chapter three

Migration of health workers in Europe: policy problem or policy solution?

James Buchan

Introduction

International recruitment has become a solution to health professional skill shortages in some countries. This active cross-border recruitment of nurses, doctors and other professionals is in addition to any natural migration flows of individuals moving across borders for a range of personal reasons.

International migration and recruitment can have positive aspects: they can be a solution to staff shortages in some countries; they can assist source countries that have an oversupply of staff; and they can be a method for individual health workers to improve their skills and standard of living. However, it can exacerbate problems in countries that are understaffed and have a negative impact on the effectiveness of their health systems. This was highlighted in the World Health Assembly resolution in May 2004 (WHO 2004).

The migration of health professionals has therefore become a more significant feature of international health policy debate in the past few years (Buchan 2001; Chanda 2002; Pang et al. 2002; Tjadens 2002; Stilwell et al. 2003), and achieved additional prominence in the EU with the accession of the new Member States in 2004 (Krieger 2004). Some European countries, such as the United Kingdom, are recruiting staff from other countries. Others, such as Poland, were concerned about out-migration of health workers following accession although, by early 2005, this had not seemed to have become a significant issue.

This chapter assesses the implications of health worker migration in Europe: to what extent is it a problem or a solution to staffing requirements? It focuses on international migration: the movement of health workers across national borders. Although internal migration (i.e. movement within national

boundaries) is also a major factor for some countries, often compounding existing problems of geographical distribution, it is not examined here.

The chapter is divided into three sections, examining: (a) general issues related to migration and active international recruitment of health workers; (b) the current situation of health worker migration in Europe, looking at the migration of workers within, to and from Europe; and (c) the policy implications of migration, particularly health worker migration in an enlarged EU.

General trends in international migration

Recent research findings indicate five main trends in general migration.

- An increasing rate of international migration (Castles 2000; OECD 2000): the number of people migrating doubled from 75 million in 1965 to an estimated 150 million in 2000 (International Organization for Migration (IOM) 2000) when international migrants are defined as 'those who reside in countries other than those of their birth for more than one year'. Of these, about 80–97 million were migrant workers and members of their families (IOM 2000).
- A growth in migration of skilled and qualified workers (International Labour Organization (ILO) 2000; OECD 2000, 2002).
- More complex migration flows owing to greater information exchange, global awareness (Stalker 2000) and better transportation links (Castles 2000). Thus, between 1970 and 1990, the numbers of countries that qualified as major receivers of migrant workers rose from 39 to 67 and those that qualified as major senders rose from 29 to 55 (ILO 2000).
- Less distinct categories of migrant, e.g. planned migration for employment or asylum seekers (Stalker 1997). There has been an increasing mix of temporary/permanent migrants and legal/illegal immigrants (Timur 2000) and a recent reported switch from permanent to temporary migration (Findlay and Lowell 2002).
- Increasing numbers of females migrating independently of partners or families (Timur 2000).

Krieger (2004) reported on countries of the EU, and EU enlargement, in an overview for the European Foundation for the Improvement of Living and Working Conditions, completed before the accession of new Member States in 2004.

- Thirteen million non-national citizens were living in the 15 EU Member States in 2000, half being nationals of other EU countries.
- The net inflow of migrants to the EU in 2000 was 680 000 people (2.2 per 1000 population).
- There is an income gap of 60% between central and eastern acceding countries and existing Member States, much higher than in the previous enlargement of the EU.
- The number of migrants from the new Member States and candidate countries will increase from one to four million by 2030, and the EU 'should not expect a tidal wave of emigrants from eastern and Mediterranean acceding and candidate countries'.

- Migrants from the new Member States are likely to be relatively young and educationally well qualified. Women will make up 40–45% of the total, creating a potential 'youth drain' in the source countries.
- The main target destination countries for these migrants will be Germany and Austria.

Stilwell et al. (2003) summarized the different types of migration.

- **Permanent settlers** are legally admitted immigrants who are expected to settle in the country, including persons admitted to reunite families.
- **Documented labour migrants** include both temporary contract workers and temporary professional transients: *temporary migrant workers* are skilled, semi-skilled or untrained workers who remain in the receiving country for finite periods as set out in an individual work contract or service contract made with an agency; *temporary professional transients* are professional or skilled workers who move from one country to another, often with international firms.
- **Undocumented labour migrants** are those who have no legal status in the receiving country because of illegal entry or overstay.
- **Asylum seekers** are those who appeal for refugee status because they fear persecution in their country of origin.
- **Recognized refugees** are those deemed at risk of persecution if they return to their own country. Decisions on asylum status and refugee status are based on the United Nations Convention Relating to the Status of Refugees, 1951.
- **Externally displaced persons** are those not recognized as refugees but who have valid reasons for fleeing their country of origin (such as famine or war).

Most health professionals moving *within* the EU will fall into one of the first two categories in the typology. Some coming from *outside* the EU, from other parts of the world, will be refugees, asylum seekers and displaced persons.

With the data available it is not possible to develop either a detailed Europe-wide or an international picture of the trends in flows of doctors, nurses and other health workers, or to assess the balance between temporary and permanent migrants. There is little international standardization of migration-related documentation so it is difficult to compare levels of general migration between countries (Auriol and Sexton 2002). The general lack of specific data related to health professionals requires primary research coordinated across all relevant source and destination countries (Mejia et al. 1979).

However, it is possible to illustrate country-level examples of the in- and outflow of health professionals, enabling the dynamics of international recruitment and migration to be examined and the policy considerations to be illuminated.

The drivers of migration

The drivers for individuals to consider migrating are often characterized as push and pull factors. Table 3.1 summarizes some of the possible main factors related

Table 3.1 Main push and pull factors in migration and international recruitment of health workers

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

Source: adapted from Buchan et al. (2003).

to health workers. To a certain extent, these present a mirror image on the issues of relative pay, career prospects, working conditions and environment available in the source and destination countries. Where the relative (or perceived) gap is significant, the pull of the destination country will be felt.

