



# Migration of health personnel in the WHO European Region

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## ABSTRACT

This report discusses the flows of health workers in the WHO European Region: where health workers are moving to and from, why they migrate, the magnitude of these flows, and the effects on the health care systems of both source and recipient countries. The report brings together the information that is available on these flows and discusses its limitations. It reviews the literature on the types of health workforce migration and on the factors associated with the decision to migrate and the choice of a destination.

The report distinguishes between the effects of migration on the health workers involved, on the health services in source and recipient countries, and on these two types of countries more generally. It also identifies policy options that have been used to address problems with health workforce migration, examining in particular the adoption of codes of ethics for the recruitment of foreign health workers. While there exist several examples of such codes, their effects have not been systematically assessed yet.

The World Health Organization (WHO) is proposing a global code of ethics for recruiting foreign health workers. The report makes several suggestions in connection with an upcoming European Region consultation on this code.

### Keywords

HEALTH PERSONNEL  
EMIGRATION AND IMMIGRATION  
DELIVERY OF HEALTH CARE  
CODES OF ETHICS  
PUBLIC POLICY  
EUROPE

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## **Abbreviations**

EU	European Union
HRH	human resources for health
OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organization

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## Introduction

At the end of the 1970s, a WHO report described the international migration of doctors and nurses and its possible consequences (Mejia, Pizurki & Royston, 1979). Countries had just signed the Declaration of Alma-Ata on developing primary health care as a strategy to achieve “health for all” by 2000 (WHO, 1978). The basic message of the WHO report was that losing health workers to emigration could become an obstacle to achieving this goal.<sup>1</sup>

The alert did not appear to have a major impact. Awareness of the possible negative effects of migratory flows was reignited more recently, as it became clear that achievement of health objectives such as the Millennium Development Goals (MDGs) that relate to health was being hampered by the absence of strong health workforces, and that part of the problem was related to emigration losses. Member States of the WHO European Region raised the issue with the WHO Regional Committee for Europe (WHO Regional Office for Europe, 2008a), and the European Commission recently initiated a consultation on health workforce policies that reflects on migration.<sup>2</sup> The chief concern is that while migratory flows of health workers may benefit some countries, they may hurt others that cannot afford to lose highly qualified workers who have been trained at high cost and provide essential services (Buchan, 2008).

This paper reviews recently published data and documentation in order to contribute to an informed debate on the migration of health workers. It situates the issue of migration in the dynamics of the health labour market and in workforce challenges that affect the performance of health care systems. We begin by briefly reviewing the context of the current debate and detailing the strategy we have used to collect and review information. Then we summarily describe the dynamics of the supply of health workers and how migratory flows contribute to it. The main chapter of the paper is devoted to describing the migration of health workers in the European Region: what the trends are, who migrates, from and to which countries and for what motives. We also discuss the impact of migration on recipient countries, source countries and the migrating workers themselves. In the final chapter, we review policies for managing the health workforce in general and the migration of health workers in particular. We identify the options for intervening in their migration from a labour market economics point of view, looking at policy options that have been tried and their results. One option that we examine at greater length, in Annex 1, is the adoption of ethical codes for the international recruitment of health workers, and policies that seek to achieve the same end.

## Health workforce challenges on the policy agenda

In the last five years, numerous publications and meetings have alerted policy-makers to the urgent need for strengthening health workforce policies to improve the performance of health care systems and enable them to better provide accessible, efficient, safe and effective

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<sup>1</sup> Article VII of the Declaration states, “Primary health care ... relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community”.

<sup>2</sup> The European Commission’s Directorate-General for Health and Consumers (DG SANCO) launched a *Green paper on the EU health workforce* in December 2008 to provide EU member states consultation on how the EU can help them address problems with human resources for health (HRH).

services.<sup>3</sup> The argument in favour of solid health workforce policies is fairly straightforward: without a workforce that performs well, a health care system cannot perform well. Problems such as shortages and imbalances in the geographical distribution of personnel, poor skill mixes, low productivity and poor motivation have to be identified and addressed.

The WHO Regional Office for Europe is committed to supporting its Member States in their efforts to strengthen their health care systems and achieve their health objectives – which is why it has put workforce issues on its agenda. In most European Region countries, the number of elderly people is increasing more rapidly than other age groups; such developments have a substantial impact on the national epidemiological profile, increasing the burden of chronic illness and the incidence of multimorbidity. Migrants from inside and outside the Region also contribute to changing health needs in many countries. Populations are better informed and have higher expectations in relation to health care, while technological and organizational innovations have been generating new diagnostic and treatment possibilities. All these changes significantly affect the demand for health services and, by extension, how the health workforce needs to perform.

The health workforce is changing too; it is ageing like the rest of the population. There are forecasts of significant reductions in certain categories of personnel, such as nurses and general practitioners in the European members of the Organisation for Economic Co-operation and Development (OECD), (OECD, 2008). New health workers have to be recruited from a smaller pool of young people, whose expectations and behaviours differ from those of the generation that is retiring, e.g. they have higher expectations for the balance between work and life. Younger health workers aspire to a professional life that allows for continuous learning and skill development. They also tend to be more mobile and better prepared to shift work environments and move from one country to another.

The work is changing rapidly as well: workloads are increasing faster than the number of personnel, and general/family practice is developing, though specialization remains strong. Ambulatory and home care are expanding too. Teamwork is becoming the main organizational arrangement, and there is now a great deal of pressure to be simultaneously more effective and more efficient.

In sum, the present context is one of changing health needs, a changing demand for health services and a changing supply of health services. In an ideal world, needs, demand and supply would all be equal. In the health sector, such balance is impossible: the needs are nearly limitless and difficult to identify and measure (e.g. in mental health), while demand and supply are defined by many factors other than need, such as cultural perceptions of health and disease, available funding, professional interests and policy decisions. At issue is how the workforce, the most critical input in the production of services (WHO Secretariat, 2006), is affected by and will respond to the challenges posed by these changes. The migration of health workers is both a response to these changes and a challenge in itself.

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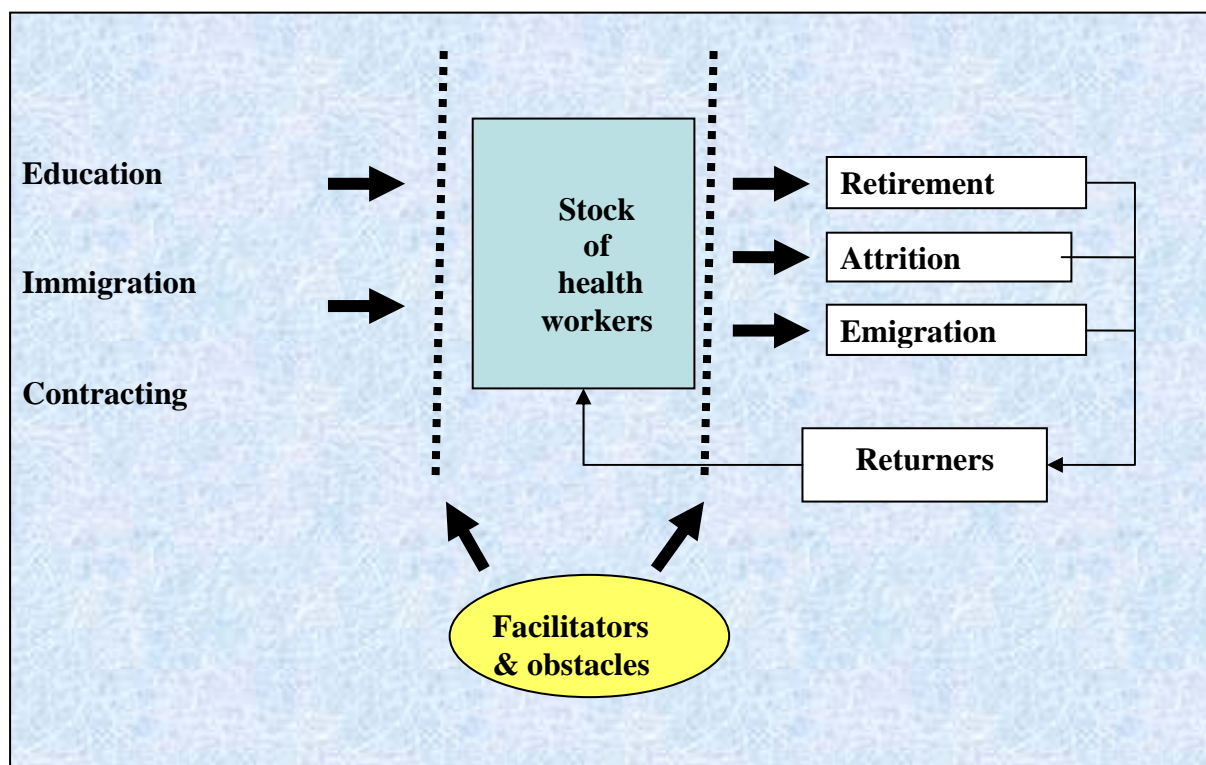
<sup>3</sup> Recent examples include the Tallinn Charter, which addressed health systems in June 2008 (WHO Regional Office for Europe, 2008b), and the report of the fifty-eighth session of the WHO Regional Committee for Europe, which met in Tbilisi in September 2008 ([http://www.euro.who.int/Document/RC58/RC58\\_eres04.pdf](http://www.euro.who.int/Document/RC58/RC58_eres04.pdf)).

## Migratory flows and the supply of workers

Labour markets, including the ones for health services, evolve according to the changing dynamics of worker demand and supply. Demand is a function of the type and number of workers a market can absorb; it is affected by how many health workers employers are prepared to hire, and how many people are prepared to pay for health services. Demand differs from need, which refers to how many workers of each type are required to achieve certain health objectives, for instance to provide qualified personnel to cover 100% of all deliveries. When we observe unemployment in low-income countries, it is because demand is lower than elsewhere, not because needs are less. Conversely, when we observe labour shortages in high-income countries, it is not because need is greater, but because demand is.

On the supply side, the national stock of health workers, which includes all workers who are active on the health labour market, whether employed or not, varies according to the flows of people entering and exiting the market. The majority of entrants are graduates of national training institutions; the rest are migrants who either come on their own or are recruited. As shown in Fig. 1, there may also be some re-entrants, i.e. people who left the market at some point and later became active again. They may have left temporarily for family, health or other reasons, or they may have retired but are willing to continue working on a contractual basis, or perhaps they left the country and returned. The diminution of the stock of health workers can be the result of planned, predictable exits such as retirement; of attrition due to ill health or death before retirement; of decisions to leave the health sector for another sector; and of decisions to leave the country (emigration).

Fig. 1. A simple model of how the stock of health workers evolves



As Fig. 1 illustrates, migratory flows are only one dimension in the dynamics of the health labour market. That means that care should be taken not to analyse such flows out of context,

and that interventions relating to migration should consider the dynamics of the entire market. It is also important to understand what forms migration can take (see Box 1 for a typology), what motivates migration decisions, how migration occurs and what impacts it may have on migrants, source countries and destination countries.

### ***Data limitations***

Before we present statistical data on the movement of health professionals in the following sections, a word of caution is warranted. The migratory flow data used by the OECD, the European Union (EU) and WHO<sup>4</sup> are only as good as the data that individual countries provide them. These data have several main limitations.

- Most countries have no reliable data on the stock of health professionals, nor on the proportion of them who are active.
- Information on the private sector is generally scarce.
- International comparisons are difficult because definitions of occupational categories are not homogeneous and because data are rarely available for the same year or period.
- Most countries do not systematically collect information on migratory flows.
- Some countries collect information on health workers' country of birth and others on their country of training, either of which may be used as a proxy for migration data.<sup>5</sup>

These limitations do not mean that the available information cannot be used for identifying trends or making general comparisons, just that any analysis and interpretation must take them into account.

