International Migration of Health Workers
Advancing Evidence and Governance

Ibadat Dhillon
World Health Organization
International Migration of Health Workers

I. WHO Global Code
II. Evidence
III. Next Steps
I. WHO Global Code
WHO Global Code of Practice

- Adopted in May 2010 through consensus by the 193 WHO Member States
  - Only the second instrument of its kind promulgated by the WHO
  - Broadest possible articulation of the challenges: elaboration of ethical norms, principles, and practices.
Code Structure and Substance

- Preamble
- Article 1: Objectives
- Article 2: Nature and Scope
- Article 3: Guiding Principles
- Article 4: Responsibilities, Rights and Recruitment Practices
- Article 5: Health Workforce Development and Health Systems Sustainability
- Article 6: Data Gathering and Research
- Article 7: Information Exchange
- Article 8: Implementation of the Code
- Article 9: Monitoring and Institutional Arrangements
- Article 10: Partnerships, Technical Collaboration, and Financial Support
**Legal and Institutional Arrangements**

- While the WHO Global Code is voluntary, it contains a robust process for reporting
  - WHO’s reporting on the Code is mandatory ("shall")
- Progress on the Code is to be reported upon at the World Health Assembly every three years

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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<tr>
<td>2015</td>
<td>First review of Code Relevance (high) &amp; Effectiveness (emerging)</td>
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<tr>
<td>2016</td>
<td>WHO DG Report on 2nd Round of National Reporting</td>
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| 2019  | Second review of Code Relevance & Effectiveness  
 |       | WHO DG Report on the 3rd Round of National Reporting |
Increasing Legitimacy and Value

Second round of Code reporting
- **37% increase** in countries appointing NDAs
- **32% increase** in countries submitting complete national reports
  - Improvement in the quality and quantity of data and information

Reports **publically available**
2nd round Code reporting
- 34 countries identified bilateral agreements
- 65 agreements identified
- 22 countries reported taking ethical considerations into account, as called for by the Code
II. Evidence
Key Sources

• OECD, International Migration Outlook, 2015

• 2nd Round of Reporting WHO Global Code of Practice on the International Recruitment of Health Personnel

• Targeted implementation of the WHO Global Code
  – India (Kerala), Ireland, Nigeria (Cross River State), Uganda and South Africa
Share of foreign trained doctors in OECD countries

2013 or latest year available

Source: OECD, 2015
International migration on the rise

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<td>Doctors</td>
<td>19.5 %</td>
<td>22 %</td>
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<tr>
<td>Nurses</td>
<td>11 %</td>
<td>14.5 %</td>
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The number of migrant doctors and nurses working in OECD countries has increased by **60%** over the past 10 years (from 1,130,068 to 1,807,948).

Source: OECD, 2015
Complex Patterns of Mobility: A blurring of “source” and “destination”

**South to South movement**
- Nigeria, Cuba, and Democratic Republic of the Congo (DRC) are respectively the 1st, 3rd, and 4th largest sources of immigrant medical doctors who entered South Africa between 2010-2015.

More than 1/2 of emigrant nurses from Kerala (India) are estimated to reside in Gulf countries according to the Kerala Migration Survey.

Approximately 1/5th of all new entrants licensed to practice in Nigeria were foreign medical graduates, with an estimated half from Asia and one third from African countries.

Approximately 1/2 of doctors in Trinidad and Tobago are foreign born and foreign trained, with one third from India, and a quarter each from Jamaica and Nigeria.

**Globalization of medical education**
- In the General Division of Ireland’s Health Services Executive, less than 1/2 of European medical school graduates (excluding Ireland) are EU passport holders.
- From 2010-2016, 18 foreign nationals from 10 countries (including Kenya, India, Iran, Mexico, and Poland) received their basic medical qualification in Uganda.

**Intra-regional movement**
- Over 1/2 of emigrant GPs from Uganda (2010-2015) are estimated to have moved within Africa, primarily to Southern and Eastern Africa with Namibia and Kenya as leading destinations.

**North to South movement**
- 1/3rd of GPs who registered in Uganda (2010-2015) were trained and hold nationality in Europe or North America. Nationals from 74 countries registered in Uganda during the period.
- UK was the 2nd largest source of immigrant medical doctors who entered South Africa (2011-2015).

**Temporary migration**
- Of doctors who received their basic medical qualification in South Africa and registered in Ireland, only 1/5th reported practising only in Ireland.
Key lessons

• All countries are source and destination, albeit to varying degrees.
• Policies for the integration of foreign health professionals are relevant across all countries.
• Strategic linkages must and can be made across the health labour market: production, licensing and registration, employment, and migration.
• Potential to improve global reporting of immigration data across countries, with information sharing facilitated through the Code.
• Targeted support to implementation of the Code in low-income and middle-income countries fundamental.
III. Next Steps: elevating dialogue, knowledge and co-operation
Scaling Up Innovative Practice

National
E.g. South Africa, Foreign Health Professionals Policy / Ireland

Bilateral
E.g. Sudan, Bilateral Agreements

Regional
E.g. East African Community, Regional Harmonization Process
- Harmonized medical and dental education, registration/licensure, and practice
As an immediate action, calls on ILO, OECD and WHO, with relevant partners, to:

1. **Establish an international platform on health worker mobility**
   - Maximize benefits from health worker mobility
   - Initiate dialogue, expand evidence, consider new options and solutions
   - Strengthen and support implementation of the WHO Global Code and relevant ILO Conventions and Recommendations
   - Link to the Global Compact for Safe, Orderly and Regular Migration
International Platform on Health Worker Mobility
Thank you

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