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## *working paper* 3

## Where do the best go?

*Global competition for healthcare professionals. What role does migration play in their career future?*

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«Where do the best go?»

*Global competition for healthcare professionals.*

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## Foreword

In OECD countries, the health sector is one of the most important in terms of employment. The demand for qualified health professionals generally far exceeds domestic supply. In the case of Switzerland, about one third of the health workforce has foreign passports. This figure is expected to grow, the reasons for which are twofold. On the one hand, this can be attributed to steadily increasing demand, comparatively high salaries, good training opportunities and favourable working conditions. On the other hand, the insufficient number of people trained to replace those reaching retirement age will also play a significant role (see Careum Working Paper 1).

Neither the migration nor the shortage of health professionals is a recent phenomenon. Indeed, according to the WHO, there is a global shortage or, as the OECD puts it, «a looming crisis in the health workforce». The number of health professionals required worldwide amounts to 4.25 million. This shortage is, in itself, a matter of concern because it compromises the quality of care delivery. The real issue, however, is seen in the migration of skilled health workers, which is characterised by a «cascade-type» pattern whereby the wealthier countries attract qualified personnel from countries in the East or South. This situation raises ethical issues because «care drain» results in the deterioration of already disadvantaged health systems. Moreover, it transfers considerable investments intended to provide relief and causes additional exposure and vulnerability. On the other hand, the labour market is very much global in nature and offers opportunities to talented and skilled labour. Several initiatives have been launched to address the discrepancy between these two opposing situations and to tackle the migration of health workers. The goal in this regard is to develop strategies to mitigate the adverse effects on health systems.

The Swiss Federal Office of Public Health has been commissioned with the present Careum Working Paper with the aim of stimulating discussions in the workshop focusing on the global competition for healthcare professionals at the «Careum Congress 2009». This paper sheds light on the relevance of the migration of health workers for Switzerland, the measures taken to hopefully raise self-sufficiency, and it sets the country in regards to the WHO code of practice on the international recruitment of health personnel. It appears that the mobility of healthcare workers will remain an important element for the Swiss health care system. However, it cannot be seen as the definitive solution. The Careum Foundation, which has been actively involved in educational matters within the healthcare sector for 130 years, would like to generate the new ways of thinking that are needed to improve the domestic supply through strategies that focus on education, practice and policies that will enable the recruitment, training and retention of many more health professionals.

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## International migration of health workers

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In recent years, the health workers' job market has become more and more globalized. This is revealed, on the one hand, by the facilitated access to the information allowed by the new information and communication technologies (NTIC) and by the apparition of new private recruitment agents. On the other hand, the international circulation of health workers is a strong indicator of a globalized job market<sup>1</sup>. Health workers migration was already significant since the sixties<sup>2</sup>. In 1972, about 6 per cent of the world's physicians and 5 per cent of the world's nurses were located in countries other than those of which they were nationals, mainly in Australia, Canada, the Federal Republic of Germany, the United Kingdom and the United States<sup>3</sup>. Since then and especially in recent years, flows of health professionals have continuously increased, making the health sector one of the main employers of foreign professionals in most of the OECD countries<sup>4</sup>. This increase includes the migration of health workers between developed countries, which mostly profit to countries such as USA, Canada or Australia. It also includes migration between developing countries and from developing to developed countries, where immigration partially makes up partially for the health workforce shortage and compensates for the emigration of those skilled workers.

International migration of health professionals has been described as a «cascade type»<sup>5</sup> model according to which health professionals move from one country to another, at least partially in order to compensate the emigration of the health professionals in the destination country. This phenomenon has also been described as a «domino-effect»<sup>6</sup> or as an international «carousel»<sup>7</sup>. This model reflects the countries' efforts to attract and retain health professionals. This phenomenon is reinforced by shortages of health workers faced by many countries. The factors explaining the prevailing shortages are numerous. In developed countries, they include an ageing population and health workforce, an increased demand generated by new technologies, increased expectation of patients and changing working patterns such as the feminization or an early retirement<sup>8</sup>. According to the World Health Organization<sup>9</sup>, there is a deficit of 4.25 million health workers in the world. The crisis is particularly serious for many developing countries which are the most affected by the global burden of diseases and those with the weakest human health resources. These countries are also those facing most difficulties to retain their workforce who are leaving to find better

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**The international migration of health workers have continuously increased since the sixties, especially in recent years.**

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**The international migration of health workers occurs in a context of global shortage of human health resources.**

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<sup>1</sup> Clark, P.F. and al. 2006: La mondialisation du marché du travail des personnels de santé. *Revue internationale du travail*, 145(1-2), p.53.