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<sup>4</sup> Such data are available through respectively the OECD Health Workforce Migration Project database (OECD, 2009); the Eurostat health data; and the WHO Statistical Information System (WHOSIS), the WHO Global Atlas of the Health Workforce, and the European Health for All Database (HFA-DB).

<sup>5</sup> Another proxy indicator that may be used is the number of foreign health professionals applying for confirmation of credentials by a professional council or relevant government agency.



## Migratory flows of health workers in the European Region

### Trends

Migration of health workers has been observed in the WHO European Region since the 1940s, when health workers were moving to the United States from Europe, and to the United Kingdom from other parts of Europe (Dodani & LaPorte, 2005). The migratory flows involving health workers in the Region have included:

- movements from low-income countries to high-income countries (Akl et al., 2008; Aly & Taj, 2008; Watkins, 2005) – specifically, the migration of doctors and nurses from Commonwealth countries to the United Kingdom since the 1960s and 1970s (Likupe, 2006); of nurses from the Philippines, India and South Africa to the United Kingdom since the late 1980s (Buchan, Jobanputra & Gough, 2005; Buchan, Seccombe & Thomas, 1997; Wibulpolprasert et al., 2004; Wickett & McCutcheon, 2002; Xu & Zhang, 2005); and of doctors, nurses and midwives from sub-Saharan Africa to OECD countries (the United Kingdom, the United States, Canada, Denmark, Finland, Ireland and Portugal) (Bevan, 2005; Kirigia et al., 2006; Likupe, 2006; WHO Secretariat, 2006; Yumkella, 2006); and
- movements among high-income countries – specifically, the migration of doctors and nurses from Australia and New Zealand to the United Kingdom and Ireland, and from the United Kingdom and Ireland to Australia, New Zealand, the United States and Canada (Buchan, Jobanputra & Gough, 2005; Buchan, Seccombe & Thomas, 1997; Likupe, 2006; Watkins, 2005; Wibulpolprasert et al., 2004; Wickett & McCutcheon, 2002; Xu & Zhang, 2005); of doctors among Germany, France, the Netherlands, Ireland, Sweden and Norway (Jakubowski & Hess, 2004); of workers in general among Nordic countries with the creation of a common Nordic labour market in 1954 (Rechel, Dubois & McKee, 2005, a study that also addressed policy restricting migration outside this common market after 1975 and the signing of the European Economic Area agreement in 1994); and of health workers since 2005 from new member states of the enlarged EU (specifically Poland, Romania and the Czech Republic) to older ones (Germany and Austria) (Buchan & O'May, 2008; Eke, 2008; Gerlinger & Schmucker, 2007; Jakubowski & Hess, 2004; Vladescu & Olsavsky, 2008; Zajac, 2004).

This literature has not always specified whether these flows represented temporary migration, as may have been the case for flows among richer countries, flows that can include workers migrating to obtain training or gain experience before returning to their countries of origin. More recently, new forms of temporary migration appear to have developed, with some workers maintaining family and work lives in separate countries, either migrating for successive short periods or working abroad for a few days at a time while retaining positions in their own countries (Buchan, 2004; Buchan, 2006; Haour-Knipe & Davies, 2008).

The globalization of labour markets (ICN, 2006) and the growing economic and social inequality among countries (Mejia, Pizurki & Royston, 1979) have led to an increase in the number of migrant health workers, and of countries that supply such migrants (ICN, 2006; Nichols & Oulton, 2005). However, the number of countries that absorb migrant health workers remains limited: Australia, Canada, Germany, the United Kingdom and the United

States (Dodani & LaPorte, 2005). Dodani & LaPorte (2005) suggest that over three quarters of all migrant doctors are in the United States, the United Kingdom and Canada.

According to one recent analysis, the United Kingdom is the country with the largest proportion of foreign-trained doctors in the European Region, followed by Ireland (OECD, 2008). In 2008, 37.5% of the doctors in the United Kingdom had been trained abroad; in Ireland, the corresponding percentage in 2007 was 30.1% (see Table 1). When compared to other European countries of similar size, such as France and Italy, the United Kingdom has almost eight times as many practising doctors who were trained overseas (Eastwood et al., 2005). Norway, Finland and Denmark also have significant numbers of foreign doctors (Table 1), comprising a “Nordic cluster” of doctors’ migration that is likely thanks to the common Nordic labour market that was created in 1954 and to the subsequent restrictions on migration flows from outside this market (Rechel, Dubois & McKee, 2005).

**Table 1. Foreign-trained doctors and foreign doctors in selected countries of the WHO European Region, varying years**

Country	Year	Total number of doctors	Foreign-trained doctors		Foreign doctors		Source
			n	%	n	%	
Austria	2005	29 164	964	3.3	—	—	Austrian Medical Chamber
Belgium	2005	44 455	—	—	3 990	9.0	European Migration Network, <i>Managed migration and the labour market: the health sector: the Belgian case</i>
Denmark	2005	25 326	2 769	10.9	—	—	Danish National Board of Health
Finland	2005	25 208	1 816	7.2	—	—	National Authority for Medicolegal Affairs
France	2004	207 736	12 124	5.8	—	—	Ordre des Médecins
Germany	2007	413 689	—	—	20 434	4.9	Federal Medical Association
Ireland	2007	15 512	4 663	30.1	—	—	Irish Medical Council
Italy	2006	353 945	—	—	12 527	3.5	Italian National Federation of Doctors (FNOMCEO)
Netherlands	2007	62 988	3 907	6.2	—	—	Individual Healthcare Professions Register (BIG-register)
Norway	2005	18 173	—	—	2 833	15.6	Norwegian Medical Association (Den Norske Legeforening)
Poland	2005	113 854	837	0.7	—	—	Polish Chamber of Physicians and Dentists
Portugal	2003	34 440	—	—	1 830	5.3	Foreign health professionals working at the Portuguese National Health System (Direcção-Geral da Saúde)
Slovakia	2004	17 317	—	—	139	0.8	Ministry of Health of Slovakia
Switzerland	2005	28 251	5 302	18.8	—	—	Swiss Medical Association (FMH)
Turkey	2005	107 347	21	—	—	—	Ministry of Health, General Directorate of Health Education, Branch Office of Residency
United Kingdom	2008	243 770	91 360	37.5	—	—	General Medical Council

Source: based on OECD, 2009.

In the early part of this decade, between 30% and 50% of all the new additions to the United Kingdom register of the nursing workforce were from foreign countries, including a significant inflow of nurses from low-income countries (Buchan & Seccombe, 2005; Buchan, 2007a; Buchan, 2007c). In Ireland, 14.3% of the nursing workforce is foreign-trained, and in Denmark, the proportion is 6.2% (see Table 2). In both cases, this percentage represents about half of the corresponding percentage for doctors (30.1% and 10.9%).

**Table 2. Foreign-trained nurses and foreign nurses in selected countries of the WHO European Region, various years**

Country	Year	Number of nurses	Foreign-trained nurses		Foreign nurses		Source
			n	%	n	%	
Belgium	2005	120 004	—	—	4 015	3.3	European Migration Network, <i>Managed migration and the labour market: the health sector: the Belgian case</i>
Denmark	2005	81 912	5 109	6.2	—	—	Danish National Board of Health
Finland	2005	84 077	274	0.3	—	—	National Authority for Medicolegal Affairs
France	2005	461 503	—	—	7 058	1.6	Direction de la Recherche, des Etudes, de l'Evaluation (DREES); Automatisation des Listes (ADELI)
Germany	2005	678 313	25 462	3.8	—	—	Federal Medical Association
Ireland	2004	61 291	8 758	14.3	—	—	An Bord Atranais (Irish Nursing Board)
Italy	2005	334 178	—	—	6 730	2.0	Federazione Nazionale Collegi Infermieri Professionali, Assistenti Sanitari, Vigilatrici d'Infanzia (IPASVI)
Netherlands	2007	242 549	3 479	1.4	—	—	Individual Healthcare Professions Register (BIG-register)
Sweden	2005	107 814	2 878	2.7	—	—	National Board of Health and Welfare
Turkey	2005	83 926	51	0.1	—	—	Ministry of Health, General Directorate of Health Education, Branch Office of Residency

Source: based on OECD, 2009.

The classification of countries as either source countries or destination countries for migration can be difficult (Pittman, Aiken & Buchan, 2007). Indeed, “Migration patterns are increasingly circular, with people moving back and forth between countries of origin, transit and destination, returning home, and then frequently migrating on again. ... The patterns are highly complex and shift rapidly” (Haour-Knipe & Davies, 2008:2).

The United Kingdom is a good example of a country that both receives and sends out health care workers: it recruits from the Philippines, African countries (especially South Africa), India, Pakistan, Australia and New Zealand, and it exports chiefly to Australia, Canada and other high-income English-speaking countries (Buchan, 2000; Buchan, 2002b; Cooper & Aiken, 2006; O’Dowd, 2003; Watkins, 2005).

## Flows out of the European Region

In New Zealand, 46% of all foreign-trained doctors in 2006 were from the European Region. The United Kingdom and, to a lesser extent, Ireland were the primary suppliers of these doctors (Table 3). In 2001, 6–9% of British-trained doctors were working outside Britain (Hassell, Nichols & Noyce, 2008). In Canada, European Region doctors accounted for 38% of all foreign-trained doctors in 2005, mainly from the United Kingdom, Ireland and France (see Fig. 2).

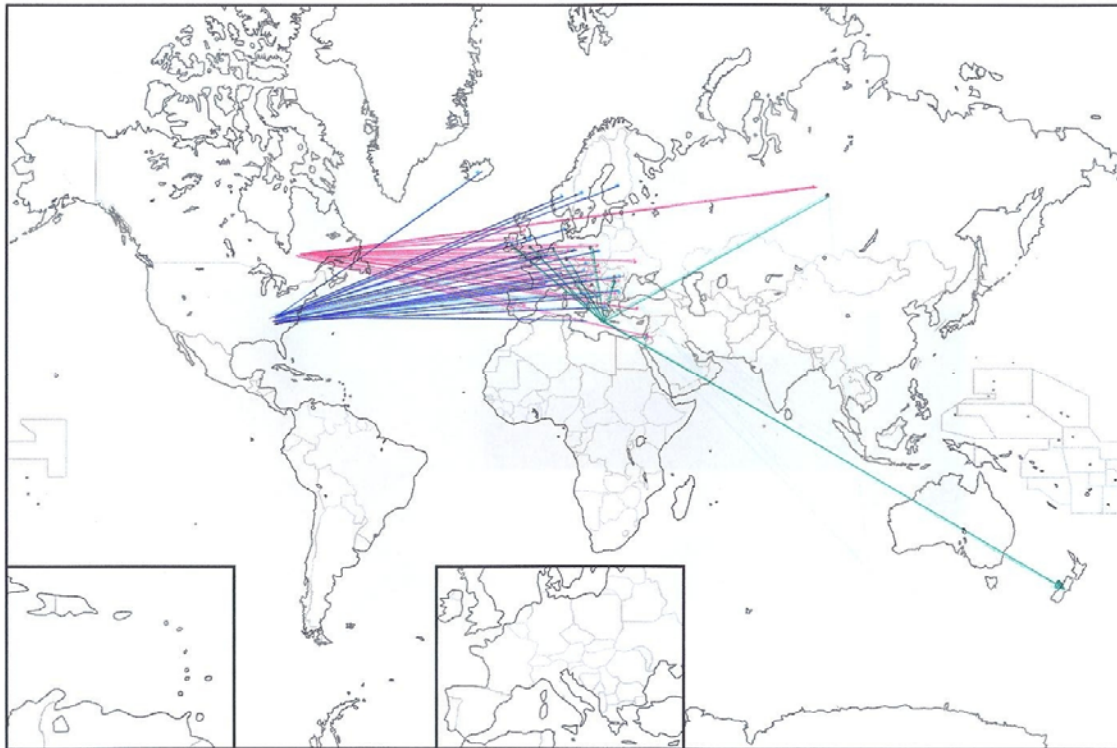
**Table 3. Doctors working in Canada, New Zealand and the United States who have been trained in countries of the WHO European Region, 2005 and 2006**

