both internal and external) is discussed, drawing prima-

rily from the five country examples. Second, the policy implications are considered in detail, including those for the EU accession states.

It should be noted that while the main focus of the country case studies was to assess overall trends in the movement of health workers, this was not feasible, because the data for many countries was limited, incomplete or inexistent. There is a clear need to improve data availability to support monitoring (WHO and OECD are already in dialogue about this issue). The case studies also highlight specific migration issues that merit further policy research, and these are the subject of our final section.

2. Country case studies

This section reports on current staff shortages, assesses migratory flows of various categories of health workers and examines policies. As countries define and categorize health workers differently, and collect different types of workforce data, it is not possible to undertake a complete, detailed comparison. However, the country case study information can be used to examine how countries are affected by immigration and emigration of health workers. The country reports are based on analyses by the country-based authors. More detailed information is contained in the country reports, which are available from the WHO Regional Office for Europe.

Table 3: Health workforces, country case studies

Country	Population of main categories of health worker	Number/ (whole time equivalent) working in health sector	Skill shortages (or oversupply)
Estonia	P 5 085 N 9 772	P 4 420 N 8 099 (6% of P and 13% of N in country not practising)	P: in some specialities, N: significant shortages in some regions & specialities
Germany	P 273 000 N/M 539 000 (Total workforce: 3 280 000)	P 187 000 (176 000) N 705 000 (539 000)	In some specialities, regions
Lithuania		P 396/100 000 N 759/100 000 61% of P were practising	In some specialities, regions; “Surprisingly high” drop-out rates from younger cohorts of P
Poland	P 113 512 N 263 983 (2004)	P 87 617 N 192 538 4 614 unemployed N (2004)	Unemployment in some regions/ specialities
United Kingdom	P 200 000 N 640 000	P 110 000 National Health Service (NHS) (England) N 400,000 NHS 100,000 (other)	Some specialties, regions (particularly London)

Source: country reports

It is important that any examination of emigration of health workers relates the numbers leaving the country to the overall number leaving the health workforce; many workers may have left the health sector, but actually remain in the country. Emigration may be the most obvious aspect of out-flow of workers, but it will not necessarily be the biggest flow from the health system.

Health workforces

The Table below provides background data from the country correspondents, showing the size of the physician (P) and nursing (N) work force (where midwives are reported separately, “M” is used) in each of the countries, and indicating skills shortages.

The first point to note is that the actual size of the medical doctor and nursing workforce, and its size relative to the country population, varies significantly. The five countries examined represent extremes of size: three of the larger countries in Europe (Germany, Poland and the United Kingdom) and two of the smaller. The second point to note is that all country respondents highlight some geographical and/or skill shortage. Countries with relatively small workforces, either in absolute terms, or relative to population size, may be particularly vulnerable to negative effects of emigration.

Significance of migration

There are two main indicators of the relative significance of migration and international recruitment to a country: the in-flow of workers from other countries (or the out-flow to other countries), and the stock of international health workers in the country. In some cases, the data and information presented in the country reports can be used for these purposes.

Limitations and gaps in data are reported in all countries, constraining the detailed overview and, more critically, leaving policy-makers in some countries without the information necessary to make informed decisions about health worker migration.

The United Kingdom reports the highest level of in-flow. About one in three physicians in the NHS is from another country. This is a result of an explicit policy of international recruitment, based on bilateral agreements (for example, an agreement with Spain on nurse recruitment), and regulated



Table 4: Country case studies: key indicators of migration and international recruitment of health workers