However, other factors may also act as significant push factors in specific countries at specific times, such as the impact of HIV/AIDS on health systems and health workers, concerns about personal security in areas of conflict and economic instability. Other pull factors, such as the opportunity to travel or to assist in aid work, will also be a consideration for some individuals.

Taking account of push and pull factors and individual circumstances, a typology of different categories of international overseas nurses has been developed (Buchan et al. 1997) (Table 3.2). This typology helps to delineate different push and pull factors, and could be applied to the type(s) of health workers' mobility to any European country. Different individuals will be motivated to move for different reasons and the mix of different types of migrant health workers may be different in different countries and at different times. Some temporary moves will become permanent, while some planned permanent moves will be short-lived in practice.

Other factors, such as geographical proximity and shared language, customs and educational curricula, may affect the choice of destination country. Postcolonial ties (often where source countries continue to share similar educational curricula and language) may also be a factor for some EU countries, such as the United Kingdom and Portugal.

Issues of professional and cultural adaptation must be considered. Doctors and nurses moving from one country to another may speak the language and possess recognized qualifications but it is likely that there will still be a period of adapting to the specific clinical processes and procedures and the broader organizational culture. This issue is underresearched (but see Yi and Jezewski 2000; Daniel et al. 2001; Buchan 2003).

Table 3.2 Typology of migrant health workers

Permanent move	
Economic migrant	Attracted by better standard of living
Career move	Attracted by enhanced career opportunities
Migrant partner	Unplanned move, result of spouse or partner moving
Temporary move	
Working holiday	Health professional qualification used to finance travel
Study tour	Acquisition of new knowledge and techniques for use in home country
Student	Acquisition of post-basic qualifications for use in home country
Contract worker	Employed on fixed-term contract; often awaiting improved job prospects in home country

Health worker migration in Europe

This section assesses the flows of some categories of health worker within Europe and the inflow of health workers to European countries from elsewhere. The latter, in particular, has been the focus of much of the recent policy attention. This section draws from information and data reported in the country case studies and reports mainly on doctors and nurses.

Three issues are examined in this section, each using different data sources: (a) cross-border migration of health professionals within EU countries, using data compiled by Directorate General XV of the European Commission (DGXV); (b) the findings from the country case studies; and (c) additional data from selected EU countries, providing illustrative examples of the dynamics of health workers' flows between countries.

There are two main indicators of the relative importance of migration and international recruitment to a country: the inflow of workers into the country from other source countries (and/or the outflow to other countries), and the actual stock of international health workers in the country at a certain time. Some of the recent policy documents and reports on the international migration of health professionals have highlighted the need to improve monitoring of cross-border flows. Currently, even the best available data are incomplete for any one country and not compatible between countries, constraining any attempt to develop a clear international or global picture of the overall flows of health workers. However, it is possible to take a national focus and use available data to fix any one country within the international dynamic and also to assess the connections with other countries in terms of the flows of workers.

Cross-border flows within the EU

DGXV collates statistics on the migration of doctors and general nurses within the EU, presented annually between 1977 and 2000 (European Commission

2004a, b). Unfortunately, no data are available for many EU countries and those data that are available are incomplete. Table 3.3 shows data on the numbers of doctors and general nurses authorized to practise in another EU country in 2000, by virtue of EU directives. This is the most recent year for which data are available. However, these cannot be used as a matrix to assess cross-border flows of doctors and nurses in the EU.

Country case studies

The limited data on internal migration of health professionals raise important questions in relation to EU accession. Some new Member States, such as Poland and Lithuania, are reporting that significant numbers of their health professionals are considering moving to longer established EU countries following enlargement. In the absence of improved monitoring capacity, it will be difficult to assess the actual flows in a systematic and comparable manner.

The country case studies highlight that some countries, such as the United Kingdom, hold more data on the inflow and outflow of health professionals than have been available to DGXV. At least in part, improved monitoring could be based on better access to and compilation of current country-level data rather than the generation of new data. Data and information presented in the

Table 3.3 Doctors and nurses of EU Member States obtaining authorization to practise in other EU countries in 2000

	Total no. authorized to practise in (country) in 2000		
	Doctors by virtue of basic qualification	*Doctors by virtue of specific training in general medical practice*	*General nurses by virtue of EU Directive*
Germany	[a]	4019	88
France	[a]	[a]	[a]
Italy	72	12	138
Netherlands	215	[a]	126
Belgium	[a]	[a]	[a]
Luxembourg	[a]	[a]	[a]
United Kingdom	[a]	[a]	[a]
Ireland	[a]	[a]	1097
Denmark	50	68?	17
Greece	[a]	[a]	[a]
Spain	257	61–63	128–133
Portugal	[a]	[a]	1611
Austria	72	5	99
Finland	29	22	4
Sweden	174	9	231

Source: European Commission (2004a, b).
[a] No data

country case studies can be used to highlight current stocks of health professionals in each of the countries and to identify current main source countries. Table 3.4 reports on country information from EU Member States and the Russian Federation.

These data present a mixed picture of current EU Member States. The United Kingdom reports a significant inflow of doctors and nurses, mainly from non-EU countries. Norway also reports some active recruitment, while migration has a negligible impact in France. Spain reports some outflow of nurses, including via a 'country to country agreement' with the United Kingdom. In some new Member States (Malta, Poland, Lithuania) there is an expectation that accession may lead to an increase in outflow of doctors and nurses. Poland and Lithuania report on surveys suggesting that many young doctors and nurses are considering moving westward.