<sup>2</sup> Connell, J., 2008: *The International Migration of Health Workers*. Routledge, p.5.

<sup>3</sup> Mejia, A. and al. 1979: *Physician and nurse migration: Analysis and policy implications*, Geneva, WHO.

<sup>4</sup> OECD, 2007: *Recent Trends in International Migration*. In: *International Migration Outlook*.

<sup>5</sup> *Ibid*, p.174.

<sup>6</sup> Dussault, G. and Francescini, M. C. 2006: Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. *Human Resources for Health*. BioMed Central Ltd 4(12).

<sup>7</sup> Martineau, T., Decker K. and Bundred P. 2002: Briefing note on international migration of health professionals: leveling the playing field for developing country health systems. p.6.

<sup>8</sup> Obsan, 2007: *Evolution du taux d'activité en médecine ambulatoire entre 1998 et 2004*.

<sup>9</sup> WHO, 2006: *Fact sheet N°302*.

working conditions and new career opportunities elsewhere. According to several researchers<sup>10</sup>, migration of health workers should distinguish itself from other professionals' movement owing to their possible consequences on the health of the source country's population. However, the needs in human resources in developing countries, as estimated by the World Health Organization, largely outstrip the numbers of immigrant health workers in the OECD. Thus, «international migration is neither the main cause nor would its reduction be the solution to the worldwide health human resources crisis, even though it exacerbates the acuteness of the problems in some countries»<sup>11</sup>.

**The World Health Organization has addressed the issue since 2004.**

Considering the global shortage, these movements and their consequences, the issue has been addressed by several international organizations but is principally under the aegis of the WHO. The first step was the adoption in 2004 and 2005 of the resolutions WHA 57.19 and WHA 58.17 «International migration of health personnel: a challenge for health systems in developing countries». The resolutions were notably calling countries to frame and implement policies and strategies that could enhance effective retention of health personnel. The development of a code of practice on the international recruitment of health workers, especially from developing countries was also requested. Five years later, countries are still in consultation regarding the perspective of the formulation of such a code. It also has to be stressed that a collaboration between OECD and WHO has been initiated in order to address the health workers migration issue. Two publications<sup>12</sup> and a conference<sup>13</sup> have notably resulted from it.

<sup>10</sup> Connell, J., 2008: The international Migration of Health Workers. Routledge, p.3; Alkire, S. and Chen, L., 2005: Medical Exceptionalism in International Migration: Should Doctors and Nurses be treated differently? In Tomas, M. and Palme, J. Migration Regime. Ashgate Press, p.22.

<sup>11</sup> OECD, 2007: Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration in International Migration Outlook, Paris, p.179.

<sup>12</sup> OECD, 2007: Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration in International Migration Outlook, Paris; OECD, 2008: The Looming Crisis in the Health Workforce: How Can OECD Countries Respond? Paris.

<sup>13</sup> WHO-OECD hosted dialogue on migration and other health workforce issues in a global economy, 20-21 October 2008, Geneva.