Country of training	Canada (2005)		New Zealand (2006)		United States (2006)	
	n	%	n	%	n	%
Albania	—	—	—	—	65	0.03
Austria	—	—	—	—	742	0.30
Belgium	99	0.72	—	—	1 417	0.57
Bulgaria	14	0.10	—	—	539	0.22
Croatia	38	0.28	14	0.21	—	—
Czech Republic	121	0.88	—	—	909	0.36
Denmark	—	—	—	—	158	0.06
Estonia	—	—	—	—	15	0.01
Finland	—	—	—	—	88	0.04
France	422	3.08	—	—	1 316	0.53
Germany	106	0.77	117	1.76	4 462	1.79
Greece	40	0.29	—	—	1 714	0.69
Hungary	72	0.52	—	—	1 418	0.57
Iceland	—	—	—	—	181	0.07
Ireland	1 115	8.13	151	2.28	2 882	1.15
Israel	46	0.34	—	—	3 229	1.29
Italy	75	0.55	—	—	4 980	1.99
Latvia	—	—	—	—	43	0.02
Lithuania	—	—	—	—	64	0.03
Malta	—	—	—	—	48	0.02
Netherlands	42	0.31	34	0.51	853	0.34
Norway	—	—	—	—	77	0.03
Poland	410	2.99	25	0.38	2 997	1.20
Portugal	5	0.04	—	—	159	0.06
Romania	158	1.15	25	0.38	2 687	1.08
Russian Federation	78	0.57	26	0.39	—	—
Slovakia	39	0.28	—	—	—	—
Spain	61	0.44	—	—	4 570	1.83
Sweden	—	—	—	—	352	0.14
Switzerland	77	0.56	—	—	1 984	0.79
The former Yugoslav Republic of Macedonia	—	—	—	—	—	—
Turkey	5	0.04	—	—	1 974	0.79
Ukraine	29	0.21	—	—	—	—
United Kingdom	2 164	15.78	2 634	39.73	4 358	1.75
Yugoslavia	51	0.37	—	—	1 441	0.58
<b>All European Region countries</b>	<b>5 267</b>	<b>38.40</b>	<b>3 026</b>	<b>45.65</b>	<b>45 722</b>	<b>18.31</b>
Unspecified countries	417	3.04	—	—	155	0.06
<b>Total</b>	<b>13 715</b>	<b>100.00</b>	<b>6 629</b>	<b>100.00</b>	<b>249 711</b>	<b>100.00</b>

Source: based on OECD, 2009.

In the United States, doctors trained in the European Region represented 18% of all foreign-trained doctors belonging to the American Medical Association in 2006. Italy, Spain, Germany and the United Kingdom were the main suppliers of doctors to the United States (see Annex 1). McLean (2008) describes the migration of German doctors to the United States and attributes this choice in part to their fluency in English. About 70–80% of Maltese medical graduates migrate to the United States and the United Kingdom; a large part of this flow is for the purpose of additional specialist training (Rechel, Dubois & McKee, 2005).

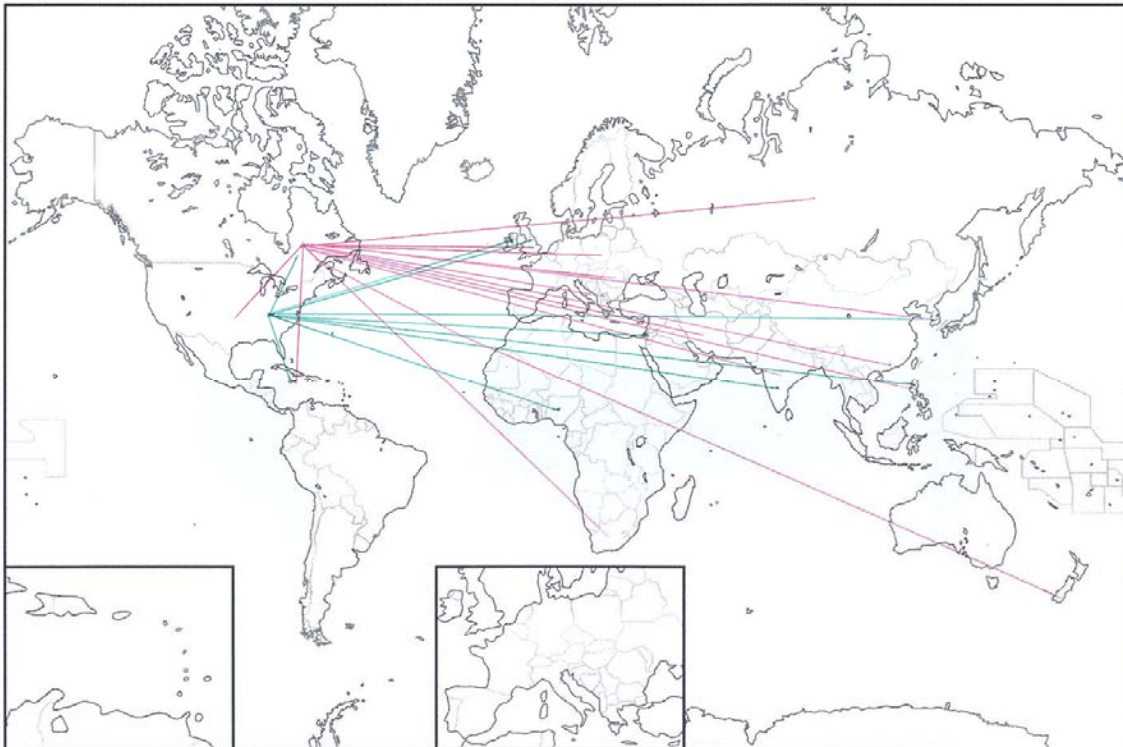
Fig. 2. Migratory flows of physicians from the WHO European Region



Blue lines: migratory flows from the European Region to the United States; red lines: migratory flows from the European Region to Canada; green lines: migratory flows from the Middle East to the European Region (and New Zealand).

In 2005, almost 34% of all foreign-trained nurses in Canada were from the European Region, with more than 55% of them trained in the United Kingdom (see Fig 3). Nurses trained in Poland and in France accounted for 10% and 6% of the total, respectively, while those trained in Ireland accounted for 2%.

**Fig. 3. Migratory flows of nurses to the United States and Canada**



Red lines: primary flows of nurses migrating to Canada; green lines; primary flows of nurses migrating to the United States.

Flows of nurses from Poland and France to Canada and United States have been described in the literature (Rechel, Dubois & McKee, 2005). Language (especially in the case of French nurses moving to Canada) seems to be an important factor in choosing which country to migrate to. The contribution of the remaining WHO European countries is almost negligible (see Tables 4 and 5).

**Table 4. Distribution of foreign-trained nurses in Canada by country of training, 2005**

Country of training	n	%
Albania	9	0.05
Austria	14	0.07
Belgium	64	0.33
Bosnia and Herzegovina	10	0.05
Bulgaria	22	0.11
Croatia	5	0.03
Czech Republic	95	0.50
Denmark	29	0.15
Finland	35	0.18
France	379	1.98
Germany	183	0.95
Greece	8	0.04
Hungary	34	0.18
Ireland	145	0.76
Israel	122	0.64

*Migration of health personnel in the European Region*

Country of training	n	%
Italy	15	0.08
Netherlands	133	0.69
Poland	639	3.33
Portugal	7	0.04
Romania	236	1.23
Russian Federation	313	1.63
Slovakia	13	0.07
Soviet Union (before 1991)	6	0.03
Spain	7	0.04
Sweden	26	0.14
Switzerland	39	0.20
Ukraine	12	0.06
United Kingdom	3 592	18.73
Yugoslavia (before 1992)	305	1.59
<b>Total, WHO European Region</b>	<b>6 497</b>	<b>33.88</b>
Australia	387	2.02
China, Hong Kong Special Administrative Region	957	4.99
China, Province of Taiwan	54	0.28
China, all other	209	1.09
Japan	34	0.18
Malaysia	35	0.18
New Zealand	242	1.26
Phillippines	5 811	30.31
Singapore	31	0.16
<b>Total, WHO Western Pacific Region</b>	<b>7 760</b>	<b>40.47</b>
Democratic People's Republic of Korea	12	0.06
India	1 008	5.26
Republic of Korea	212	1.11
Sri Lanka	46	0.24
<b>WHO South-East Asia Region</b>	<b>1 278</b>	<b>6.67</b>
Aruba	21	0.11
Barbados	18	0.09
Brazil	5	0.03
Chile	23	0.12
Colombia	20	0.10
El Salvador	12	0.06
Guyana	61	0.32
Haiti	198	1.03
Jamaica	356	1.86
Peru	25	0.13
Saint Vincent and the Grenadines	11	0.06
Trinidad and Tobago	99	0.52
United States	1 241	6.47

Country of training	n	%
<b>WHO Region of the Americas</b>	<b>2 090</b>	<b>10.90</b>
Algeria	15	0.08
Democratic Republic of the Congo	9	0.05
Ethiopia	28	0.15
Ghana	61	0.32
Kenya	46	0.24
Nigeria	88	0.46
Senegal	37	0.19
South Africa	211	1.10
Zambia	9	0.05
Zimbabwe	10	0.05
<b>Total, WHO African Region</b>	<b>514</b>	<b>2.68</b>
Egypt	14	0.07
Iran	248	1.29
Jordan	6	0.03
Lebanon	119	0.62
Morocco	5	0.03
Pakistan	114	0.59
Somalia	21	0.11
<b>Total, WHO Eastern Mediterranean Region</b>	<b>527</b>	<b>2.75</b>
Other foreign countries	508	2.65
<b>Total, all foreign countries</b>	<b>19 174</b>	<b>100.00</b>

Source: OECD, 2009.

**Table 5. Distribution of foreign-trained nurses in the United States by country of training, 2004**

Country of training	n	%
Canada	20 562	20.20
India	1 323	1.30
Ireland	1 527	1.50
Israel	1 018	1.00
Jamaica	1 120	1.10
Nigeria	2 341	2.30
Philippines	51 099	50.20
Republic of Korea	1 018	1.00
United Kingdom	8 550	8.40
Other foreign countries	12 215	12.00
<b>All European Region countries</b>	<b>11 095</b>	<b>10.90</b>
<b>All foreign countries</b>	<b>101 791</b>	<b>100.00</b>

Source: OECD, 2009.

## Flows into the European Region

The European Region includes high-income countries that have been the destination of migrants from all over the world for many years, and that continue to attract migrants, both



passively and actively, especially from low- and middle-income countries. Colonial history, common languages and membership in certain communities of nations<sup>6</sup> all appear to contribute to these flows. Health workers are no exception to this general pattern<sup>7</sup> (Anderson & Isaacs, 2007; Dodani & LaPorte, 2005; Kingma, 2006).

The OECD Health Workforce and Migration Project database has detailed information on the migration of doctors to 12 countries in the Region: Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Poland, Turkey and the United Kingdom. Upon analysing these data, three kinds of national patterns emerge with respect to migration flows (see Table 6). The countries in the first group, comprising Austria, Belgium, Denmark, Finland, Germany, the Netherlands, Poland and Turkey, are characterized by having nearly 30% of their migrant doctors coming from outside the European Region. In Denmark and Finland, the major non-European source of migrant doctors is the Middle East and north Africa, in a proportion. In Belgium and the Netherlands, the major non-European source of doctors is sub-Saharan Africa, and in Poland it is South America.