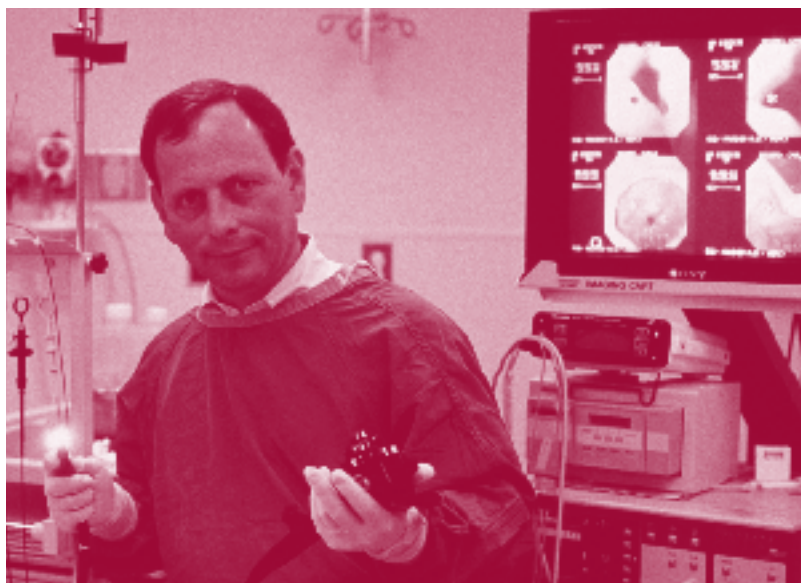
Country	International workers in country (medical workers' % of total in brackets)	In-flow (% of total in brackets)	Out-flow (% of total in brackets)	Major source / destination countries	General comments
Estonia		Small number (only 24 P since 2001)	P 182 N 90 (approx 4% of working P; 1% of working N) (2004–2005)	To Finland, UK, Sweden, Germany	Migration “not biggest problem”- non-practice in country is bigger issue; Pay increase in January 2005 to combat out-flow
Germany	P 17 318 (approx 6%; upward trend) No data on N	upward trend	Low, based on incomplete data	P from: Russia, Iran, Greece, Austria, Poland P to: UK, Norway, Sweden	Increasing in-flow of P from EU accession countries (mainly Poland)
Lithuania	exact data on migration of HHR is not available	Incomplete information, but small numbers	416 certificates issued for P (3.1%) 129 for N (0.5%) (2004–2005)	Stated preference of P to: Germany, UK, Nordic countries	“National-level policy interventions in Lithuania are aimed at targeting the main reasons for migration, i.e. salaries, working conditions and career possibilities.”
Poland	Incomplete data 8% of registered nurses (2002)	No information; no active recruitment from other countries 12 000 N (38% of new in-flow) (2004–2005)	2 533 EU certificates for P 2 830 for N 797 for dentists Highest potential out-flow: anaesthesiologists, 7.7% of total (2004-2005)	N in-flow: India, Philippines, South Africa, Australia. N out-flow: Australia, Ireland, USA	“Health profession migration during one year of accession to the EU is not as big as it was foreseen.”
United Kingdom	Approx one third of the total of 70 000 NHS hospital medical staff were from other countries (2002)	Over 10 000 doctors in 2003 (70% of total in-flow of new full registrants)	8000 N (2004–2005)	P in-flow: India, South Africa, Australia, EU	International recruitment an explicit policy to assist in increasing NHS workforce; Targeted recruitment of physicians and nurses; Ethical recruitment code for NHS- no active recruitment from specified developing countries

by a code preventing NHS employers from actively recruiting staff from developing countries. Much of the UK international recruitment activity has been focused on English-speaking countries outside Europe, but doctors are being recruited from a range of EU countries, and nurses have been leaving the UK to go to Ireland (these are likely to be Irish nationals who were trained as nurses in the UK). A recent OECD report (Simoens & Hurst, 2006) noted that migrant doctors in the UK come from a broad range of countries, most notably India and Ireland, but also from a range of European countries such as Germany, Greece, Poland, Spain and Ukraine.

In Germany there is a rising trend of recruiting physicians from Poland, with which Germany shares a border, and some indication of increased out-flow to the UK. The federal and devolved structure within Germany makes it difficult to get an accurate national picture, but data suggest that 6–7% of physicians are from other countries, and recruitment activity has been noted in eastern Germany. OECD notes that 27% of foreign doctors in Germany are from other EU countries, 37% are from other European countries, and 35.5% are from outside Europe (Simoens & Hurst, 2006).

The limited data available from Estonia, Lithuania and Poland suggest that in-flow has been insignificant and that out-flow of health professionals may be increasing. The small number of specialists in some categories, particularly in Estonia and Lithuania, means that even small-scale movement will have an impact. Long-term trend data are not available, and in any case the situation changed fundamentally for these countries with EU accession in May 2004. The three countries were not able to provide detailed information on the impact of migration.