## Switzerland in the global system of migration of health workers

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Switzerland always faced a relative shortage of home trained health professionals, meaning that the indigenous workforce does not fulfill the need of the health system. Thus, foreign professionals have always been an essential component of the health workforce, ranking Switzerland among the importing countries category. In 2000, 28.1% of the doctors and 28.6% of the nurses practicing where foreign-born<sup>14</sup>. Existing data generally describe the importance of the foreign-born workforce. Yet, a significant share of the foreign-born health professionals is often trained in the receiving country, which does not necessarily imply a loss for the country of origin. In order to identify the very specific role of immigration in a national health workforce, variations in the pool of foreign-trained professionals across time are preferably observed. In the case of doctors in Switzerland, an increasing reliance on international recruitment has actually been revealed, in particular these last years: foreign-trained doctors were contributing to 44% of the net increase in the number of practicing doctors between 1995 and 2000 and to 76% between 2000 and 2005<sup>15</sup>. From an international comparative perspective, Switzerland has a rather high immigration of health professionals but a low expatriation rate of its own professionals (4.2% for doctors and 2.3% for nurses<sup>16</sup>). Moreover, although little data exists, it is quite likely that emigrant Swiss health professionals have very different career path than foreign health professionals immigrating to Switzerland. Swiss emigrants often pursue their training abroad before coming back with a better background. Immigration into Switzerland probably tends to be more lasting, constituting a net loss for the source countries. When analysing the strong reliance on foreign health professionals, one should not forget that Switzerland in general is an immigration country. The relative share of foreign people is almost twice the amount of the USA: 23.8% for Switzerland and 12.9% for the United States in 2005<sup>17</sup>. Thus, the immigration of health workers has to be replaced in a broader immigration of professionals. In 2000, the share of foreign-born persons with a tertiary education was 0.9% higher than for health professionals<sup>18</sup>.

Regarding the provenance of the foreign professionals, they are mostly from border countries (Germany, France, Italy and Austria) and more broadly from the European region. For doctors as for nurses, almost 70% (respectively 69.6% and 64.2%) of the foreign-born are from the European Union with which Switzerland has an agreement on the free movement of people. In addition, frontier workers

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**Switzerland is in general an immigration country and employs a high share of foreign health professionals.**

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**Foreign health professionals working in Switzerland mostly come from European countries.**

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<sup>14</sup> OECD, 2007: Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration in International Migration Outlook, Paris, p.165.

<sup>15</sup> OECD, 2008: The Looming Crisis in the Health Workforce: How Can OECD Countries Respond? Paris, p.34.

<sup>16</sup> OECD, 2007: Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration in International Migration Outlook, Paris, p.215.

<sup>17</sup> OECD, 2007: Statistical Annex in International Migration Outlook, Paris, p.330.

<sup>18</sup> OECD, 2007: Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration in International Migration Outlook, Paris, p.171.

play an essential role in some areas such as Geneva or Basel. There were 5'994 persons living across the border working in the health and social domain during the first trimester of 2009 in the canton of Geneva and 2'565 in Basel-City<sup>19</sup>. The share of foreign professionals from developing countries is limited. In 2008, only 2.26% of physicians and 0.93% of the nurses newly entering into Switzerland were from developing countries<sup>20</sup>. The distribution by country of origin of foreign-trained health professionals in Switzerland indicates that the recruitment of foreign health workers is mainly (but not exclusively) a passive recruitment as opposed to an active one in the sense of the targeting of health professionals «in a manner that entices them to come when they might otherwise have not chosen to relocate»<sup>21</sup>. Indeed, Switzerland seems enticing enough to attract health professionals who make themselves available to work there, without having to engage in active recruitment practices. Like many other countries, the situation at the national level also hides strong regional disparities. A majority of OECD countries actually face problems of health professionals repartition between rural, remote or economically less developed areas and urban, central and rich areas. Thus, the medical density between cantons varies and as a consequence does the need for foreign health professionals. Some regions are less attractive for national professionals as well as foreign workers from EU countries having a free choice of where they go. In Switzerland the mostly rural cantons of Jura, Valais, Neuchâtel and Appenzell have shown the highest rate of foreign professionals from non European countries<sup>22</sup>.

Due to the «cascade-type» model, even though immigration of health professionals towards Switzerland mainly comes from border countries and from the European region, Switzerland still fits in a global system of international migration of health workers. Thus, the recruitment of European health professionals also affects developing countries. This situation raises ethical issues and questions about the Swiss responsibility towards developing countries. The Question n°1 from below addresses the domestic health workforce issue as one of the areas in which Switzerland would have wiggle room to decrease its pressure on human health resources of developing countries.

Moreover, the current position of Switzerland on the international job market concerning wage but also working conditions seems for the moment rather

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<sup>19</sup> Swiss Statistics, Statistique des frontaliers.