The second group is composed of France and Italy, in which around 60% of the migrant doctors stem from outside the European Region. In France, 47% of migrant doctors are from north Africa and the Middle East and 7% from sub-Saharan Africa, while in Italy the respective figures are 13.5% and 13%. Piccoli, Palese & Di (2005) mention that, in 2004, 12.5% of foreign doctors who applied to the Medical College of Turin to obtain certification for practising in Italy were from Peru, 4.8% from other countries in Latin America and 4.4% from Tunisia.

The third group comprehends Ireland and the United Kingdom, which have the highest proportion of doctors from outside the Region (more than 70%). In the United Kingdom, the major proportion of immigrant doctors (42.5%) are from south Asia (India and Pakistan), while sub-Saharan Africa, north Africa and the Middle East contribute another 22%. These figures confirm the importance of India, Pakistan and South Africa as source countries for health sector migration (Dodani & LaPorte, 2005). In 2002, 5.5% pharmacists in the country were foreign trained; 6.5% were in 2003 and 7.1% in 2004.

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<sup>6</sup> Examples include the Community of Portuguese Language Countries for Portugal as a destination country; the Commonwealth for Cyprus, Malta and the United Kingdom; and the International Organisation of La Francophonie for France, Luxembourg, Switzerland and the French part of Belgium.

<sup>7</sup> “The Nordic countries, Baltic States, Caribbean Community (CARICOM), and New Zealand/Australia have each developed their regional mutual recognition agreement. In these examples, although nurses migrating within the regions provide services in their destination countries, the agreements delegate the regulatory jurisdiction to the source country.” (Kingma, 2006:29)

**Table 6. Doctors in selected WHO European Region countries who are foreign-trained or have foreign citizenship, various years**

Region of origin	Austria 2005		Belgium 2005		Denmark 2005		Finland 2005		France 2004		Germany 2005		Ireland 2007		Italy 2006		Netherlands 2007		Poland 2005		Turkey 2005		United Kingdom 2007	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
WHO European Region	891	92.4	3 538	88.7	2 128	76.9	1 747	96.2	4 873	40.2	14 418	70.6	1 233	26.4	5 068	40.5	2 943	75.3	784	93.7	18	86	24 224	26.5
Middle East and north Africa	0	0.0	45	1.1	200	7.2	22	1.2	5 652	46.6	2 666	13.0	0	0.0	1 686	13.5	25	0.6	6	0.7	3	14	7 242	7.9
North America	0	0.0	111	2.8	5	0.2	10	0.6	28	0.2	280	1.4	0	0.0	771	6.2	14	0.4	2	0.2	0	0	408	0.4
Central America and the Caribbean	0	0.0	0	0.0	8	0.3	2	0.1	49	0.4	102	0.5	0	0.0	0	0.0	5	0.1	2	0.2	0	0	1 171	1.3
South America	0	0.0	19	0.5	21	0.8	9	0.5	364	3.0	422	2.1	0	0.0	1 327	10.6	41	1.0	25	3.0	0	0	434	0.5
Sub-Saharan Africa	0	0.0	95	2.4	18	0.7	3	0.2	844	7.0	289	1.4	0	0.0	1 590	12.7	128	3.3	0	0.0	0	0	12 886	14.1
East Asia	0	0.0	0	0.0	21	0.8	9	0.5	33	0.3	208	1.0	0	0.0	0	0.0	4	0.1	7	0.8	0	0	1 285	1.4
South-east Asia	0	0.0	80	2.0	8	0.3	0	0.0	221	1.8	236	1.2	0	0.0	0	0.0	8	0.2	5	0.6	0	0	1 319	1.4
South Asia	0	0.0	0	0.0	65	2.3	5	0.3	48	0.4	305	1.5	0	0.0	0	0.0	12	0.3	5	0.6	0	0	38 842	42.5
Pacific islands	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0	25	0.0
Australia and New Zealand	0	0.0	0	0.0	8	0.3	0	0.0	1	0.0	17	0.1	0	0.0	107	0.9	7	0.2	1	0.1	0	0	3 520	3.9
Unknown/other	71	7.4	132	3.3	287	10.4	9	0.5	11	0.1	1 491	7.3	3 430	73.6	1 978	15.8	720	18.4	0	0.0	0	0	4	0.0
<b>Total</b>	<b>964</b>	<b>100.0</b>	<b>3 990</b>	<b>100.0</b>	<b>2 769</b>	<b>100.0</b>	<b>1 816</b>	<b>100.0</b>	<b>12 124</b>	<b>100.0</b>	<b>20 434</b>	<b>100.0</b>	<b>4 663</b>	<b>100.0</b>	<b>12 527</b>	<b>100.0</b>	<b>3 907</b>	<b>100.0</b>	<b>837</b>	<b>100.0</b>	<b>21</b>	<b>100</b>	<b>91 360</b>	<b>100.0</b>

*Inclusion criteria and national sources.* **Austria:** country of training; Austrian Medical Chamber; **Belgium:** country of citizenship; European Migration Network, *Managed migration and the labour market: the health sector: the Belgium case*; **Denmark:** country of training, only active certified personnel younger than 70; the authorization registry of the National Board of Health; **Finland:** country of training; National Authority for Medicolegal Affairs; **France:** country of training; Ordre des Médecins; **Germany:** country of citizenship; Bundesärztekammer (German Medical Association), 2005; **Ireland:** country of training, for physicians holding full registration; Medical Council of Ireland; **Italy:** country of citizenship; Italian National Federation of Doctors; **Netherlands:** country of training, registered doctors; Individual Healthcare Professions Register (BIG-register); **Poland:** country of training; Polish Chamber of Physicians and Dentists; **Turkey:** Ministry of Health, General Directorate of Health Education, Branch Office of Residency; **United Kingdom:** country of training; General Medical Council.

*Regional designations.* **Middle East and North Africa:** Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, the Libyan Arab Jamahiriya, Morocco, Oman, the Palestinian Self-Rule Areas, Qatar, Saudi Arabia, , the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen; **Africa:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, the Central African Republic, Chad, the Comoros, the Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Réunion (France), Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, the Sudan, Swaziland, Togo, Tunisia, Uganda, the United Republic of Tanzania, Western Sahara, Zambia and Zimbabwe; **North America:** Canada and the United States; **Central America and the Caribbean:** Antigua and Barbuda, Aruba, the Bahamas, Barbados, Belize, the Cayman Islands, Costa Rica, Cuba, Dominica, the Dominican Republic, El Salvador, Grenada, Guadeloupe (France), Guatemala, Haiti, Honduras, Jamaica, Martinique (France), Mexico, Nicaragua, Panama, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands and the United States Virgin Islands; **South America:** Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, French Guiana (France), Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela; **Pacific islands:** Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu; **East Asia:** China; China, Hong Kong Special Administrative Region; China, Macao Special Administrative Region; China, Province of Taiwan; the Democratic People's Republic of Korea; Japan; Mongolia; and the Republic of Korea; **Southeast Asia:** Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Timor-Leste and Viet Nam; **South Asia:** Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

Source: based on OECD, 2009.

The OECD Health Workforce and Migration Project database also provides information on the migratory flow of nurses in Belgium, Denmark, Finland, France, Ireland, the Netherlands and Turkey (Table 7). The patterns are quite similar to those described for doctors, even though it is not possible to distinguish them so clearly. In three countries (Denmark, France and Turkey), more than 90% of the migrant nurses come from other European Region countries, although Turkey is exceptional in only having 51 migrant nurses total. For Denmark, the second biggest supplier of nurses is North America (the United States and Canada), while for Finland it is the Middle East and north Africa.

**Table 7. Nurses in selected WHO European Region Countries who are foreign-trained or have foreign citizenship, various years**

Region of origin	Belgium 2005		Denmark 2005		Finland 2005		France 2005		Ireland 2004		Netherlands 2007		Turkey 2005	
	n	%	n	%	n	%	n	%	N	%	n	%	n	%
WHO European Region	2 976	74.1	4 245	95.6	267	97.4	3 894	55.2	2 505	28.6	1 237	35.6	50	98
Middle East and north Africa	641	16.0	20	0.5	3	1.1	0	0.0	42	0.5	37	1.1	0	0
North America	13	0.3	42	0.9	1	0.4	0	0.0	317	3.6	45	1.3	0	0
Central America and the Caribbean	0	0.0	1	0.0	0	0.0	0	0.0	16	0.2	80	2.3	0	0
South America	17	0.4	9	0.2	0	0.0	0	0.0	4	0.0	314	9.0	0	0
Sub-Saharan Africa	154	3.8	12	0.3	0	0.0	0	0.0	529	6.0	68	2.0	0	0
East Asia	0	0.0	7	0.2	0	0.0	0	0.0	16	0.2	4	0.1	0	0
South-east Asia	13	0.3	33	0.7	2	0.7	0	0.0	3 632	41.5	440	12.6	0	0
South Asia	0	0.0	7	0.2	1	0.4	0	0.0	1 314	15.0	7	0.2	1	2
Pacific islands	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0
Australia and New Zealand	0	0.0	26	0.6	0	0.0	0	0.0	316	3.6	61	1.8	0	0
Unknown/other	201	5.0	40	0.9	0	0.0	3 164	44.8	67	0.8	1 186	34.1	0	0
<b>Total</b>	<b>4 015</b>	<b>100.0</b>	<b>4 442</b>	<b>100.0</b>	<b>274</b>	<b>100.0</b>	<b>7 058</b>	<b>100.0</b>	<b>8 758</b>	<b>100.0</b>	<b>3 479</b>	<b>100.0</b>	<b>51</b>	<b>100</b>

*Inclusion criteria and national sources.* **Belgium:** country of citizenship; European Migration Network, *Managed migration and the labour market: the health sector: the Belgium case*; **Denmark:** country of training; the authorization registry of the National Board of Health; **Finland:** country of training, National Authority for Medicolegal Affairs; **France:** country of citizenship, Direction de la Recherche, des Études, de l'Évaluation (DREES), Répertoire Automatisation des Listes (ADEL); **Ireland:** country of training, data refer to active registered nurses; An Bord Atranais (Irish Nursing Board); **the Netherlands:** country of training, data refer to registered nurses; Individual Healthcare Professions Register (BIG-register); **Turkey:** Ministry of Health, General Directorate of Health Education, Branch Office of Residency.