Dynamics of flows of health workers in Europe: examples from Ireland, Norway and the United Kingdom

A source country becomes a destination country: nurses in Ireland

In the past, Ireland has been a major source of nurses for other English-speaking countries, particularly the United Kingdom, the United States and Saudi Arabia. Some Irish nationals travelled to the United Kingdom to work as nurses or to train there, staying on after qualification. This traditional outflow of nurses changed dramatically from the mid-1990s when the Irish economy began a sustained period of rapid growth, the health sector expanded and there was a growing nursing shortage, particularly in the capital city of Dublin (Department of Health and Children 2002).

Having been a country of emigrants, Ireland has become an active recruiter of nurses from elsewhere, encouraging Irish nurses to return home and actively recruiting in other English-speaking countries such as the United Kingdom and South Africa, as well as the Philippines (Figure 3.1). Thus, in 1990 approximately three of every four new registrations on the nursing register in Ireland (An Bord Altranais) had trained in Ireland; only 27% were from other sources. However, while numbers registering from Ireland remained constant at around 1500–1700 per year during the following decade, the numbers registering from non-Irish sources rose threefold. By 2000 non-Irish sources accounted for more than half of all new registrations, the United Kingdom being the main source country.

A measure of the outflow of nurses from Ireland to the United Kingdom, and vice versa, can be assessed using registration data in each country (Figure 3.2), highlighting the changing dynamics over the period. In the mid-1990s the net exchange of nurses, measured by registration data, was slightly in favour of the United Kingdom. However, by the end of the decade the situation had changed dramatically, with many more nurses now moving from the United Kingdom to Ireland.

Registration data can never give a complete and accurate picture but the trend

Table 3.4 Key indicators of migration and international recruitment of health workers

Country	*Stock of international workers in country (% of total stock)*	*International inflow (% of total inflow)*	*Major source/destination countries*	*General comments*
France	Doctors: 7000–8000 (3%).		Inflow from Belgium (nurses).	In-migration from EU 'not yet significant'. 'Very few' French physicians do their training in another EU country. 'No country in EU contributes more than 1 in 1000 health professionals working in France' – other than in nursing, where Belgium contributes 2 in 1000. Impact of migration is 'minimal'.
Germany	Doctors: 15 143. 'No data' on nurses.		Former Soviet Union, Iran, Greece, Turkey.	'Negligible' outflow of doctors.
Norway	2623 physicians (15% of stock, but includes Norwegian nationals trained in other countries).	32 physicians (active recruitment by Labour administration, 2002). 260 nurses (active recruitment by Labour administration, 2002).	Inflow from other Nordic countries, Germany, some Baltic states, Poland.	'Historically a large percentage of Norwegian physicians have received their education abroad'.
Spain			Inflow of physicians from Argentina. Outflow to Portugal, Sweden, France. Outflow of nurses to United Kingdom.	Agreement between Spain and United Kingdom for active recruitment of nurses by United Kingdom.

United Kingdom	8% of registered nurses (2002). Approx. one-third of the total of 70 000 NHS hospital medical staff were from other countries (2002).	12 000 nurses in 2002/3 (43% of new inflow). Over 10 000 doctors in 2003 (70% of total inflow of new full registrants).	*Nurses* Inflow: the Philippines, South Africa, Australia, India. Outflow: Australia, Ireland, United States. *Doctors* Inflow: e.g. India, South Africa, Australia, EU (e.g. Germany).	International recruitment an explicit policy to assist in increasing NHS workforce. Targeted recruitment of physicians and nurses. 'Ethical' recruitment code for NHS – no active recruitment from specified developing countries.
Lithuania			Doctors' outflow: Nordic countries, United Kingdom, Germany. Nurses' outflow: Nordic countries, Germany, United Kingdom, Ireland.	60% of medical residents and 27% of physicians intend to leave for other EU countries.
Malta			Physicians' outflow to United Kingdom and USA; inflow from eastern Europe. Nurses' inflow from Serbia and Montenegro and 'developing countries'.	'Large proportion of physicians migrate in 3–5 years following qualification . . . 70–80%'. 'Negligible' number of nurses migrating. 'Post accession brain drain . . . could seriously affect the local health care sector'. Seven-year period negotiated with EU to halt inflow if oversupply occurring.

Continued overleaf

Table 3.4 *Continued*

Country	*Stock of international workers in country (% of total stock)*	*International inflow (% of total inflow)*	*Major source/destination countries*	*General comments*
Poland	16 000 physicians have left to work abroad since 1995. 50 nurses to Netherlands (2002); 100 nurses to Sweden (2002).		Germany, Italy. Offers also reported from Netherlands, Spain, Norway, Sweden and Denmark (physicians). USA, Italy, United Kingdom, Saudi Arabia (nurses).	40% of first-year nursing students thinking of working abroad; language a barrier to mobility. Agreement signed in 2001 between Labour Offices of Poland and Norway, for Polish health workers to work in Norway.
The Russian Federation				No report of doctors recruited from other countries.

Source: country case-studies (see Chapter 1).

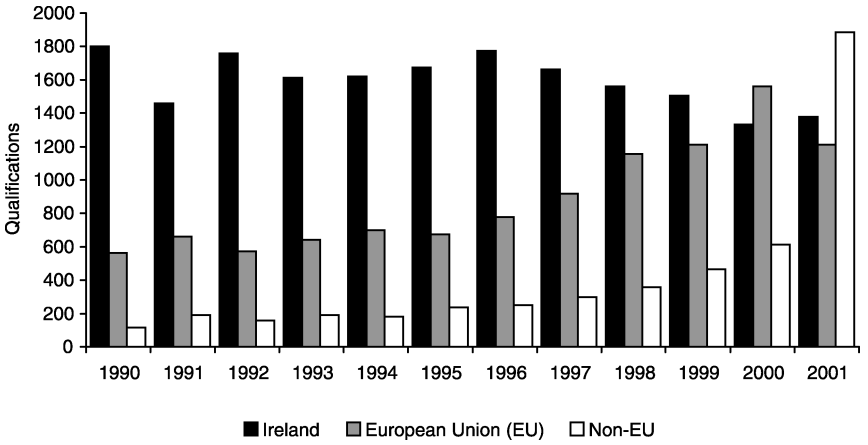

Figure 3.1 Origin of new qualifications registered with An Bord Altranais (from An Bord Altranais and Buchan et al. 2003).