Some other countries in the WHO European Region are very active recruiters. For example, Ireland has been recruiting nurses from a range of countries, both within Europe (UK and Spain) and elsewhere (India and Philippines) (Buchan et al., 2003), while Israel has received significant numbers of doctors from countries of the former Soviet Union (Borow et al., 2004). Others, such as the Netherlands, have had only limited active recruitment, and are focussing on developing their own human resources (Tjadens & Roerink, 2002).



Outside Europe, the United States has been an active recruiter in Europe and elsewhere; historically, there has been a strong trend of in-flow of doctors and nurses to the US (Hart et al, 2005).

EU accession

The information in the table also suggests that, in the first 12–18 months of EU accession, the out-flow of physicians and nurses from Estonia, Poland and Lithuania was not as high as had been expected by authorities in these countries. Prior to accession the concern had been that out-flow of health professionals would increase markedly once movement became easier (see Borzeda et al., 2002; PRAXIS, 2004).

Because of these concerns, surveys were conducted before accession to estimate potential out-flow. For example, the Lithuanian country report notes:

In 2002 Stankunas et al. performed a survey of a representative sample to determine the rates of physician and medical resident migration abroad. The survey indicated that 60.7% of medical residents and 26.8% of physicians intended to leave for the EU or other countries. The first-choice countries were Germany, the United Kingdom and the Nordic countries (Denmark, Norway and Sweden). Intentions to move to the EU or other countries permanently were expressed by 14.5% of medical residents and 5.4% of physicians. More than a half of those who intended to work in the EU planned to do that immediately after accession. It was a definitive decision of 2.5% of medical residents and 3.8% of physicians. (Lithuania country report)



In Estonia, the Ministry of Social Affairs: *...commissioned a migration survey from PRAXIS Centre for Policy Studies in order to estimate the potential migration flow of Estonian health care professionals, and its causes. On the basis of the survey, it was concluded that the intentions, reasons and obstacles behind the health care professionals' seeking employment abroad did not differ much from the intentions of the rest of the Estonian population. About 5% of health care professionals had a certain plan of seeking employment abroad. (Estonia country report).*

Relevant authorities in Poland, Lithuania and Estonia have all been attempting to monitor the impact of accession on the out-flow of health professionals, primarily by recording the number of certificates being issued to competent authorities. Data from Latvia that after accession, documents were issued to 211 medical staff considering leaving the country (mainly doctors, dentists and anaesthesiologists)

from May 2004 to September 2005 (Alka, 2005). It is also significant that Estonia, Lithuania and Poland all report increased activity by recruitment agencies. Poland registers and certifies both local and EU recruiters through the Ministry of Economy and Labour.

It is clear that authorities in these countries had already begun to plan for the broader health workforce implications of accession, by looking at methods of improving their long-term workforce planning (for example, Estonia was developing a new health workforce planning model) and by trying to improve retention of staff by improving facilities: Poland reported improving working conditions; Lithuania reported a policy of salary increases, facilities renovation with new equipment and offices for general practitioners; Estonia reported pay increases in January 2005 and similar efforts have been reported in Latvia (Council of Ministers, 2005).

Reasons for migration

The PRAXIS Centre for Policy Studies survey of intent to migrate, conducted in Estonia, showed that health professionals' main reason for considering emigration was the expectation of higher income and better working conditions, while having a family and a home in Estonia were the main reported obstacles to emigration. Using information from this survey, the Estonian country report provided some estimates of the impact of pay differentials on the likelihood of emigration:

Drawing on the 2004 migration survey, there is an estimate of how much the income in the country of destination should exceed the income in the homeland for the doctors and nurses to emigrate. [To justify moving, one's] pay in the destination country should naturally be higher than [the income earned in the] native country. ... [One fourth of those wanting to work abroad want to get a net salary that is three to four times higher than [their present salary]. A quarter of the employees agree to go abroad only if their pay is at least six times higher ... Most employees feel that the fair pay for their present work is lower than the salary for which they would agree to go abroad. This shows the realistic view that one should earn at least enough to cover one's resettling costs when moving abroad. Nearly 60% feel that the fair pay for their work would be 1 to 2 times higher than it is now, and one fifth believes that the pay should be 2 to 2.5 times higher.

(Estonia country report)

This assessment from Estonia shows that while pay differentials will play a part in the decision to stay or move, the additional costs of moving and disruption to family life are also taken into account. The report from Poland noted that "better salaries, better working conditions, better possibilities of professional development" were the main reasons for health professionals emigrating.