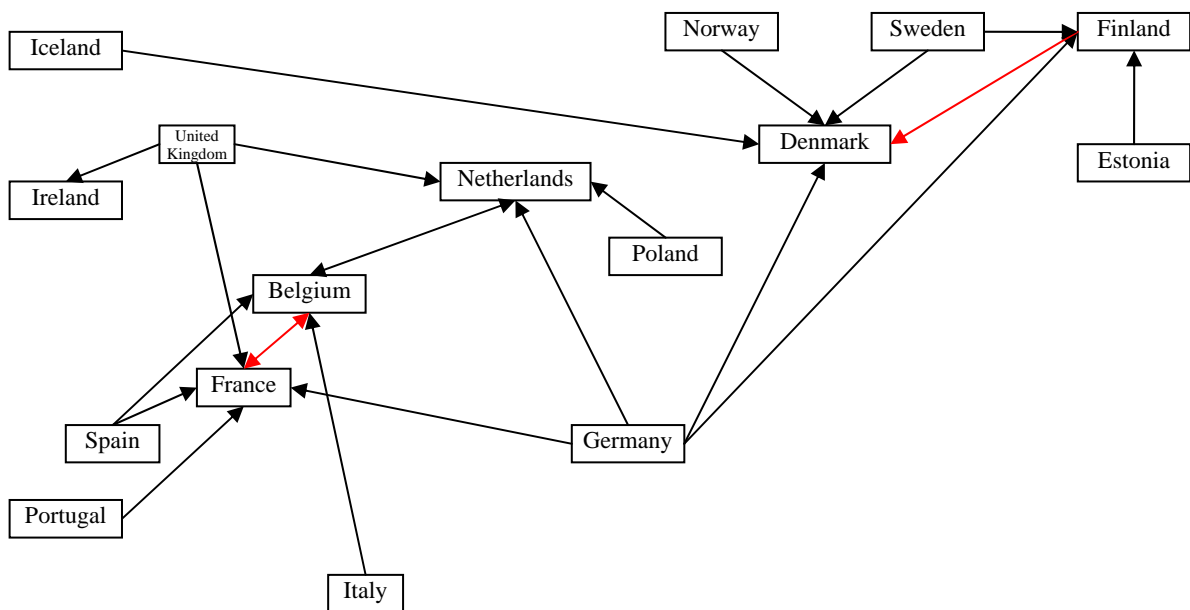
*Regional designations.* **Middle East and North Africa:** Algeria, Bahrain, Egypt, Iraq, Iran, Jordan, Kuwait, Lebanon, the Libyan Arab Jamahiriya, Morocco, Oman, the Palestinian Self-Rule Areas, Qatar, Saudi Arabia, the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen; **Africa:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, the Central African Republic, Chad, the Comoros, the Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Réunion (France), Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, the Sudan, Swaziland, Togo, Tunisia, Uganda, the United Republic of Tanzania, Western Sahara, Zambia and Zimbabwe; **North America:** Canada and the United States; **Central America and the Caribbean:** Antigua and Barbuda, Aruba, the Bahamas, Barbados, Belize, the Cayman Islands, Costa Rica, Cuba, Dominica, the Dominican Republic, El Salvador, Grenada, Guadeloupe (France), Guatemala, Haiti, Honduras, Jamaica, Martinique (France), Mexico, Nicaragua, Panama, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands and the United States Virgin Islands; **South America:** Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, French Guiana (France), Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela; **Pacific islands:** Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu; **East Asia:** China; China, Hong Kong Special Administrative Region; China, Macao Special Administrative Region; China, Province of Taiwan; the Democratic People's Republic of Korea; Japan; Mongolia; and the Republic of Korea; **Southeast Asia:** Brunei Darussalam, Cambodia, Indonesia,



The flows of migrant nurses and doctors among Belgium, France and the Netherlands are also multidirectional: from Belgium to France and the Netherlands, from France to Belgium, and from the Netherlands to Belgium. Doctors from Denmark are most likely to migrate to the United Kingdom, whereas those from Norway and Iceland go to Denmark. Doctors and nurses from Sweden migrate to Finland and Denmark. Danish nurses tend to choose France. Nurses from Finland, Norway and Iceland migrate to Denmark. Doctors from Poland, Romania, the Russian Federation, Slovakia, Turkey and Spain choose the United Kingdom and Germany to migrate to (see Table 8). As for nurses, migration from these countries is not pronounced within the Region, except for Spanish nurses, who tend to migrate to France (Table 9).

There have been several recent studies examining the possible outflow of health professionals from selected countries in eastern and south-eastern Europe. Such surveys may overemphasize the actual outflow (see Buchan & Perfilieva, 2006). Eke (2008) reports that from 2004 to 2007, there were 2065 Hungarian physicians working abroad in the European Region, the majority in Great Britain (68%), Germany (15%) and Sweden (12%). In the same period, 2187 physicians and 577 nurses from Hungary requested a certificate that would enable them to work abroad. Other recent studies from the area have examined the situation in Slovakia and Poland (Hasselhorn et al., 2005) and in Romania (Vladescu & Olsavsky, 2008).

Fig. 5. Migration of nurses within the WHO European Region (red arrows represent two-way flows)



**Table 8. Doctors in selected European Region countries who have training/citizenship from other countries in the Region, various years**

Source country	Recipient country		Austria 2005		Belgium 2005		Denmark 2005		Finland 2005		France 2004		Germany 2005		Ireland 2007		Italy 2006		Netherlands 2007		Poland 2005		Turkey 2005		United Kingdom 2007	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Albania	0	0.0	0	0.0	6	0.3	0	0.0	8	0.2	0	0.0	0	0.0	204	4.0	0	0.0	0	0.0	0	0.0	0	0	26	0.1
Armenia	0	0.0	0	0.0	4	0.2	1	0.1	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	0.5	0	0	0	0	32	0.1
Austria	0	0.0	15	0.4	10	0.5	27	1.5	30	0.6	1 613	11.2	8	0.6	0	0.0	29	1.0	4	0.5	0	0	0	0	306	1.3
Azerbaijan	0	0.0	0	0.0	1	0.0	1	0.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1	2	11	0	0	8	0.0
Belarus	0	0.0	0	0.0	10	0.5	0	0.0	6	0.1	0	0.0	0	0.0	0	0.0	0	0.0	81	10.3	0	0	0	0	62	0.3
Belgium	1	0.1	0	0.0	9	0.4	4	0.2	1 582	32.5	231	1.6	15	1.2	256	5.1	1 495	50.8	0	0.0	0	0	0	0	357	1.5
Bosnia and Herzegovina	0	0.0	0	0.0	34	1.6	0	0.0	8	0.2	0	0.0	0	0.0	0	0.0	3	0.1	0	0.0	0	0	0	0	61	0.3
Bulgaria	0	0.0	0	0.0	26	1.2	7	0.4	59	1.2	462	3.2	0	0.0	0	0.0	2	0.1	42	5.4	9	50	0	0	327	1.3
Croatia	0	0.0	0	0.0	4	0.2	4	0.2	15	0.3	135	0.9	0	0.0	0	0.0	5	0.2	0	0.0	0	0	0	0	50	0.2
Cyprus	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	52	0.4	1	0.1	0	0.0	0	0.0	0	0.0	0	0	0	0	0	0.0
Czech Republic	0	0.0	7	0.2	7	0.3	1	0.1	44	0.9	304	2.1	46	3.7	0	0.0	15	0.5	45	5.7	0	0	0	0	884	3.6
Denmark	0	0.0	9	0.3	0	0.0	30	1.7	16	0.3	61	0.4	6	0.5	0	0.0	6	0.2	1	0.1	0	0	0	0	164	0.7
Estonia	0	0.0	0	0.0	6	0.3	427	24.4	2	0.0	27	0.2	2	0.2	0	0.0	1	0.0	0	0.0	0	0	0	0	44	0.2
Finland	1	0.1	9	0.3	27	1.3	0	0.0	5	0.1	106	0.7	6	0.5	0	0.0	4	0.1	0	0.0	0	0	0	0	56	0.2
France	1	0.1	930	26.3	16	0.8	15	0.9	0	0.0	398	2.8	30	2.4	649	12.8	20	0.7	4	0.5	0	0	0	0	529	2.2
Georgia	0	0.0	0	0.0	1	0.0	0	0.0	2	0.0	0	0.0	0	0.0	0	0.0	1	0.0	1	0.1	1	6	0	0	11	0.0
Germany	818	91.8	302	8.5	615	28.9	238	13.6	685	14.1	0	0.0	103	8.4	1 034	20.4	800	27.2	21	2.7	1	6	0	0	3 894	16.1
Greece	2	0.2	133	3.8	21	1.0	7	0.4	109	2.2	1 554	10.8	23	1.9	646	12.7	62	2.1	0	0.0	0	0	0	0	1 703	7.0
Hungary	0	0.0	7	0.2	12	0.6	17	1.0	27	0.6	359	2.5	59	4.8	0	0.0	27	0.9	11	1.4	0	0	0	0	1 002	4.1
Iceland	0	0.0	0	0.0	30	1.4	1	0.1	2	0.0	0	0.0	0	0.0	0	0.0	2	0.1	0	0.0	0	0	0	0	35	0.1
Ireland	0	0.0	8	0.2	4	0.2	3	0.2	24	0.5	32	0.2	0	0.0	0	0.0	11	0.4	0	0.0	0	0	0	0	5 389	22.2
Israel	0	0.0	23	0.7	0	0.0	0	0.0	0	0.0	134	0.9	0	0.0	280	5.5	3	0.1	0	0.0	0	0	0	0	49	0.2
Italy	46	5.2	339	9.6	49	2.3	31	1.8	632	13.0	719	5.0	41	3.3	0	0.0	99	3.4	1	0.1	0	0	0	0	1 711	7.1
Kazakhstan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	175	1.2	0	0.0	0	0.0	0	0.0	15	1.9	0	0	0	0	20	0.1
Kyrgyzstan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0	0	0	4	0.0
Latvia	0	0.0	0	0.0	7	0.3	3	0.2	6	0.1	43	0.3	6	0.5	0	0.0	1	0.0	3	0.4	0	0	0	0	105	0.4
Lithuania	0	0.0	3	0.1	114	5.4	6	0.3	5	0.1	61	0.4	8	0.6	0	0.0	2	0.1	24	3.1	0	0	0	0	205	0.8

Migration of health personnel in the European Region

Source country	Recipient country		Austria 2005		Belgium 2005		Denmark 2005		Finland 2005		France 2004		Germany 2005		Ireland 2007		Italy 2006		Netherlands 2007		Poland 2005		Turkey 2005		United Kingdom 2007		
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	
Luxembourg	1	0.1	177	5.0	0	0.0	0	0.0	5	0.1	147	1.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0	0	0	0
Malta	0	0.0	0	0.0	1	0.0	0	0.0	0	0.0	5	0.0	9	0.7	0	0.0	1	0.0	0	0.0	0	0.0	0	0	0	411	1.7
Netherlands	5	0.6	1 118	31.6	27	1.3	5	0.3	69	1.4	525	3.6	34	2.8	0	0.0	0	0.0	0	0.0	0	0.0	0	0	0	698	2.9
Norway	2	0.2	5	0.1	113	5.3	26	1.5	3	0.1	73	0.5	2	0.2	0	0.0	4	0.1	0	0.0	0	0.0	0	0	0	53	0.2
Poland	0	0.0	21	0.6	187	8.8	40	2.3	193	4.0	1 332	9.2	155	12.6	207	4.1	131	4.5	2	0.3	0	0.0	0	0	0	2 022	8.3
Portugal	1	0.1	45	1.3	2	0.1	3	0.2	22	0.5	74	0.5	3	0.2	0	0.0	8	0.3	0	0.0	0	0.0	0	0	0	95	0.4
Republic of Moldova	0	0.0	0	0.0	4	0.2	0	0.0	2	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.3	0	0.0	0	0	0	16	0.1
Romania	0	0.0	35	1.0	58	2.7	7	0.4	568	11.7	824	5.7	0	0.0	389	7.7	16	0.5	4	0.5	0	0.0	0	0	0	644	2.7
Russian Federation	0	0.0	0	0.0	108	5.1	244	14.0	139	2.9	1 624	11.3	0	0.0	0	0.0	5	0.2	271	34.6	1	6	6	6	646	2.7	
Serbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	366	2.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0	0	171	0.7
Slovakia	0	0.0	6	0.2	2	0.1	1	0.1	4	0.1	454	3.1	43	3.5	0	0.0	9	0.3	18	2.3	0	0.0	0	0	0	183	0.8
Slovenia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	28	0.2	2	0.2	0	0.0	1	0.0	1	0.1	0	0.0	0	0	0	19	0.1
Spain	3	0.3	233	6.6	30	1.4	15	0.9	327	6.7	356	2.5	21	1.7	0	0.0	49	1.7	0	0.0	0	0.0	0	0	0	1 096	4.5
Sweden	4	0.4	17	0.5	489	23.0	534	30.6	22	0.5	99	0.7	11	0.9	0	0.0	9	0.3	1	0.1	0	0.0	0	0	0	410	1.7
Switzerland	0	0.0	22	0.6	11	0.5	8	0.5	68	1.4	181	1.3	7	0.6	760	15.0	16	0.5	0	0.0	0	0.0	0	0	0	144	0.6
Tajikistan	0	0.0	0	0.0	0	0.0	2	0.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	6	6	8	0.0
The former Yugoslav Republic of Macedonia	0	0.0	0	0.0	2	0.1	1	0.1	25	0.5	0	0.0	0	0.0	437	8.6	15	0.5	4	0.5	1	6	6	6	18	0.1	
Turkey	0	0.0	0	0.0	13	0.6	14	0.8	32	0.7	884	6.1	0	0.0	0	0.0	8	0.3	0	0.0	0	0.0	0	0	0	187	0.8
Turkmenistan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0	0	3	0.0
Ukraine	0	0.0	0	0.0	20	0.9	9	0.5	32	0.7	777	5.4	0	0.0	0	0.0	2	0.1	221	28.2	0	0.0	0	0	0	335	1.4
United Kingdom	6	0.7	74	2.1	45	2.1	14	0.8	102	2.1	203	1.4	592	48.0	206	4.1	81	2.8	1	0.1	0	0.0	0	0	0	0	0.0
Uzbekistan	0	0.0	0	0.0	3	0.1	1	0.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1	2	11	11	11	31	0.1	
<b>Total</b>	<b>891</b>	<b>100.0</b>	<b>3 538</b>	<b>100.0</b>	<b>2 128</b>	<b>100.0</b>	<b>1 747</b>	<b>100.0</b>	<b>4 873</b>	<b>100.0</b>	<b>14 418</b>	<b>100.0</b>	<b>1 233</b>	<b>100.0</b>	<b>5 068</b>	<b>100.0</b>	<b>2 943</b>	<b>100.0</b>	<b>784</b>	<b>100.0</b>	<b>18</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>24 224</b>	<b>100.0</b>	