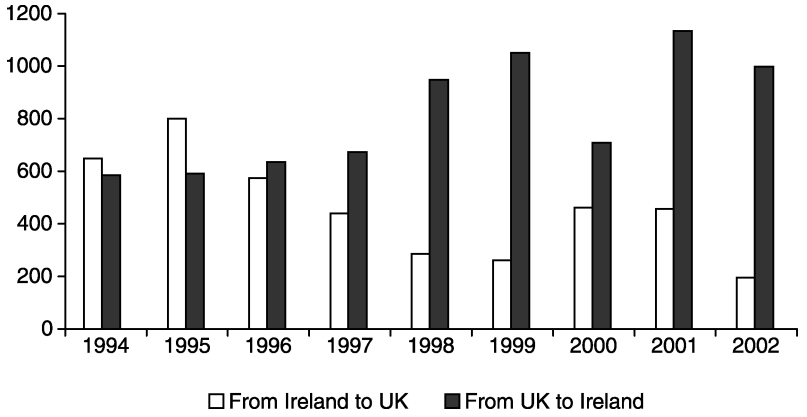

Figure 3.2 Flow of nurses between Ireland and the United Kingdom, as measured by number of requests for verification, 1994–2002.

is clear. The main point highlighted in the inflow data from Ireland is that in recent years it has been very dependent on international recruitment. Indeed, currently it appears to be significantly more reliant on international nursing labour markets than other developed countries. It is also apparent that the United Kingdom has become a main source of nurses to Ireland. Correspondingly, the United Kingdom has become less important as a potential destination for Irish nurses.

This dynamic has two major implications. First, the data suggest that many Irish nationals who travelled to the United Kingdom for nurse education have been returning to Ireland. Some may return soon after qualification but others do so after working in the United Kingdom or elsewhere after qualification. As a

result, the United Kingdom is experiencing a significant increase in the net outflow of registered nurses to Ireland, just as it attempts to redouble efforts to stimulate inflow.

A similar example of this changing dynamic is the recruitment of Finnish nurses to the United Kingdom. This was a significant feature for a few years in the late 1990s as a result of a temporary oversupply of nurses in Finland. Several hundred nurses were recruited but when nursing jobs became available in Finland, migration to the United Kingdom dropped and many Finnish nurses returned home.

This also illustrates the second main point. If there is no expectation that the employment situation in the home country will improve over time, it is likely that health workers will plan their moves to be long term or permanent. Conversely, migration is likely to be considered a temporary solution if there is an expectation of improvement in the home situation, with the view of returning when attractive career opportunities become available.

Broadening the sources of recruitment: Filipino nurses in Norway

Norway is not a member of the EU but has close ties to other Scandinavian countries. There has been an agreement for free movement of nurses within the Nordic countries for about 20 years. Nurses from other countries applying to work in Norway are recorded by a state registration organization (SAFH). Figure 3.3 illustrates the recent trend in the number of nurses registered by SAFH.

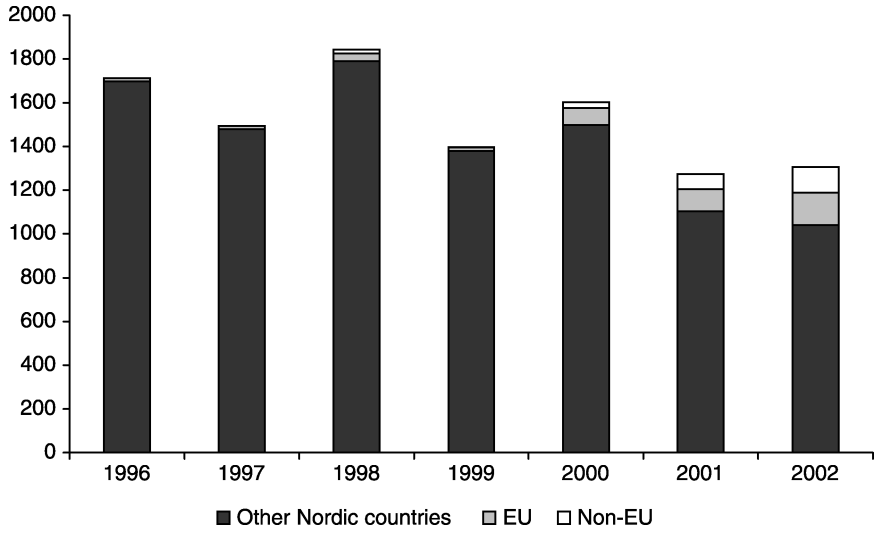

Figure 3.3 Number of international nurse registrants to Norway as recorded by SAFH 1996–2002 (2002 data are provisional). Other Nordic countries: Denmark, Finland and Sweden (from SAFH statistics on overseas recruitment and Buchan et al. 2003).

This suggests that there has been a relatively stable inflow of nurses annually to Norway since 1996 compared to the rapid increase recorded in Ireland. However, there appears to have been a broadening of source countries, with fewer nurses recruited from other Nordic countries and more from other European countries and elsewhere. Data for 2002 indicate that Sweden, Denmark, Finland, Germany and the Philippines were the five main sources of recruits.

Aetat, the Norwegian Public Employment Service, has been recruiting nurses from other countries on behalf of Norwegian employers since 1998. It is set a specific annual target limit for the number of recruits: 228 in 2001 and 260 in 2002. Aetat targets specific countries for active recruitment, conducts interviews and screening and arranges language training etc. Initially, the focus was within the EU, Finland and Germany being the two main 'cooperating countries' for the recruitment of nurses and a signed agreement between Aetat and a country counterpart. More recently, recruitment activity has spread to other countries, such as Poland and the Philippines. While Aetat is the main state-sponsored source, private sector recruitment agencies also recruit nurses on behalf of Norwegian employers.