Limitations of available data on health worker migration

It is clear that none of the five countries can provide accurate, complete information on international flows of health professionals. All report some degree of limitation in the available information. The most common measure of flow is from certificates issued to competent authorities ("verifications"), who give an overall annual measure of how many professionals considered moving to another coun-

try, but not all of them actually move, and others may apply more than once. For example, the Estonia country report notes that 182 doctors actually emigrated out of the 344 who took out certificates (53%), and 90 out of the 155 nurses (58%).

Another limitation of available information is that it is virtually impossible to track out-flow when the professional does not take up a similar position in the destination country. For example, a Polish nurse who takes up a post as a care assistant in the UK will not be recorded in professional registration data (Buchan, 2005).

Summary

The conclusion that can be drawn from the reports from the three countries that recently joined the EU is that initial emigration of physicians and nurses wishing to continue working in the profession elsewhere in the EU was at a lower rate than that had been suggested by surveys conducted before accession. This does not mean that out-flow will not increase (indeed the information from Germany suggests that the flow of physicians from Poland was increasing), nor does it mean that the actual level of out-flow has not created problems and challenges.

The limited information available from the countries points to overall growth in the migration of health professionals. In Germany and the UK this is primarily immigration, stimulated by the need to fill vacancies, and the promise of better salary, career and educational opportunities. For the UK, the major sources are English-speaking countries (but with increasing recruitment in Germany and Poland), while German immigration is mainly from countries close at hand. There are indications of increased emigration of health professionals from Poland, Lithuania and Estonia; so far the numbers are not as large as anticipated, and all three may be vulnerable to any increase in out-flow.

Box 1: Health worker migration: policy questions and subsidiary research questions

Source countries

Policy

- Should out-flow be supported or encouraged?
- Should out-flow be constrained or reduced? If so, how?
- Should recruitment agencies be regulated?

Research

- What are the emigration destination countries?
- How much emigration is permanent or temporary?
- How much emigration is going to health sector-related employment and education in other countries? To non-health-related employment?
- What is the impact of emigration?
- Why are health workers leaving?
- How should flows be monitored?

Destination countries

Policy

- Is immigration sustainable?
- Is it a cost-effective way of solving skill shortages?
- Is it ethically justifiable?
- Should recruitment agencies be regulated?

Research

- What are the source countries?
- How much immigration is permanent or temporary?
- How much immigration is going to health sector-related employment and education in the country? To non-health-related employment?
- Is immigration effectively managed?
- Why are health workers coming?
- How should flows be monitored?

International agencies

- How should international flows of health workers be monitored?
- What is the appropriate role and response of agencies to the issue of international mobility?
- Should agencies intervene in the process (for example, develop an ethical framework, support government-to-government contracts or introduce regulatory compliance)?

3. Policy implications of health worker mobility in Europe

The flow of health workers across national boundaries in Europe and beyond creates a series of policy questions for national governments and international agencies, as summarized in Box 1.

Estonia, Lithuania, Poland: source countries

The country case studies provide at least a partial response to these policy questions. Countries experiencing a net out-flow of health workers need to be able to assess its causes and impact on the provision of health care. The country reports showed that it was possible to develop a limited assessment of recent trends in out-flow (particularly since accession), but that there was only limited understanding of its effects.

Policy-makers must be able to assess the relative loss of staff due to emigration compared to internal flows, such as health workers switching from the public to the private sector or leaving the profession. In some cases emigration may be very visible but small compared to the number of workers leaving the public sector for other employment within the country. It is significant, for example, that the Estonia country report characterizes non-practise of health professionals within the country as a bigger issue than emigration.

Unplanned or unmanaged out-flow of health workers may damage the health system, undermine planning projections and erode the skills base. It does not appear from the limited information presently available that this situation had been reached in Estonia, Lithuania or Poland, but it is clear that authorities were aware of the potential for these, and were trying to implement policies to improve retention (cf. Latvia Council of Ministers, 2005). Policy responses to reduce out-flow by dealing with poor pay and career prospects, poor working conditions, high workloads and security and improving educational opportunities, are all possibilities.