*Inclusion criteria and national sources.* **Austria:** country of training; Austrian Medical Chamber; **Belgium:** country of citizenship; European Migration Network, *Managed migration and the labour market: the health sector: the Belgium case*; **Denmark:** country of training, active certified personnel younger than 70; the authorization registry of the National Board of Health; **Finland:** country of training; National Authority for Medicolegal Affairs; **France:** country of training; Ordre des Médecins; **Germany:** country of citizenship; Bundesärztekammer (German Medical Association), 2005; **Ireland:** country of training, for physicians holding full registration; Medical Council of Ireland; **Italy:** country of citizenship; Italian National Federation of Doctors; **Netherlands:** country of training, registered doctors; Individual Healthcare Professions Register (BIG-register); **Poland:** country of training; Polish Chamber of Physicians and Dentists; **Turkey:** Ministry of Health, General Directorate of Health Education, Branch Office of Residency; **United Kingdom:** country of training; General Medical Council.

Source: based on OECD, 2009.

**Table 9. Nurses in selected WHO European Region countries who have training/citizenship from other countries in the Region, various years**

Source country	Belgium 2005		Denmark 2005		Finland 2005		France 2005		Ireland 2004		Netherlands 2007		Turkey 2005	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Albania	64	2.2	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0
Austria	1	0.0	10	0.2	1	0.4	11	0.3	6	0.2	14	1.1	0	0
Azerbaijan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	2
Belarus	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	1	0.1	0	0
Belgium	0	0.0	11	0.3	3	1.1	1 092	28.0	8	0.3	377	30.5	0	0
Bosnia and Herzegovina	0	0.0	40	0.9	0	0.0	0	0.0	0	0.0	8	0.6	0	0
Bulgaria	0	0.0	2	0.0	0	0.0	0	0.0	2	0.1	0	0.0	48	96
Croatia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.2	0	0
Czech Republic	6	0.2	0	0.0	0	0.0	0	0.0	5	0.2	6	0.5	0	0
Denmark	1	0.0	0	0.0	4	1.5	46	1.2	9	0.4	17	1.4	0	0
Estonia	0	0.0	1	0.0	64	24.0	0	0.0	4	0.2	5	0.4	0	0
Finland	6	0.2	230	5.4	0	0.0	25	0.6	44	1.8	6	0.5	0	0
France	831	27.9	24	0.6	2	0.7	0	0.0	23	0.9	33	2.7	0	0
Georgia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1	0	0
Germany	107	3.6	223	5.3	35	13.1	405	10.4	127	5.1	418	33.8	1	2
Greece	46	1.5	1	0.0	1	0.4	4	0.1	1	0.0	6	0.5	0	0
Hungary	7	0.2	1	0.0	1	0.4	0	0.0	2	0.1	8	0.6	0	0
Iceland	0	0.0	327	7.7	0	0.0	0	0.0	0	0.0	2	0.2	0	0
Ireland	10	0.3	12	0.3	2	0.7	112	2.9	0	0.0	12	1.0	0	0
Israel	2	0.1	8	0.2	1	0.4	0	0.0	0	0.0	11	0.9	0	0
Italy	1 165	39.1	11	0.3	2	0.7	164	4.2	16	0.6	12	1.0	0	0
Latvia	0	0.0	1	0.0	1	0.4	0	0.0	3	0.1	1	0.1	0	0
Lithuania	1	0.0	3	0.1	0	0.0	0	0.0	12	0.5	12	1.0	0	0
Luxembourg	52	1.7	0	0.0	0	0.0	7	0.2	1	0.0	0	0.0	0	0
Malta	0	0.0	1	0.0	0	0.0	0	0.0	1	0.0	0	0.0	0	0
Netherlands	327	11.0	110	2.6	4	1.5	186	4.8	26	1.0	0	0.0	0	0
Norway	4	0.1	717	16.9	9	3.4	4	0.1	5	0.2	12	1.0	0	0
Poland	27	0.9	60	1.4	2	0.7	0	0.0	19	0.8	87	7.0	0	0
Portugal	37	1.2	1	0.0	2	0.7	256	6.6	1	0.0	4	0.3	0	0
Republic of Moldova	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	0	0
Romania	24	0.8	3	0.1	0	0.0	0	0.0	22	0.9	8	0.6	0	0
Russian Federation	0	0.0	0	0.0	11	4.1	0	0.0	7	0.3	2	0.2	0	0
Slovakia	2	0.1	1	0.0	0	0.0	0	0.0	2	0.1	10	0.8	0	0
Slovenia	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0
Spain	187	6.3	8	0.2	0	0.0	1 155	29.7	68	2.7	20	1.6	0	0
Sweden	1	0.0	2 227	52.5	105	39.3	20	0.5	11	0.4	15	1.2	0	0
Switzerland	18	0.6	13	0.3	8	3.0	0	0.0	7	0.3	22	1.8	0	0



Migration of health personnel in the European Region

Recipient country	Belgium 2005		Denmark 2005		Finland 2005		France 2005		Ireland 2004		Netherlands 2007		Turkey 2005	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
The former Yugoslav Republic of Macedonia	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	1	0.1	0	0
Turkey	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	5	0.4	0	0
Ukraine	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1	1	0.1	0	0
United Kingdom	50	1.7	196	4.6	9	3.4	407	10.5	2 069	82.6	98	7.9	0	0
<b>Total</b>	<b>2 976</b>	<b>100.0</b>	<b>4 245</b>	<b>100.0</b>	<b>267</b>	<b>100.0</b>	<b>3 894</b>	<b>100.0</b>	<b>2 505</b>	<b>100.0</b>	<b>1 237</b>	<b>100.0</b>	<b>50</b>	<b>100</b>

*Inclusion criteria and national sources.* **Belgium:** country of citizenship; European Migration Network, *Managed migration and the labour market: the health sector: the Belgium case*; **Denmark:** country of training; the authorization registry of the National Board of Health; **Finland:** country of training; National Authority for Medicolegal Affairs; **France:** country of citizenship; Direction de la Recherche, des Études, de l'Évaluation (DREES), Répertoire Automatisation des Listes (ADELI); **Ireland:** country of training, active registered nurses; An Bord Atranais (Irish Nursing Board); **the Netherlands:** country of training, registered nurses; Individual Healthcare Professions Register (BIG-register); **Turkey:** Ministry of Health, General Directorate of Health Education, Branch Office of Residency.

Source: based on OECD, 2009.

## Factors associated with health workforce migration

There are several factors associated with migration flows that can stimulate migration and affect the choice of a destination country. These factors have been identified and discussed in many recent reports. The key ones for the health workforce include:

- *individual/professional/family factors* that increase the probability of being mobile, such as relative youth, higher educational level, portability of skills, single status, fluency in the language of a potential destination country, and the presence of relatives or friends who have already emigrated;
- *organizational factors* (real or perceived), such as a heavy workload, insufficient compensation (pay, financial benefits and non-financial benefits), occupational risks, poor management (e.g. top-down authoritarian decision-making, favouritism or lack of due process), a lack of equipment or medicines, a dearth of career prospects or further education opportunities, and lack of recognition;
- *health care system factors*, such as the absence or inadequacy of human resource policies (including retention strategies) or poor implementation of existing ones, insufficient funding of health services, and centralized decision-making;
- *general environmental factors*, such as poor economic conditions (e.g. low growth or high inflation) or poor domestic prospects relative to those in possible destination countries, lack of security (urban violence, civil unrest or war) and climate change (inundated zones); and
- *other factors*, which include active recruitment by foreign agencies, regulations facilitating mobility, recognition of qualifications and conditions of entry.

The literature categorizes these factors as either *push factors*, which can incite one to leave one's country, or *pull factors*, which can attract one to another country. Most push and pull factors exist as opposite pairs, such as the absence/availability of continuing education opportunities or career prospects (Buchan, 2002a; Denton, 2006; Dodani & LaPorte, 2005; Gadit, 2008; Kingma, 2001; for pharmacists, Hassell, Nichols & Noyce, 2008), lower/higher pay (Buchan, 2002a; Buchan, 2004; Kingma, 2001; Rechel, Dubois & McKee, 2005) and high/low occupational or personal risks (Dodani & LaPorte, 2005; Kingma, 2001). Language seems to be an important pull factor when choosing where to migrate (Buchan, 2002b), as does geographic proximity (Silva & Fernandes, 2008) and the presence of a migrant community in the destination country. The relative influence of each factor varies according to context and the characteristics of the source and destination countries.

The literature is more extensive when it comes to factors that incite migration from low-income to middle- or high-income countries. The mobility of health workers within the European Region is still not well documented, except for specific countries such as the United Kingdom and Ireland.

Health policies and health sector reform, which often result in budgetary and public sector employment cuts, mandatory retirement and uncertainty in the public sector labour market, can also stimulate emigration (Anderson & Isaacs, 2007; Buchan, 2002a). This factor is likely to become more pronounced over the next few years in the Region as health funding and health employment levels come under cost-containment pressure. Yet the same factors may

also limit employment opportunities in potential destination countries that face economic difficulties.

## **The impact of health worker migration**

Moving from one country to work in another has repercussions for the individual, the source country and the recipient country. These effects can be positive (benefits), negative (costs) or a mixture of both. At the individual level, the costs may include disruption of family life, separation from relatives, difficulties in the process of adaptation (learning a new language or fitting into a new culture), travel and setting-up expenses, negative reactions from colleagues and loss of professional status (e.g. doctors who take jobs as nurses or nurses who take jobs as auxiliaries) (Yan, 2006). Benefits may include professional gains, such as access to a better job, continuing education, career advancement and a better work environment (e.g. more and newer equipment, less occupational risk or a lighter workload). There may also be financial gains in terms of higher remuneration, better retirement benefits and access to health insurance. Other possible benefits are better living conditions for one's family, work opportunities for one's spouse, better education for one's children and better access to cultural and leisure activities.

