Context for the Code: Global labour mobility

• Background
• Things change........
• Different data, different picture
• What are the key messages for policy makers: Context for the Code
Background

• Health workforce migration is not a new phenomenon
• Our understanding of health workforce migration data, patterns and trends has improved, but remains fragmented
• There are multiple perspectives on the reasons for, drivers of, and impact of migration
• The global financial crisis was a short term shock, but underlying demographic trends are a main driver of migration
• Effectiveness/Ethics........tensions
• The WHO Code marks a watershed, but is unfinished business
Things change: Germany: recent trends in inflows of doctors
Things change: UK: new international nurses, EU and non EU 1993-2014
Things change: pre-crisis outflow of nurses from Philippines 1997-2008
Things change- new mobility patterns

Scottish Daily Mail

FREE LEGO TOY TODAY CITY ARCTIC PLANE
Pick up at WHSmith and Toys R Us

NHS pays medic to fly from India to cover shift in Aberdeen hospital

DOCTOR AIRMILES WILL SEE YOU NOW

A CRISIS-hit hospital drew a doctor in from India after its A&E department was left without weekend cover.

By Victoria Ahme
A CRISIS-hit hospital drew a doctor in from India after its A&E department was left without weekend cover.

The hospital contracted a medic for a round trip of more than 9,000 miles to step in after NHS

Hollywood sails in to Venice to see George wed
Things change: different types of mobility, and the mobile worker

- **Mobility**- daily/short term/ long term; temporary/fixed term/permanent
- **Mobile worker**- reasons for mobility:
  - The livelihood migrant
  - The career oriented migrant
  - The “backpacker”
  - The commuter
  - The undocumented.
  - The returner
Fig. 5.2  Reliance levels on foreign-trained, foreign-born and foreign-national nurses, 2008 or latest year available for countries

Percentage active nurses among all active nurses

- Luxembourg: 69.1%
- New Zealand: 47.1%
- Ireland: 22.1%
- Malta: 22.7%
- United Kingdom: 18.4%
- Australia: 14.5%
- Austria: 12.9%
- Sweden: 5.1%
- Italy: 9.4%
- Latvia: 4.9%
- Belgium: 4.4%
- Portugal: 3.5%
- USA: 3.0%
- Germany: 2.2%
- Greece: 1.6%
- Canada: 1.6%
- Denmark: 1.4%
- Netherlands: 1.4%
- France: 1.1%
- Hungary: 1.1%
- Slovak: 0.5%
- Bulgaria: 0.2%
- Poland: 0.1%
- Spain: 0.0%
- Estonia: 0.0%

- % active foreign-trained
- % active foreign-born
- % active foreign-nationals
Different data, different picture.

- **Loose** intention to leave – no active steps
  - Hungary: 60-70% (of medical students)

- **Moderate** intention to leave – some (self-reported) steps
  - Hungary: 10-20% (of medical students)

- **Firm** intention to leave – active steps in host/destination countries
  - Hungary: 2-3% (of MDs) yearly, 2004-2007
  - Romania: 10.2% (of MDs, 2007)

**Actual mobility - outflows**
- Hungary: unknown
- Romania: 3% in 2007

**Data:** Self-administered surveys on interest in working abroad, e.g., in Hungary (Eke et al 2009)

**Data:** Self-administered surveys, more reliable questions, e.g., in Hungary 10-20% of medical students/residents took “active steps” as self-reported (Eke et al 2009)

**Data:** Recognition of diplomas, application for work permits, e.g., in Hungary, approx 2-3% yearly (Eke et al 2011)

**Data:** Surveys on outflows, registration data from destination countries
The policy context

• A changing map of mobility?
  – Widening gap wealthier >< poorer Member States
  – Increasing/ new mobility flows

• Major driver- increasing demand/ declining domestic supply: key occupations [notably nursing] in some member states

• Mobility is...
  – a right for individuals
  – a policy solution for some MS with workforce deficits
  – a risk for health system access, responsiveness and to achieving UHC
  – A cost / a benefit. (Whose cost, whose benefit?)
5  Key messages for policy makers

• 1. You cannot be “isolationist”: your health workforce policy, planning and regulation can no longer be regarded as separate and unconnected, or as a purely domestic issue.......... 

• 2. You (almost certainly) do not have all the data and analysis you need to be to be effective in monitoring and managing mobility, but (almost certainly) don’t make the best use of data that does exist
5 Key messages for policy makers

• 3. Migration/mobility cannot be “solved” as a stand alone policy challenge:
  – part of broader dynamic of workforce mobility
  – alignment with economic, education, immigration, regulation, health, gender, equal opportunities, and health workforce policy (incl. fair and effective integration of international recruits)
  – “whole of government” action

• 4. Countries must develop and share strategic intelligence beyond own system and country:
  – joint actions
  – bilateral and multilateral links
  – EU...ASEAN...
5 Key messages for policy makers

• **You must consider how to respond to the WHO Code**... a sustainable and effective response is to:
  a) integrate monitoring with broader national health workforce analysis and planning
  b) use a whole of government/whole of society approach to adopting the Code (not a “tick box”)
  c) develop and share strategic health labour market intelligence beyond your own system and country
  d) recognise that the Code extends beyond migration to other critical aspects of health workforce policy
  e) ...aim for health workforce sustainability...
  f) where appropriate and mutually beneficial, initiate joint policy action on health workforce migration through bilateral and multilateral links.
Reference