<sup>20</sup> Federal Office for Migration, Registre central des étrangers according to the list of recipients of official assistance established by OECD.

<sup>21</sup> McIntosh and al., 2007: The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada, Canadian Policy Research Networks Inc., p.4.

<sup>22</sup> Obsan, 2007: Monitorage des médecins actifs en milieu hospitalier, p.11.

favorable to the Swiss employers, making the international recruitment relatively easy. But the situation of the Swiss market and of its position within the global health market may evolve and change the attractiveness of Switzerland. Thus, in the future, the strong reliance on foreign health workforce may threaten the ability of Switzerland to get the suitable health workforce. Furthermore, due to the ethical aspects of the phenomenon, it can be questioned whether it is desirable for States to compete for health professionals the same way that they do for other highly skilled professionals and whether these movements should be treated differently. These issues are discussed along the following three questions.

Finally, this paper discusses to what extent the international cooperation, either bilateral or multilateral contributes to reduce the negative impact of health worker migration on source countries.

## Question N°1: Increase domestic health workforce?

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**Domestic policies have an impact on the demand of foreign health professionals.**

In the frame of international discussions about the migration and shortage of health workers, it is often suggested that countries should direct efforts towards better health workforce self-sufficiency<sup>23</sup>. As a matter of fact, although numerous instruments have been mentioned in order to reverse effects of migration of health personnel and minimize its negative impact on health systems (see codes of conducts, bilateral agreements, etc.), training medical professionals domestically to fill the labour shortages and ease the reliance on external sources is generally considered as the only way to deal with the structural cause of international migration and thus prevent its negative consequences. As described below, actions can be taken on different levels in order to attain a better self-sufficiency. Yet, considering the range of the questions raised, we will concentrate the discussion upon the training issues in the perspective of a better self-sufficiency.

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**Orientation toward a better self-sufficiency can be achieved in many ways.**

From a theoretical point of view, this proposition questions the concept of self-sufficiency as there is no accepted definition of it. For example, it is difficult to define which portion of foreign professionals is considered in a self-sufficient health system<sup>24</sup> as long-term policies of national self-sufficiency usually co-exist with short-term or medium-term policies to attract health workers from abroad<sup>25</sup>. Despite this vagueness, in the prospect of a global health workforce shortage, it can be agreed that importing countries should orient efforts towards a better balance between health resource requirements and domestic workforce rather than increasing reliance on immigration.

In order to achieve a better self-sufficiency, several policy options emerge and intervene at different levels. They include<sup>26</sup>:

- Education of sufficient numbers of health personnel to meet their own need
- Reduction of student attrition
- Increasing productivity of the workforce by
  - increasing participation rates in the workforce
  - increasing full time employment rates
  - promoting skill-mix
- Improving staff retention through a number of incentives (creation of healthy work environment, better pay, reasonable workloads, etc.)

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**In Switzerland, competences in the health sector are scattered.**

In Switzerland, the situation is particularly complex as these various levels of intervention are within the responsibility of several sectors. Two different federal

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<sup>23</sup> Buchan, J. 2008: Comment maîtriser les migrations des professionnels de la santé de façon à réduire leurs effets néfastes sur l'offre de service? Bureau régional de l'OMS pour l'Europe et Observatoire européen des systèmes et des politiques de santé. Tallinn.

Bach, S. 2006: International Mobility of health Professionals: Brain Drain or Brain Exchange? UNU-WIDER.

<sup>24</sup> According to LITTLE and BUCHAN (2008: 4), a self-sufficient health system «does not exclude some level of immigration as a secondary element to developing a sustainable stock».

<sup>25</sup> Bourassa Forcier and al., 2004: Impact, regulation and health policy implications of physician migration in OECD countries, *Human Resources for Health*, 2(12).