For the health care system in the source country, emigration can be a major cause of attrition and shrinkage in the health labour pool. It can thereby also contribute to the disruption of services that occurs when a key staff member (such as an anaesthesiologist, radiologist or surgical nurse) leaves; to loss of training capacity, when trainers leave; and to heavier workloads for those who stay and may thus struggle to maintain quality, generating in turn greater dissatisfaction and grounds for leaving (Rechel, Dubois & McKee, 2005). The source country also loses its investment in the education of health care professionals, as well as the contributions they would have otherwise made to the health care system (Dodani & LaPorte, 2005; Dwyer, 2007; Gostin, 2008).

Source countries may also benefit from the emigration of health workers, for instance through reductions in staff surpluses (which has occurred in some eastern and central European countries), the easing of unemployment or underemployment in the health sector, an increase in remittances (Anderson & Isaacs, 2007; Denton, 2006; Dodani & LaPorte, 2005; Gostin, 2008) and access to new knowledge and skills through collaboration with health professionals who have emigrated. The last benefit requires that emigrants maintain a working relationship with their former employers and transfer some of the knowledge and skills they acquire abroad. It is thus to the advantage of source countries to encourage the return of emigrating health workers. Other gains occur when migrating health professionals develop collaborative training programmes, research projects and teaching activities with their source countries (Dodani & LaPorte, 2005; Gostin, 2008; Nichols, 2006). There is a recent current of thinking in labour economics that argues that "brain drain" may be compensated by "brain gain" since the prospect of potential migration encourages more young people to pursue a high-level education. If the increase in education seekers is higher than the increase in emigrants, the net change may be a brain gain (Beine, Docquier & Rapoport, 2008). However, this mechanism has not yet been observed or tested empirically.

In destination countries, the benefits are likely to be more obvious: available positions are filled without any investment in the cost of educating the health worker (Dwyer, 2007); migrant workers may accept lower salaries and compensation packages (Watkins, 2005); and they may accept work in geographic or service areas that national workers tend to avoid (Bevan, 2005).

For the destination countries there are also costs, often overlooked but nonetheless real. Cultural differences can create barriers in communication with health system users; lack of familiarity with advanced equipment, particular medicines or differing practices may lead to higher error rates; and for temporary migrants, investment in workplace induction can be high relative to time of service (Aiken, 2007; Brush, Sochalski & Berger, 2004; ICN, 1999; Likupe, 2006; WHO, 2004; Xu & Zhang, 2005).

In sum, the benefits for the recipient country mirror the losses for the source country, consisting of access to additional human capital with little investment. The costs for the recipient country are more difficult to measure, and they will depend on how well it integrates the new arrivals.

## **Health workforce policies and options**

Migration issues need to be addressed in the context of broader workforce policies (Martineau, Decker & Bundred, 2004; Buchan, 2008). Before considering policies that encourage or discourage the migration of health workers, policy-makers should consider alternative options. If the problem is a workforce shortage, one obvious option is to scale up the domestic production of new workers. It may require investing in infrastructure and recruiting more educators, and there will be a time lag before any results are seen (up to 10 years for some medical specialties). On the other hand, the benefits will be there for decades. Another option is to strengthen retention policies to reduce losses of personnel. These policies typically include financial and professional incentives, such as improved remuneration and benefits, performance-related bonuses, career options, access to continuing education, occupational safety measures, flexible hours or part-time employment (Dolea & Adams, 2005; ICN et al., 2008). Other strategies for reducing workforce shortages include raising the retirement age, allowing retirees to work on a contract basis, improving productivity through better use of technology and teamwork, reviewing the definitions for scope of practice (extending responsibilities), delegating tasks, encouraging emigrants to return and improving the planning and coordination of services. These measures all have the potential to reduce any demand–supply imbalance (OECD, 2008). Some countries also impose “civic or community service” after graduation to keep graduates in the country, but these policies appear to have limited effect (WHO, 2009).

When the issue is a surplus of health workers, an issue that few countries in the Region currently face, policy options include reducing the production of new health workers, reducing working hours, encouraging part-time work and facilitating early retirement. Each option presents difficulties: limiting the production of training institutions means imposing stricter entry restrictions, which can provoke adverse reactions from students and parents. Some countries “solve” the problem by opening up the admission process and then reducing the number of trainees through a tough advancement process. This approach is costly and generates much frustration. It is also a strategy that tends to overvalue academic performance with respect to other skills and attitudes, such as communication and empathy, that are critical in the health sector. Also, it may be difficult to increase production again when necessary.

The reduction of working hours will not reduce the stock of workers, only spread out a reduced workload.<sup>8</sup> It may encourage some health workers to leave the sector for more highly remunerative jobs elsewhere and discourage potential future health workers from entering the field. Encouraging early retirement is an attractive option as it also reduces salary expenses. On the other hand, the workers urged to leave early are the ones who are most experienced, and their competencies may be rare and not easy to replace.

## **Policies targeting the migratory flows of health workers**

Some countries outside the European Region, such as Cuba and the Philippines, have a history of deliberately producing health workers for export. They send workers to other countries with which they have signed bilateral agreements on the magnitude and conditions of health worker recruitment. The Philippines has agreements with Ireland, Japan and the United Kingdom. Recent evaluations have shown that this export strategy has negative consequences, reducing their populations' access to services and lowering the quality of training (Brush & Sochalski, 2007).

Keeping in mind that workers have a right to emigrate, as specified by Article 13 of the Universal Declaration of Human Rights, Buchan suggests that policy-makers should try to “manage” migratory flows if they are significant enough to affect the health services system, as “unplanned or unmanaged outflow of health professionals may damage the health system, undermine planning projections and erode the current and future skills base in the country” (2008:14). In addition to improving retention, countries can consider strategies such as staff exchanges, bilateral agreements, the fast-tracking of immigration procedures for certain categories of workers, compensation for source countries, regulation of recruitment agencies, and codes of recruitment.

## **Codes of ethical recruitment**

The World Health Assembly will consider adopting an international code for the ethical recruitment of health workers when it meets in 2010 (WHO Secretariat, 2008) (see Annex 1 for details, including an overview of ethical recruitment). The European Region represents a special case in the debate because it includes some of the world's most significant destination countries, as well as a major bloc of countries, the EU, that protects the mobility of all its workers.<sup>9</sup> Since some countries and organizations within the Region have already adopted codes and guidelines (Buchan, 2008), proper consideration of regional specificities in discussing a WHO code is an important matter for the Region's Member States. Most European countries guarantee freedom of movement to their citizens as a basic human right. Ease of transportation within the European Region also makes temporary and short-term cross-border work a special issue. In addition, the EU has adopted labour measures facilitating the cross-border mobility of professionals, and it supports the Bologna Process, which facilitates the recognition of academic qualifications, and the development of a “blue

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<sup>8</sup> Policies formulated outside the health sector can interfere with workforce strategies in health; one example is the adoption of the 35-hour week in France in 2000, which set limits to the weekly number of hours worked. The result was an immediate increase in the demand for additional health workers to compensate for productivity losses.

<sup>9</sup> The freedom of movement guaranteed by Article 39 of the Treaty Establishing the European Community (the EC Treaty) also applies to the non-member countries of Iceland, Liechtenstein, Norway and Switzerland. Note that the free movement is not immediately “free” in all cases, as transitional restrictions, lasting up to seven years, apply to some countries that acceded in 2004 and 2007 (see [ec.europa.eu/social/main.jsp?catId=457](http://ec.europa.eu/social/main.jsp?catId=457)).

card” that would facilitate mobility in the EU labour market for member states’ doctors, dentists, pharmacists, midwives and nurses.<sup>10</sup> Most of the countries in the Region are market economies, and the employers and recruiters of health workers are often private organizations. The Region also has strong civil society organizations, including labour unions and professional associations, that expect countries to engage in the international debate on ethical recruitment.

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<sup>10</sup> See [hprocard.eu](http://hprocard.eu) for information on the Health Professional Card project.

## Conclusion and key messages

After reviewing the available literature on the migration of health workers in the WHO European Region, several conclusions emerge.

- The magnitude, direction and impact of migratory flows of health workers are in general poorly documented. There is no mechanism to compile migration data and monitor flows in the Region. Existing data tend to be fragmentary and unreliable since they do not represent direct measurement of migration. Some European countries have paid greater attention to the issue and developed a solid information base through high-quality data collection and research. These countries tend to be ones that receive large numbers of immigrants, such as the United Kingdom and Ireland.
- There is a broad consensus on the need for countries to tackle health workforce issues in a comprehensive manner by adopting policies that address all their dimensions: the production of new health workers, the quality and relevance of training, the skill mix of the workforce, retention, geographical distribution and so on. Migratory flows are *symptoms* that should be examined closely to understand why health workers leave certain countries and why certain countries need to import them.
- Even though it is not desirable, and possibly not feasible, to impede professional mobility, there do exist strategies to manage it better. Countries of the Region would benefit from exchanging their experiences with such strategies and lessons learned.
- Codes and guidelines for ethical recruitment can be a useful part of strategies to manage the migratory flow of health workers, as can bi- and multilateral agreements. Experiences with these instruments are recent and few in the Region, and thus far no systematic evaluation of them has been conducted, making it difficult to draw firm conclusions about their utility.<sup>11</sup> That should not deter a country from considering such strategies as part of a set of tools to address what it may regard as a problem with an outflow or inflow of migrant health workers.

This review confirms three key messages that have already been conveyed by various authors and meetings (Buchan, 2008; OECD, 2008; WHO Regional Office for Europe, 2008b; Global Health Workforce Alliance, 2008). First, it is imperative to invest in data collection and analysis to assess whether migratory flows constitute a problem, and if so, the magnitude, composition and causes of these flows. A Region-wide data collection and monitoring mechanism, though more difficult to set up, would be particularly useful, as it would facilitate the development of common indicators and methodologies, without which comparability among countries is impossible. It could also provide support to smaller or poorer countries that may not have the financial or technical capacity to collect and analyse national data. In addition, such a mechanism could help coordinate the flow of relevant information between countries.

The second message is that, irrespective of its situation with regard to migratory flows, every Member State needs to prioritize the development of a comprehensive health workforce policy as a component in its strategy to improve health system performance. This policy should cover migration issues as part of the country's efforts to retain and adequately utilize the available health workforce.

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<sup>11</sup> A first assessment of the effects of the English Code has been conducted by Buchan et al. (2009).



Finally, regional and international organizations such as WHO, the European Commission and the OECD should play a leadership role in encouraging and supporting national efforts to develop health workforces. Coordination of these organizations is needed so that their interventions are synergistic. The migration of health professionals is here to stay, and developing policies for this new reality is one of the major challenges on the health system agenda.

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## **Annex 1. Regional consultation on the proposed WHO code of practice for the international recruitment of health workers**

In the global discussion about a code of practice for the international recruitment of health personnel, the WHO European Region is a special case because it includes both source and destination countries for migrant health workers, and because workers from the European Union are entitled to move freely among countries. In addition, some countries and organizations in the Region have already adopted normative instruments to address international recruitment. It is important to consider the regional specifics involved in implementing a global code, such as the one that WHO is currently considering (WHO Secretariat, 2008).<sup>12</sup>

The first part of this annex explains the importance of a consultation in the European Region on the proposed WHO code of practice, as well as describing the objectives for such a consultation. The next part reviews the contents of the proposed code and proposes a list of topics for regional discussion. Finally, we suggest a list of key stakeholders who should be consulted.

