

EDITORIAL FROM THE 2007 ISSUE OF THE OECD INTERNATIONAL

MIGRATION OUTLOOK

THE MEDICAL BRAIN DRAIN: MYTHS AND REALITIES

There are renewed fears of a “brain drain” from developing countries to the profit of OECD countries, especially with respect to health professionals

Increasing immigration of highly-skilled workers into OECD countries over the past 10-15 years, often from developing countries, has refuelled fears of a “brain drain” from developing countries of much of their skilled labour, to the profit of OECD countries. This concern has been loudest in recent years concerning the recruitment of foreign doctors and nurses by OECD countries, and with ageing populations in OECD countries driving up the demand for health professionals, there are real fears that the health care sector in many developing countries could be severely damaged by the medical brain drain.

This edition of the Outlook presents new evidence on this issue

Despite the heightened policy interest, solid evidence on the international mobility of health professionals has been limited and indeed often anecdotal. This has given rise to much speculation regarding what is a complex issue, and has hindered the development of effective policy responses. To fill the gap, one of the two special chapters in this year’s edition of the Outlook presents an up-to-date and comprehensive picture of immigrants in the health sector in OECD countries. It provides answers to a number of basic questions that are at the heart of national and international debates on these issues.

What is the scope of the international mobility of health professionals in OECD countries? Which origin and receiving countries are the most concerned? To what extent has migration affected health-care systems in developing countries? What should governments do in both sending and receiving countries to adapt to the current international mobility patterns of health workers?

Health professionals are generally not over-represented among highly-skilled migrants

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One claim not supported by the data is that health professionals are over-represented among highly-skilled migrants. Results show that around the year 2000, 11% of employed nurses and 18% of employed doctors on average in the OECD were foreign-born. These figures are similar to those observed for professionals as a whole. There are, however, important variations across countries, which reflect in part differences in the characteristics of their health workforces and in historical migration patterns. For example, the percentage of foreign-born doctors ranges from less than 5% in Japan and Finland, to more than 30 % in

Ireland, the United Kingdom, Canada, Australia and New Zealand. Similarly, the percentage of foreign-born nurses is above 20% in Australia, Switzerland and New Zealand. And in absolute terms, the United States is the only net receiving *vis-à-vis* all other countries for both doctors and nurses. In many OECD countries, immigrants make an important contribution to health-care delivery, not only because of their numbers but also because they help ensure the continuity of service at night or during week-ends and the provision of care in under-served areas.

... and in large origin countries, such as India, China and the Philippines, the number of health professionals working abroad is low relative to the domestic supply

Some origin countries, such as the Philippines for nurses, or India for doctors, play a prominent role in providing health care workers to OECD countries. But intra-OECD mobility is also significant, particularly from the United Kingdom and Germany. And, there are important South-South migrations of health professionals, in particular from Africa and Asia to the Middle East and South Africa. Caribbean countries and a number of African countries have particularly high emigration rates of doctors. In some cases, relatively few doctors remain behind, making it difficult to deliver basic health care to the population. But for large origin countries such as India or China, the number of health professionals working overseas, although high, is low relative to the domestic supply and the number of doctors per person has not been strongly affected.

Stopping the outflows of doctors and nurses from low income countries would not solve the shortage of health professionals these countries face

The chapter also shows that the number of immigrant health workers in OECD countries represents only a small fraction of health sector needs for human resources in lower income countries, as estimated by the WHO (around 12% for Africa for example). In short, although stopping the flow, if this were indeed possible, would alleviate the problem, it would not by itself solve the shortage issue.

The rise in the immigration of health-care workers has occurred, even if there are no targeted recruitment programmes

Thus far, few OECD countries have specific migration programmes targeting health professionals, and bilateral agreements do not play an important role. Despite this, there has been an upward shift in immigration trends observed over the past five years, in parallel with that observed for the highly skilled in general. In addition to the continuing role played by the main origin countries (India, China and the Philippines), there have been increasing flows from smaller African countries and from Central and Eastern Europe.

To better mobilize the skills and competencies of foreign doctors and nurses and to ensure high-quality health care, OECD countries are emphasizing the recognition of qualifications

OECD countries are trying to mobilize the skills and competencies of newly arrived foreign doctors and nurses while ensuring high standards and quality in health-care delivery. A key issue concerns the recognition of foreign medical qualifications for health professionals. OECD countries have put in place a panoply of measures to address the skills recognition question, among them theoretical and practical exams, language tests and most

often, supervised periods of practice, but some countries are stricter than others. Several countries have also developed programmes to attract back into the health sector foreign-trained health professionals who are already settled in the country but work in other jobs.

The recent acceleration in flows calls for increased co-operation between origin and receiving countries to better share the benefits of the international mobility of health professionals

The fact that international migration has so far played a limited role in the current crisis for health human resources in developing countries, should not divert the attention of the international community, nor weaken its commitments towards better health for all. Because health is an international public good, because the health-related objectives of the Millennium Development Goals are key elements of international solidarity and because, above all, access to health can be considered as a basic right, origin and receiving countries need to work together towards providing health professionals with opportunities to use efficiently their skills where they are the most needed, while guaranteeing the individual right to move.

There is no unique response to the challenges posed by the international mobility of health care workers, but data are now available to ensure a more accurate diagnosis of what is at stake. In addition, a number of sound policy proposals to better share the benefits of the international mobility of the health workers have been made. The increase in Official Development Assistance to health and the current efforts devoted by the WHO to develop a global code of practice governing the international recruitment of health workers go in the right direction. However, these measures need to be accompanied, in both sending and receiving countries, by policies aimed at increasing domestic training capacity, improving retention, developing skill mix and coordinated care, and increasing productivity.

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