<sup>26</sup> Alkire, S. and Chen, L., 2005: Medical Exceptionalism in International Migration: Should Doctors and Nurses be treated differently? In Tomas, M. and Palme, J. *Migration Regime*. Ashgate Press, p.13; Little, L. and Buchan, J., 2007: L'autosuffisance en personnel infirmier dans le contexte de la mondialisation. Centre international des migrations de l'infirmière, p.3.

departments are in charge of the academic and professional training, but only of their substance, so as to meet the quality requirements established. The number of persons to train is defined by the cantons and the school managers. Training is extended or limited if needed; but mostly based on existing infrastructures and the available budget. Training policy does not rest on a preliminary analysis of the health system requirements. In order to restrain the number of medical students, Universities of the German-speaking part of Switzerland introduced a numerus clausus in 1998 limiting every year the number of students admitted. In the universities from the French-speaking part of the country, a selection is made at the end of the first training year. Cantons and health institutions are in charge of working conditions and compensations. In many cantons, working conditions are defined in a collective labour agreement.

In the Swiss context, in order to achieve a better self-sufficiency, some areas already have been identified as actual fields where a certain wiggle room does exist. For example, it has been observed that in the universities pursuing numerus clausus, a number of accepted students actually did not initiate their training, probably because they did not obtain a place in the expected university or because they finally chose another field of study. As a consequence, for years, numerous available places were staying vacant. Since 2005, universities practice an intentional overbooking which allows them to fill all the available training places<sup>27</sup>.

Another more serious concern has emerged concerning training. Despite a relatively constant number of students starting medical training, a marked downward trend in the number of diplomas delivered has been observed in recent years. Statistics show a decrease between 25% and 33% from 1999 to 2005<sup>28</sup>. There is a student loss that remains unexplained. This situation is especially worrying as it occurs in parallel to an increased healthcare requirement in relation to the expected demographic evolutions. In light of this phenomenon, increasing the number of medical students would seem vain if students keep leaving their curriculum in such a proportion. Thus, a priority objective would be to understand and prevent the loss of students during training.

The increase in the number of medical students also raises another debated issue. Hospital managers and the Swiss university conference (CUS)<sup>29,30</sup>, are of the

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**The increase in the number of medical students is a debated issue.**

<sup>27</sup> CSST, 2007: Démographie Médicale et Réforme de la Formation Professionnelle, Berne, p.38.

<sup>28</sup> Ibid, p.42.

<sup>29</sup> L. Aubert, « La pénurie de médecins n'est pas une fatalité », 24 heures, le 30.06.2009.

<sup>30</sup> S. Malka, « Pénurie de médecins et trop d'étudiants sur les bancs. Un paradoxe ! », Université de Genève, 6.12.07.

opinion that universities are limited by their capacity to provide enough clinical training during the curriculum and once they graduate, as students pursue their training in a hospital. This constraint could constitute a bottleneck which prevents increasing the number of medical students. This is a strong argument against the increase of medical students admitted. Yet, other actors such as the Swiss Medical Association (FMH) impugn this argument, considering that the massive presence of foreign specialists indicates that there would be space for domestic physicians. Moreover, it is argued that ambulatory training courses might offer new opportunities<sup>31</sup>.

Another difficulty is that a policy of self-sufficiency requires well-grounded evaluation of the future workforce needs. Yet, a recent survey of the Swiss Health Observatory (Obsan) pointed out the numerous factors influencing the prospective health personnel needs<sup>32</sup>. These will be contingent on the demographic evolution and the population's health status but also on other factors such as the skill-mix, the employment rate or the duration of the professional activity. Hypothesis can be made about the evolution of these factors but the resulting projections can only be considered as estimated trends.

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**The feasibility as well as the desirability of a self-sufficiency for Switzerland have to be discussed.**

The few examples mentioned point out some areas where efforts could be made to improve the self-sufficiency. Yet, an over-all understanding of the reasons why Switzerland is not self-sufficient would be required in order to target the adequate measures in the appropriate areas. Are enough health professionals trained but they don't practice their profession because of weak incentives to stay at their position? Or even with an optimal retention of health professionals, would supplementary students be necessary to meet the Swiss health system needs? Moreover, beyond these practical and technical aspects, one can question the desirability of a self-sufficient health system. Measures targeting such an objective would obviously be very costly. As long as there are foreign health workers willing to come to Switzerland, do the incentives to aim at self-sufficiency really exist? In other words, can ethical issues concerning access to health in other countries take precedent over economic domestic issues? Should a country with a liberal labour market and a regulated market model in health care delivery aim at a state planned health care labour market? The next question shows us that it may also be in the self interest of Switzerland to tone down its reliance on foreign health professionals.