### **The code's relevance for the European Region**

Initiatives leading to a code of practice on the international recruitment of health personnel – hereafter referred to as a *code of practice*, or simply a *code* – gained momentum with the adoption of Resolution 57.19 by the World Health Assembly in 2004, when an increasingly competitive global market for health workers was described as a critical factor in serious health workforce deficits in more than 50 low-income countries.

The draft code being discussed by the various deliberative bodies of WHO during 2009 (WHO Secretariat, 2008) is the result of the subsequent global discussion and review of existing normative instruments.

The European Region includes both source and destination countries for migrating health workers, reflecting the differential in income among Member States. The source countries tend to have young, mobile workforces, while destination countries, where the demand for health workers has been increasing as their populations age, tend to have older workforces and difficulty replacing people who retire (Buchan, 2007b).

The economic and health system asymmetries of the Region are significant, creating “pull” and “push” factors that stimulate migratory flows. These factors combine a higher demand for health workers in higher-income countries with unattractive working and living conditions in lower-income ones, conditions that include a stagnant labour market that does not absorb all the health workers who wish to work (Afford & Lessof, 2006; Starkiene et al., 2008; Eke et al., 2008; Buchan, 2007c; Wiskow, 2006). A recent review of migratory flows in the Region found that the number of health professionals who migrated from countries that

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<sup>12</sup> A final draft of a code is being considered by the WHO Executive Board for possible discussion at the next World Health Assembly in May 2010.



joined the EU since 2004 has been below the levels projected based on such workers' "intention to migrate" (Buchan, 2007c).

Apart from ethical issues, the proposed code of practice deserves attention due to other characteristics of the European Region. The majority of the Member States are democratic societies where freedom of movement is considered a basic human right, and the governments have subscribed to various international treaties that entrench the right to migration. The European Commission is taking steps in the areas of education and labour that will facilitate the cross-border mobility of health professionals. They include support for the Bologna Process (which will facilitate the recognition of academic qualifications, including professional degrees) and a "blue card" (which will allow skilled health workers a single point of entry to the EU labour market) (Buchan, 2007c). Most countries in the Region have market economies, in which the employers and recruiters of health workers include numerous private entities that make decisions independently. In addition, temporary work abroad is a relatively attractive option in much of the Region because of short travel distances between countries and convenient cross-border transportation. The European Region may also have certain societal advantages when it comes to starting to implement the proposed code because civil society organizations, including labour unions and professional associations, are stronger in many of its Member States than in countries from other regions.

On more practical grounds, the Region also has a stock of experience with various types of codes, including unilateral codes (e.g. those in England and in Scotland and the policy initiative in Norway), bilateral instruments (e.g. the agreement between the United Kingdom and Spain and between the Netherlands and Poland) and guidelines (e.g. *Guidance for best practice on the recruitment of overseas nurses and midwives* from Ireland) (Connell, 2007; WHO, 2004; Irish DoHC Nursing Policy Division, 2001). National and regional implementation of existing and future codes would benefit from evaluating the effectiveness of these instruments.

The code of practice proposed at the next WHA would be a "soft" law, in so far as sovereign states would not be bound to adhere to it or enforce it through national legislation. Instead, national compliance would depend on political commitment and the efforts of an informed civil society (Connell, 2007; WHO, 2008) – hence the importance of a regional consultation to help mobilize stakeholder support. At the same time, the consultative process may help sensitize Member States to the importance of a comprehensive human resources for health (HRH) policy to address the causes of the problems for which the excessive migration of health workers is a symptom.

## **Topics for consultation**

The draft version of the proposed WHO code of practice (WHO Secretariat, 2008) draws on international experience with the drafting, implementation and monitoring of existing codes (national, regional and international) and memoranda of understanding (usually bilateral). The current draft covers:

- the scope of the code and the chief actors, public and private;
- good practices for the recruitment and employment of migrant health professionals;
- proposals to guarantee the reciprocity of benefits for source countries, destination countries and health workers;

- the information needed for monitoring implementation of the code and its integration into a national HRH policy; and
- the process leading to national implementation.

Consultation should take advantage of existing experience in the Region with various types of codes and bilateral agreements. The rest of this section presents some of the most important topics raised by previous reviews of existing instruments and by the public discussion of an earlier version of the proposed WHO code (see [who.int/hrh/public\\_hearing](http://who.int/hrh/public_hearing)), focusing on national and international implementation issues.

### ***Adoption of national codes***

In addition to having national authorities sign the international code of practice, effective implementation will depend on the compliance of employers (health care providers) and recruiting agencies. There are examples in the Region of public and private employers adopting their own codes, and pressure has been mounting from professional bodies demanding appropriate “best practice codes”, that would effectively accredit and monitor recruiting agencies. One issue is whether national authorities, especially those from destination countries, will be able and willing to engage and invest in the monitoring of recruitment practices. Experience in the Region suggests that public expenditure on monitoring efforts is easier to justify when the public sector is a direct provider or contractor. Effective negotiations with large networks of private providers (for example in countries where social health insurance is prevalent) should be analysed and the lessons learned from these experiences disseminated.

### ***Complementing international codes with bilateral agreements (memoranda of understanding)***

A memorandum of understanding (MoU) between a source and a destination country may help to manage migration flows and balance the interests of the parties involved. Involving a variety of governmental and nongovernmental entities in negotiations can lead to better results (e.g. by getting training institutions to support mutual exchange programmes). One typical question that arises is how much the components of such an agreement cost – e.g. incentives for return migration, and technical support for strengthening the health system of the source country – and who should pay for them (Connell, 2007).

Such bilateral agreements already exist between the United Kingdom and Spain and between the Netherlands and Poland. Information on their implementation should be gathered and disseminated to all Member States in the European Region. Both of the agreements mentioned focus on a few specific objectives and modalities (e.g. the duration of stays abroad and the focus of continuing education for migrant professionals) and make the commitments of the parties explicit.

### ***A role for multinational agreements among source countries?***

Multinational agreements have been negotiated by groups of countries in the South-East Asia and Western Pacific Regions of WHO (Connell, 2007) and by the Commonwealth (Buchan, 2008). Similarly, the African Union has expressed the common position of many of its member states in various international forums (Pagget & Padarath, 2007). The motivation for such multinational approaches may be source countries’ desire to strengthen their positions in negotiations with destination countries.

In comparison to other regions, the European Region is characterized by stronger institutional capacities among source countries and less asymmetry between source and recipient countries. Bilateral agreements may thus stand a better chance of satisfying the interests of the various parties and require less cumbersome negotiations.

### ***Involving civil society and professional associations***<sup>13</sup>

The mobilization of nongovernmental stakeholders can be useful in several ways, increasing the prospects for:

- reflecting the interests of the various parties, assuming that they are expressed during the negotiations leading to the adoption of the normative instrument;
- involving these stakeholders actively in the implementation process (e.g. in induction programmes and career management for migrant workers, or more generally in the application of best practices and guidelines);
- improving the access of potential migrants and employers to reliable information; and
- monitoring effectively the compliance of employers and recruiting agencies (Connell, 2007).

A recent review of the implementation of England's Code of Ethics (Buchan et al., 2009) showed that the objectives and mechanisms of the Code were poorly known among health professionals in two traditional source countries. Moreover, health officials in England incorrectly perceived recent decreases in the migration of professionals from these two countries as being caused by the Code, whereas they were due to reductions in demand for new staff members, changes in migration patterns and changes in regulations for professional registration.

Private providers may take proactive steps, as was the case nationally with the Independent Hospital Association in the United Kingdom, and regionally by the European Hospital and Healthcare Employers' Association (HOSPEEM) (Buchan, 2007a; ESPU & HOSPEEM, 2008). Such examples may provide a stimulus for negotiation in countries where the private sector has a strong presence as a health care provider and employer.

### ***National information systems and monitoring***

In order to support the effective national implementation of an international code of practice, health information systems need to:

- provide accurate, up-to-date information on the flows of migrant health professionals, as well as on the domestic workforce (including data that may not always be captured by routine systems, e.g. unemployment among health workers); and
- compare the information on migrant workers with other aspects of HRH policies (e.g. the projected need for health care services and projected domestic training levels).

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<sup>13</sup> The term "professional associations" should be understood as meaning not only technical or normative bodies (e.g. medical councils and professional nursing associations) but also labour entities such as trade unions. This position was iterated during the public debate on the framework and the earlier draft of the proposed code of practice.

National authorities should agree to share HRH data with the relevant regional coordinating entities.

The review of the English Code of Ethics (Buchan et al., 2009) provides evidence of the difficulties of monitoring the implementation of a code, even in a country with only one formal migration entry point and one registration body, and it suggests that the difficulties will be even greater in federated states. The review also emphasizes that traditional sources of information (such as applications for work permits and professional registration) may not provide information that is specific enough to assess whether enacting the code is achieving the intended results.

Health and HRH information systems in source countries should provide information on the consequences of migration outflows, such as unmet needs or staff shortages. Article 8.3 of the WHO draft code also calls on Member States to “designate a national authority responsible for the exchange of information regarding health personnel migration and the Code” (WHO Secretariat, 2008).

However, compliance monitoring entails a technical and financial capacity to review the procedures used by recruiting agencies and employers, both reactively (responding to complaints from individuals or nongovernmental organizations, as per Article 10.4 of the draft code (WHO Secretariat, 2008)) and proactively.

### ***International monitoring of the code***

Article 10.3 of the WHO draft code describes the position of WHO within the United Nations system and its role with respect to international laws, a role that consists of providing technical guidance in coordination with Member States and other United Nations agencies (WHO Secretariat, 2008). Article 10.2 calls on the WHO Director-General and Secretariat to “keep under review the implementation of this Code ... and report periodically to the Health Assembly” (WHO Secretariat, 2008). During the public debate on the draft code, some contributors suggested that HRH observatories, composed of representatives of the main stakeholders, might be better positioned to do so (WHO, 2008).

The Regional Office for Europe may wish to support the creation of HRH observatories that have a mandate and responsibility that go beyond the “reporting” suggested by Article 10.4.

### ***The role of WHO***

Article 10 of the draft code appears to systematize the role of WHO, but also to limit it to providing technical guidance and coordinating with Member States and other United Nations agencies. During the public debate, it was suggested that:

- the effort to reach an agreement on a code does not decrease the critical importance of supporting proper national HRH policies;
- the emphasis on monitoring does not decrease WHO’s responsibility for advocating for the code before all constituencies – national and international, governmental and nongovernmental – in order to secure maximum stakeholder commitment.

### ***Who should be consulted?***

The public debate on a draft code has been open for a long period, and it has produced numerous suggestions, some of which were incorporated in a new version. Experiences with

existing national and regional codes and bilateral agreements suggest that regional consultation will enable stakeholders to:

- improve their familiarity with similar instruments inside and outside the Region;
- negotiate with other national actors about their respective roles (and the costs involved);
- broaden their support and advocacy for the code; and
- participate in drafting and monitoring its norms and procedures.

The following national stakeholders should be represented in the consultation process:

- national and subnational health departments;
- HRH departments (particularly those responsible for HRH policies and information systems);
- public hospitals and primary care facilities;
- medical and nursing faculties and schools;
- agencies responsible for the recognition of foreign diplomas and qualifications;
- professional associations and unions;
- recruiting agencies;
- networks of private health care providers; and
- networks of international non-profit-making health care providers (such as Médecins Sans Frontières and Médecins du Monde).

In addition, governmental and nongovernmental health organizations and technical agencies from the European Region should have *ex officio* roles, as should academic and professional networks. Such organizations should include the European Commission, the WHO Regional Office for Europe, the OECD, international medical and nursing federations, etc.