Aetat's target-setting means that overseas recruitment to Norway is more regulated compared to that in many other countries. Norway also has the additional issue of having to provide language training to virtually all nurses from other countries. This has become more important with the shift from reliance on recruiting from other Nordic countries (where entry is easy and language differences are less pronounced) towards recruitment from a broader range of countries.

This example highlights several factors that any country will have to consider if it is actively to recruit health workers from elsewhere. Which countries should be targeted? Should there be an 'ethical' approach to international recruitment? How should it facilitate the adaptation of health professionals from other countries? Will it have to provide language training? Should it rely on recruitment agencies? These policy questions are discussed in the final section of this chapter.

International recruitment as an explicit policy: the United Kingdom's active recruitment of doctors

The United Kingdom is one example of a country that has used international recruitment as a deliberate policy to assist in meeting staffing growth targets in the NHS. Estimates of health professionals' inflow derived from registration records and work permits confirm that there has been a substantial increase in recent years.

In 2003, more than two-thirds of the 15 000 new full registrants on the United Kingdom's medical register were from other countries. The Department of Health (DoH) reports that about one in three of the 71 000 hospital medical staff working in the NHS in 2002 had obtained their primary medical qualification in another country (DoH 2003). The main sources of recruits were not from within the EU but from non-EEA countries, such as South Africa and India. Figure 3.4 shows the annual percentage of new doctor registrants from within the United

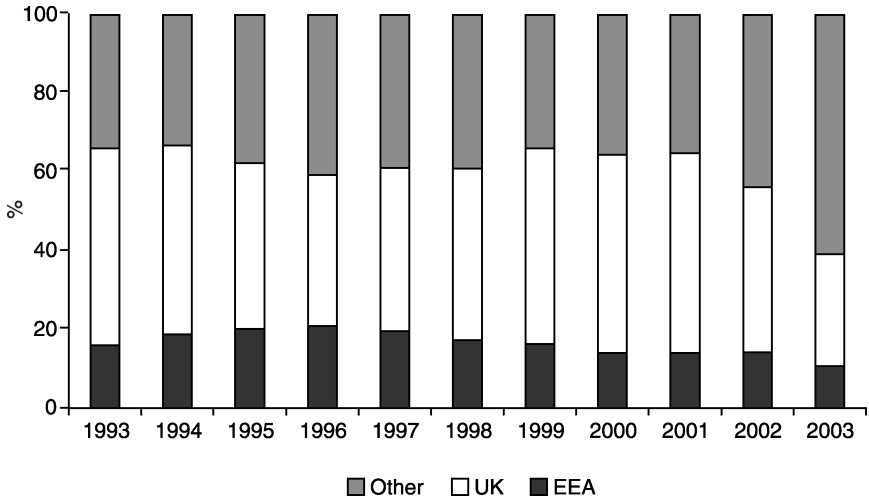

Figure 3.4 Doctors: number of new full entrants to GMC (United Kingdom) register from EEA countries, United Kingdom training and other countries, 1993–2003.

Kingdom, the EEA and non-EEA countries. This highlights a rapid upswing in the proportion of doctors registering from other (non-EEA) countries in the past two years.

This upward trend is, at least in part, a direct consequence of policy intervention. The Department of Health in England has been explicit in its support for international recruitment: 'International recruitment is a sound and legitimate contribution to the development of the NHS workforce' (DoH 2001). This support stems from the need to supplement home-based recruitment and 'return' initiatives if the NHS Plan targets for staffing growth are to be met. However, having recognized the potential consequences of such a strategy, it issued a Code of Practice on International Recruitment in October (DoH 2001), which requires that NHS employers do not recruit actively from developing countries, unless there is a bilateral agreement (Buchan 2004). A full list of proscribed countries and approved recruitment agencies was made available in early 2003.

This has important general implications. Recruitment agencies often play a key role as intermediaries in the international recruitment process. Some are based in the home country of recruits and act as an agent on their behalf to identify employment opportunities in other countries; others are based in destination countries, or are multinational, and act primarily as agents of the employer who is seeking specific types of health workers. Some agencies came under criticism in the United Kingdom as they were charging high fees to potential recruits or issuing misleading information about employment opportunities in a destination country. For this reason the Code was extended to provide a list of approved recruitment agencies that had agreed to comply with all aspects of its ethical approach.

The United Kingdom has become reliant on international recruitment, mostly from other English-speaking countries. Despite the provision of free

movement of health professionals within the EU, much of the recent international recruitment activity has been with Commonwealth countries. One exception is the recruitment of German doctors, which has continued for a number of years, despite the ending of oversupply in Germany (Simmgen 2004).

The relatively low level of migration of doctors from other EU countries to the United Kingdom highlights another general point about migration. As noted previously, many factors determine the direction and amount of migration of health workers. Entering the EU means entering a free mobility zone but factors such as language, similarity in professional education, historical (postcolonial) links and the balance of push and pull factors will also play a major role in shaping the dynamic, direction and net balance of the in- and outflows of health workers.

The impact of accession: will doctors move west?

In the lead up to EU enlargement in May 2004, there was debate about how many doctors and other health professionals from the new Member States might move west to established EU countries and to Scandinavia. At the time of writing it is too early to assess in detail the likely flows. However, it is clear that some of the outlined push–pull imbalances that will stimulate migration are present. Doctors can expect significantly higher salaries if they move west; they can also look to educational and career opportunities that are less prevalent in the new Member States.