Table 5: Policy interventions in international recruitment reported by case study countries

Type	Intervention	Countries
Organizational		
Twinning	Hospitals in source and destination countries develop links, staff exchanges, support and flow of resources to source country.	E, G, UK
Staff Exchange	Temporary move of staff to the other organization, based on personal, career and organizational development opportunities.	G, UK
Educational support	Educators, educational resources from the destination to the source organization.	E, G, UK
Bilateral agreement	Employers in the destination country develop agreement with employers or educators in the source country to contribute to or underwrite costs of training additional staff, or to recruit staff for a fixed period, linked to training prior to returning to the source country.	G (regional), UK
National		
Government-to-government agreement	The destination country develops an agreement with the source country to underwrite costs of training additional staff, and/or to recruit staff for fixed period, linked to training and development prior to staff returning to source country, or to recruit surplus staff in the source country.	UK-Spain, Poland-Netherlands
Ethical recruitment code	The destination country introduces a code restricting employers' choice of target countries and employees' length of stay. Coverage, content and compliance issues all need to be clear and explicit.	UK
Compensation	The destination country pays cash or other compensation to the source country, perhaps related to the length of stay, cost of training or cost of employment, possibly brokered via international agencies. In any case, it rarely occurs.	
Managed migration (can also be regional)	A country (or region) with out-flow of staff initiates a programme to stem unplanned emigration, by attempting to reduce the impact of push factors and supporting other to planned migration.	
Train for export	The government or private sector makes an explicit decision to develop training infrastructure to train health professionals for the export market, to generate remittances, or up-front fees.	

In some countries, emigration may be encouraged, either to reduce an oversupply of specific types of workers, or to encourage some workers to acquire additional skills or qualifications abroad to bring home. This was not the case in the three countries, but examples can be seen elsewhere in Europe, for example in the bilateral agreement whereby Spanish nurses work in the UK for an agreed period (Buchan, 2003; Blitz, 2005). Poland reported a small scale project whereby Polish nurses were to work in the Netherlands for a period.

Germany, UK: destination countries

No country is only a destination. Both the UK and Germany reported that health professionals were leaving to work in other countries. However both can best be characterized as destinations in the sense that in-flow is markedly higher than out-flow, creating a net gain in health care personnel.

Some of the main policy challenges for destination countries mirror those of source countries. The ability to monitor trends in in-flow is critical if a country is to be able to integrate this information into its planning, revealing reliance on other coun-

tries to solve skill shortages. Equally important is an understanding of why these shortages of health workers are occurring: are they due to poor work force planning, unattractive pay or career opportunities or early retirement of current health professionals?

Destination countries that are reliant on international recruiting have to be able to assess the relative contribution of international recruitment compared to other key interventions (such as home-based recruitment, improved retention, and return of non-practising health professionals) in order to identify the most effective balance of interventions. They must also ensure that the in-flow of health workers is managed so that it makes an effective contribution to the health system. Policies have included fast-tracking of work permit applications; developing coordinated, multi-employer approaches to achieve economies of scale in recruitment; developing multi-agency approaches to placement of health workers when they arrive in the country, and providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support to ensure that the newly



arrived workers can assimilate effectively. Another challenge may be trying to channel international recruits to the geographic or speciality areas that most require additional staff (as applies to eastern Germany).

The question of whether recruiting health workers from developing countries is ethically justifiable has been much debated in the World Health Assembly (WHO, 2004) and elsewhere. The simple response may be that it is not justifiable to contribute to brain drain in other countries, but a detailed examination of the issue reveals a more complex picture. Active recruitment by employers or national governments has to be contrasted with workers themselves taking the initiative to emigrate. Various types of bilateral and multilateral recruitment agreements are being developed by some recruiting countries, and there are other local and national approaches aimed at encouraging mutual benefit, where the source country is not only a loser in the process (Buchan, 2005b).

It is notable that interventions in Germany are reported at the local/regional level (most policy is determined at the *lander* level), and that the UK is the only country where there is an ethical policy for the international recruitment of health workers (which applies only to the National Health Service in England). None of the countries covered by the case studies reported being covered by any international policies on health worker migration other than EU directives.

Policy implications

1. Improving migration monitoring

There are two basic problems with the current data availability – it is, at best, incomplete for any one country, and it is not comparable between countries. The country cases suggest varying levels of migration and changing trends.