A survey of physicians in the Czech Republic, Hungary, Lithuania and Poland, conducted in 2002, showed that between one-quarter and one-half of the respondents were thinking about migrating to other EU countries, while between 4% and 10% were definitely going to move (Open Society Institute 2003) (Figure 3.5). In Lithuania, the main reasons were higher salaries, better professional opportunities and better quality of life. The Nordic countries, the United Kingdom and Germany were reported to be the first choice countries (Open Society Institute 2003).

An intention to move is not the same as actually moving, however. It remains to be seen how many physicians will migrate. It is clear that the motivation to move, in terms of aspirations of better opportunities, does exist; membership of the EU will facilitate the movement of physicians from these countries to other parts of the Union.

Health worker mobility: general policy implications

This section discusses in more detail some of the more general policy questions that are raised by health worker migration and highlights key current knowledge gaps. The flow of health workers across national boundaries within the EU and into the EU from other sources, partly as a result of the growth of active recruitment by some countries, creates a series of challenges for national governments and international agencies.

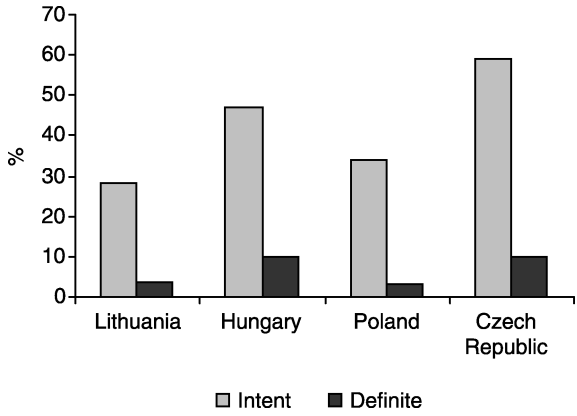

Figure 3.5 Percentage of physicians intending to migrate to EU countries, 2002 (from Open Society Institute 2003).

'Source' countries

Countries that are experiencing a net outflow of health workers need to be able to assess the underlying causes and evaluate the impact on health care provision. It is important that the available information base enables policy-makers to assess the relative loss of staff owing to outflow to other countries relative to internal flows, such as health workers leaving to work in the private sector or to take up other forms of employment. In some cases international outflow may be a very visible but only relatively small numerical loss of workers compared with flows of workers leaving the public sector for other sources of employment within the country.

In some countries, out-migration may be encouraged to reduce oversupplies of specific types of worker, or to encourage workers to acquire additional skills or qualifications. This managed flow has to be contrasted with any unmanaged outflow of health workers, which may threaten the sustainability of the health system, undermine planning and erode the current and future skills base. The creation of monetary or regulatory barriers that prevent health workers from leaving is one policy response, but this is unlikely to alleviate the push factors that motivate workers to leave in the first place and also cuts across notions of the free movement of individuals. Other policy responses to reducing outflow may aim directly at reducing push factors by, for example, addressing insufficient payment and career prospects, poor working conditions and high workloads and concerns about security or improving educational opportunities.

Another policy response is based on the recognition that outflow may not be hindered where principles of individual freedom are to be upheld, but that interventions can be developed to ensure that such outflow is managed and moderated. The 'managed migration' initiative in the Caribbean is an example of a coordinated regional intervention that aims to minimize the negative impacts of outflow while hoping to secure at least some benefit from the process (Yan 2002; Buchan and Dovlo 2004).

There is a need to place the level and impact of health workers' international

out-migration in the broader labour market context. For example, in many countries there is a need for a more detailed assessment of the actual impact of health workers moving to other countries compared to that caused by health workers leaving the health sector in-country. There is a need for more detailed evaluation of the various attempts to constrain outflow or encourage returners. Case study research would provide more evidence of 'what works' (and is appropriate) and could be linked to broader-based studies examining interventions to improve the recruitment and retention of health workers. This in turn is related to issues of capacity, governance and planning within the country.

An important related aspect is that of gender within the health care workforce, in terms not only of patterns of migration (or migration experiences) for male and female health workers but also of whether particular staff groups receive differential treatment because they are perceived to be gender specific. In particular, in some countries the undervaluing of nursing as 'women's work' may be both a direct driver for mobile nurses to leave that country and an indirect reason why interventions to reduce outflow may be ineffective.

'Destination' countries

The policy challenges for destination countries mirror those of source countries (see Buchan and Dovlo 2004). One concern is monitoring and assessment, as the ability to monitor trends in inflow (both numbers and sources) is vital if a country is to integrate this information into its planning process. Equally important is an understanding of why shortages of health workers are occurring: is it because of poor planning, unattractive pay or career opportunities, early retirements? An initial assessment of the contributing factors for staffing shortages in any country needs to be undertaken and would include that of health worker 'wastage' to other sectors or regions within the country.

It is crucial to assess the relative contribution of international recruitment compared to other key interventions, such as home-based recruitment, improved retention and return of non-practising health professionals, in order to identify the most effective balance of interventions. This assessment has to be embedded in an overall framework of policy responses to health sector workforce issues if it is to be relevant.

A second challenge for destination countries can be characterized as the 'efficiency' challenge. If there is an inflow of health workers from elsewhere, how can this inflow be moderated and facilitated so that it contributes effectively to the health system? Policy responses have included: 'fast tracking' work permit applications; developing coordinated, multiemployer approaches to recruitment to achieve economies of scale in the recruitment process; developing multiagency approaches to coordinated placement of health workers when they have arrived; and providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support to ensure assimilation of new workers into the country, culture and organization. A related challenge may be that of trying to channel international recruits to the geographical or specialty areas that most require additional staff.

Finally, a third challenge for destination countries concerns ethics. Is it

justifiable, on moral and ethical grounds, to recruit health workers from developing countries? The simple answer may be that it should not be justifiable to contribute to brain drain in other countries, but a detailed examination of the issue reveals a more complex and blurred picture. Active recruitment by employers or national governments in the destination country has to be contrasted with a situation in which the workers themselves have taken the initiative to move across national borders. Account must also be taken of the development of bilateral and multilateral agreements, and of the right of the individual to move.

Various types of bilateral and multilateral recruitment agreements are being developed by different recruiting countries, and some have an explicit ethical dimension or attempt to focus on encouraging a 'win–win' situation, where the source country does not lose in the process.

Policy implications

One key issue, for both country governments and international agencies, is developing a better understanding of the level and dynamics of the flows of health workers between countries, and into and out of the EU. This issue takes on greater prominence with the latest enlargement of the EU in May 2004. Often it is impossible to quantify even the most basic indicator of how many doctors or nurses have left or entered a country. While the country case studies suggest varying levels of current cross-border flows, it is apparent that active international recruitment of health professionals has become a significant element in overall human resource strategy for countries such as the United Kingdom and Ireland, while in others (e.g. Poland and Lithuania) there are suggestions that many health workers may flow westward when they have the opportunity. Within an enlarged EU further action could be supported in source and destination countries to improve the monitoring of flows; this could be undertaken in association with other agencies with an interest in this issue (OECD, WHO, ILO).

Another possibility is to move beyond monitoring flows and to develop policy interventions that manage or moderate them. One option is bilateral agreements between countries to facilitate the flow of health workers, e.g. between the United Kingdom and Norway.

The introduction of a uni- or multilateral code of practice that sets down principles for the practice of effective and ethical international recruitment could be a further option; for example, the Department of Health's Code (DoH 2001) outlined previously. This requires that NHS employers do not recruit actively from developing countries unless there is between-government agreement. So far, England is the only country to have introduced a detailed code of practice in an attempt to moderate the international recruitment of health workers.

Further, the EU as a whole could introduce some guidelines, codes or frameworks, similar to the multilateral code introduced by the Commonwealth (Commonwealth Secretariat 2002). However, this has had a limited impact because a number of Commonwealth countries, including the United Kingdom, Australia and Canada, have not signed. Some international health professional

associations have also promoted codes and principles for international recruitment (International Council of Nurses (ICN) 2001; WONCA 2002).

Whatever the source of such a framework or code, its effectiveness will rely on three factors. What is its *content?* What are the principles and practical details set out to guide international recruitment? What is its *coverage*? Does it cover all relevant employers and countries? Is *compliance* assured? Are there systems in place to monitor cross-border recruitment activity, and what are the penalties for non-compliance?

Conclusions

This chapter has examined issues related to the migration of health workers and their international recruitment. It is suggested that for some countries such migration may be of only marginal importance. However, the chapter has also highlighted that migration may currently be significant for several EU countries that are reliant on inflows of health workers to meet their staffing requirements, and for others that may experience unplanned outflows, such as some of the new Member States.

The demographics in many EU countries with an ageing population and an ageing health care workforce (see chapter on trends) may make it more likely that these countries actively encourage inflows of health workers over the next few years.

Essentially there are two viable options for policy-makers and international bodies faced with in-migration and/or out-migration of health workers. They can decide not to intervene, to moderate flows with some type of code of practice or to manage the migration process actively to enable approximation to a 'win–win', or at least not exclusively 'win–lose' situation.

Table 3.5 sets out some options for policy at local, state and international levels; some are relevant for source countries, some for destination countries, but few have been fully implemented or evaluated. The next round of policy research should focus on two aspects of migration. First, there is a clear need to improve the available data so that monitoring of trends in flows of health workers can be more effective. Second, research should focus on assessing the viability and effectiveness of the various possible policy interventions, to identify which, if any, are relevant and have the potential for mutual and beneficial impact.

The current levels of international recruitment of health workers are variable; this variation is likely to continue, based on the different impact of push and pull factors in different countries. However, at EU level, the aggregate effect of health worker migration is likely to become more prominent in the next few years, because demographic change and EU enlargement will alter the overall balance of these factors. The new Member States tend to report significantly lower levels of pay and career prospects for health workers; enlargement may thus trigger otherwise latent push factors, which may be stimulated further if western European countries exert a pull through active recruitment of doctors and nurses and other health workers. It is likely that health worker migration will be both a more prominent problem and a solution in Europe over the next

Table 3.5 Examples of potential policy interventions in international recruitment

Level	*Characteristics/examples*
Organizational	
Twinning	Hospitals in source and destination countries develop links, based on staff exchanges, staff support and flow of resources to source country.
Staff exchange	Structured temporary move of staff to other organization, based on career and personal development opportunities/ organizational development.
Educational support	Educators and/or educational resources and/or funding in temporary move from destination to source organization.
Bilateral agreement	Employer(s) in destination country develop agreement with employer(s) or educator(s) in source country to contribute to, or underwrite costs of, training additional staff, or to recruit staff for fixed period, linked to training and development prior to return to source country.
National	
Government-to-government bilateral agreement	Destination country develops agreement with source country to underwrite costs of training additional staff, and/or to recruit staff for fixed period, linked to training and development prior to staff returning to source country, or to recruit surplus staff in source country.
Ethical recruitment code	Destination country introduces code that places restrictions on employers – which source countries can be targeted, and/or length of stay. Coverage, content and compliance issues all need to be clear and explicit.
Compensation	Much discussed, but not much evidence in practice: destination country pays compensation (in cash or other resources) to source country. Possibly some type of sliding scale of compensation related to length of stay and/or cost of training, or cost of employment in destination country; possibly brokered via international agency?
Managed migration (can also be regional)	Country (or region) with staff-outflow initiates programme to stem unplanned out-migration, partly by attempting to reduce impact of push factors, partly by supporting other organizational or national interventions that encourage planned migration.
Train for export	(Can be a subset of managed migration) Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market to generate remittances or up-front fees.
International	
International code	As above, but covering a range of countries; its relevance will depend on content, coverage, and compliance. Commonwealth Code is an example.
Multilateral agreements	Similar to bilateral (above), but covering a number of countries (EU?). Possible brokering/monitoring role for international agency.