At the national level, two main indicators are required to be able to assess the importance of migration and international recruitment to a country: inflow (and/or out-flow) of workers, and the stock of international health workers in the country. These data may be obtained from professional registers, censuses, work permits, etc. While there has been some limited collation of such data by the EU, of cross-border movement of doctors and nurses, this

has been hampered by incomplete data, and is not readily available in a format that would facilitate policy-related assessment (European Commission, 2004; Buchan, 2005b).

It is also important to take account of temporary flows of migrants. Easier and cheaper transport links make it feasible for personnel to work weekends or at unpopular hours, or peak periods in other countries.

2. Managing flows

Countries can develop interventions to actively manage migration of health workers. One option is bilateral agreements such as those described in the case studies of Poland and the UK. Another is a code of practice – unilateral or multilateral – that articulates principles of effective and ethical international recruitment. The Department of Health in England has issued the Code of Practice on International Recruitment (Department of Health, 2004) which requires NHS employers not to actively recruit from developing countries, unless there is a government-to-government agreement, and Ireland has a best practice guide (Department of Health and Children, 2002). Norway and the Netherlands have set limits for active state recruitment, or have channelled active recruitment via bilateral agreements. Some health professional associations have also promoted codes and principles for international recruitment, including the European Federation of Nurses (ICN, 2001; WONCA, 2002; EFN, 2004).

Whatever the source of any framework or code, its effectiveness will be based on the extent of its content, coverage and compliance. To be most effective, a code should contain practical details to guide international recruitment, cover all relevant employers and countries and include cross-border monitoring mechanisms and penalties for non-compliance.

3. Human resource (HR) policy and practice

A third area for policy focus is equitable treatment for international health workers, and efficient deployment of their skills. Health systems with workers from a number of countries will have to ensure that HR policy and practice is not discriminatory and that international workers have equal access to career development opportunities. The risk factors

associated with multinational workforces with different languages, training and cultural approaches to patient care will also have to be assessed. In source countries, policies could be developed to facilitate the return of migrant workers by providing mechanisms to take relevant experience abroad into account.

Conclusion

Comparing numbers of health sector immigrants with the stock in place, or with in-flow from home-based sources can assist a country in determining how reliant it is on immigrants. By these measures, the UK is more reliant on international health professionals than Germany – the two destination countries examined in detail – but it has the advantage of drawing on a large international labour market of English-speaking health professionals.

The newly acceded EU countries examined in detail show signs of an increase in out-flow, but as yet the numbers do not appear to be as high as was projected prior to May 2004. However, it is early in the process of full integration, and the literature on general migration suggests that it will be younger more mobile health professionals who will be most likely to migrate and this will be facilitated as training curriculum across the EU become more closely aligned. Furthermore, the ageing population and an ageing health care workforce in many of the wealthier EU countries may make it more likely that they will actively encourage immigration of health workers over the next few years.

It is recommended that country governments take any action required to ensure that they are able to make informed decisions about the policy questions set out below:

Source countries

- Should out-flow be supported, to stimulate remittance income or to end oversupply?
- Should it be constrained to reduce brain drain? If so, how?
- Should recruitment agencies be regulated?

Destination countries

- Is in-flow sustainable?
- Is it a cost-effective way of solving skills shortages?
- Is it ethically justifiable?
- Should recruitment agencies be regulated?

In order to be able to make informed decisions, many countries require improved monitoring and evaluation capacity. The critical research questions include the following:

All

- What are the source/ destination countries?
- How much flow is permanent or temporary?
- How should flows be monitored?

Source countries

- How much out-flow is to health sector-related employment and education?
- What is the proportion of out-flow to internal movement into other employment sectors?
- What is the impact of outflow?
- Why are health workers moving?

Destination countries

- Is immigration in-flow effectively managed?
- Are incoming workers treated equitably?
- Why are health workers coming?

At minimum, to support more effective health work force policy and planning, there is a clear need to improve the data on migration of workers so trend monitoring can be more effective. This will enable countries and international agencies to determine if migration of health workers within Europe requires policy action. The indications from the country case studies is that policy action is already underway, but that migration is increasing and is likely to continue to do so and become more complex. Thus, migration of health workers is likely to require continued policy assessment in European countries, as well as remaining on the regional and global agenda.

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