Source: Buchan and Dovlo (2004).

few years. As such, governments and international agencies will have to be clear about their policy standpoint.

References

Auriol, L. and Sexton, J. (2002) Human resources in science and technology: measurement issues and international mobility. *In: International mobility of the highly skilled*. Paris, Organisation for Economic Co-operation and Development.

Buchan, J. (2001) Nurses moving across borders: brain-drain or freedom of movement? *International Nursing Review*, **48**: 65–7.

Buchan, J. (2003) *Here to stay? Royal College of Nursing*. London, Royal College of Nursing (www.rcn.org.uk/publications/pdf/heretostay-irns.pdf).

Buchan, J. (2004) International rescue? The dynamics and policy implications of the international recruitment of nurses to the UK. *Journal of Health Services Research and Policy*, **9**(1): 10–16.

Buchan, J. and Dovlo, D. (2004) *International recruitment of health workers to the United Kingdom: Report for the Department for International Development*. London, DFID HSRC (www.dfidhealthrc.org/shared/publications/reports/int_rec/exec-sum.pdf).

Buchan, J., Parkin, T. and Sochalski, J. (2003) *International nurse mobility: trends and policy implications*. Geneva, Royal College of Nursing/World Health Organization/ International Council of Nurses (www.icn.ch/Int_Nurse_mobility%20final.pdf).

Buchan, J., Seccombe, I. and Thomas, S. (1997) Overseas mobility of UK based nurses. *International Journal of Nursing Studies*, **34**(1): 54–62.

Castles, S. (2000) International migration at the beginning of the twenty-first century: global trends and issues. *International Migration*, 165: 269–83.

Chanda, R. (2002) Trade in health services. *Bulletin of the World Health Organization*, **80**(2): 158–63.

Commonwealth Secretariat (2002) *Code of practice for international recruitment of health workers*. London, Commonwealth Secretariat.

Daniel, P., Chamberlain, A. and Gordon, F. (2001) Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing*, **10**(4): 254–65.

Department of Health (2001) *Code of practice for NHS employers involved in international recruitment of health care professionals*. London, Department of Health.

Department of Health (2003) *Hospital, public health medicine and community health services medical and dental staff in England: 1992–2002. Statistical Bulletin 2003/04*. London, Department of Health.

Department of Health and Children (2002) *Nursing Policy Division, final report of the steering group*. Dublin, Department of Health and Children.

European Commission (2004a) *DGXV. Committee of Senior Officials on Public Health. Statistical tables relating to the migration of doctors in the Community from 1977 to 2000*. Brussels, European Commission.

European Commission (2004b) *DGXV. Committee of Senior Officials on Public Health. Statistical tables relating to the migration of nurses responsible for general care in the Community from 1977 to 2000*. Brussels, European Commission.

Findlay, A. and Lowell, L. (2002) *Migration of highly skilled persons from developing countries: impact and policy responses*. Geneva, International Labour Organization (International Migration Papers, No. 43).

International Council of Nurses (2001) *Position statement on ethical nurse recruitment*. Geneva, ICN (www.icn.ch/psrecruit01.htm).

International Labour Organization (2000) *Migration: a truly global phenomenon*. Geneva, ILO (www.ilo.org/public).

International Organization for Migration (2000) *World Migration Report 2000*. Geneva, IOM.

Krieger, H. (2004) *Migration trends in an enlarged Europe*. Dublin, European Foundation for the Improvement of Living and Working Conditions.

Mejia, A., Pizurki, H. and Royston, E. (1979) *Physician and nurse migration: analysis and policy implications. Report on a WHO study*. Geneva, World Health Organization.

Open Society Institute (2003) *Physician planning in Lithuania in 1990–2015*. Kaunas, Kaunas University of Medicine Press.

Organisation for Economic Co-operation and Development (2000) *Trends in international migration*. Paris, OECD.

Organisation for Economic Co-operation and Development (2002) *International mobility of the highly skilled*. Paris, OECD.

Pang, T., Lansang, M. and Haines, A. (2002) Brain drain and health professionals. *British Medical Journal*, **324**: 499–500.

Simmgen, M. (2004) Why German doctors enjoy British medicine. *Clinical Medicine*, **4**: 57–9.

Stalker, P. (1997) *Refugees and migration*. London, One World International.

Stalker, P. (2000) *Workers without frontiers: the impact of globalization on international migration*. Boulder, CO, Lynne Rienner.

Stilwell, B., Diallo, K. and Zurn, P. (2003) Developing evidence based ethical policies on the migration of health workers: conceptual and practical challenges. *Human Resources for Health*, **1**: 8.

Timur, S. (2000) Changing trends and major issues in international migration: an overview of the UNESCO programmes. *International Migration*, **165**: 255–69.

Tjadens, F. (2002) Health care shortages: where globalisation, nurses and migration meet. *Eurohealth*, **8**(3): 33–5 (www.lse.ac.uk/collections/LSEHealthAndSocialCare/pdf/eurohealth/vol8no3.pdf).

WONCA (2002) *A code of practice for the international recruitment of health professionals: the Melbourne manifesto*. World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (www.globalfamilydoctor.com/aboutWonca/working_groups/rural_training/melbourne_manifesto.htm).

World Health Organization (2004) *International migration and health personnel: a challenge for health systems in developing countries*. Agenda item 12.11. Fifty-seventh World Health Assembly: Health Systems Including Primary Care. 22 May. Geneva, World Health Organization.

Yan, J. (2002) Caribbean nurses develop strategy for nurse shortages. *International Nursing Review*, **49**: 132–4.

Yi, M. and Jezewski, M. (2000) Korean nurses' adjustments to hospitals in the USA. *Journal of Advanced Nursing*, **32**(3): 721–9.