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<sup>31</sup> L. Aubert, « La pénurie de médecins n'est pas une fatalité », 24 heures, le 30.06.2009.

<sup>32</sup> Obsan, 2008: Offre et recours aux soins médicaux ambulatoires en Suisse - Projections à l'horizon 2030, Neuchâtel, p.23.

## Question N°2: Which competitiveness for Switzerland?

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The globalization of the health labour market led to a global competition for human resources for health. As explained above, most of the countries experience health workers shortages (partially addressed through immigration). This leads to a global competition among States and private actors to capture human resources for health. This phenomenon is not exceptional as it can also be observed for other professionals such as managers or engineers. This competition shows up in most of the OECD countries immigration policies which tend to accept immigration from non-OECD countries only for highly skilled professionals.

Up to now, Switzerland has occupied a rather advantageous position on the international health labour market succeeding in attracting foreign health workers. On the one hand, in an international comparison, it seems that salaries in the Swiss health system are attractive in an international comparison. Yet, this assumption has to be detailed, especially concerning physicians. First, depending on the country, there is a wide income gap between general practitioners (GPs) and specialists. In an international comparison, although this gap increased these last years in Switzerland, it is still relatively thin<sup>33</sup>. Then, there is also a wide gap existing between specialties. For example, the remuneration of surgeons is around 50% higher than pediatricians in Switzerland while it is 100% greater in France<sup>34</sup>. Thus, concerning the earning, the competitiveness of Switzerland has to be assessed on a case-by-case basis. On the other hand, the earning has to be put in relation with working conditions which can be expressed by indicators such as the number of hours worked per week or the number of patients per physician or nurse. Although data available does not allow a very suitable international comparison, information concerning the number of practicing physicians and nurses per 1'000 population let us assume that Switzerland is attractive from the point of view of the working conditions: In 2005, per 1'000 population, there were 3.8 practicing physicians (3.0 for all OECD countries) and 14.1 practicing nurses (8.9 for all OECD countries)<sup>35</sup>.

Since the bilateral agreement on the free movement of people with the European Union came into force in 2002, Swiss employers can recruit freely within this area. Nevertheless some establishments experience difficulties in meeting their human resources needs. This is particularly true in the French-speaking part of Switzerland where some specialists are difficult to recruit, even within

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**There is a global competition to capture human health resources.**

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**Up to now, Switzerland has occupied a rather advantageous position on the international health labour market.**

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**Some Swiss employers have to recruit health professionals outside of the European area.**

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<sup>33</sup> Fujisawa, R. and Lafortune, G., 2008: The remuneration of general practitioners and specialists in 14 OECD countries: what are the factors influencing variations across countries? OECD Health Working Papers 41, Paris, p.34.

<sup>34</sup> Ibid, p.22.

<sup>35</sup> Ibid, p.14-15.

the European Union market. In such cases, employers sometimes have to recruit in third countries, eventually in developing countries. As Swiss authorities admit the existence of a health professional's shortage, residence permits are generally delivered in spite of the a priori closure towards, non EU third countries.

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**Ethical issues would be raised by the development of recruitment in developing countries.**

To which point is the reliance on foreign health workforce sustainable? Indeed, the health workforce shortage is an issue of which countries are more and more aware. It is actually very plausible that in the future, a certain number of OECD countries will direct efforts toward a better retention of their health professionals. As explained above, the competitiveness of one country depends of several factors among which, remuneration only constitutes one aspect. Depending on the policies implemented in the current source countries, the relative advantages of Switzerland may evolve and it may become more and more difficult for Swiss employers to attract foreign professionals. One can wonder how employers would deal with such an evolution. If they do not find the human resources neither on the Swiss nor on the EU market, it is plausible that they will have to recruit in countries where they are more competitive, eventually developing countries. Yet, whereas Switzerland can take responsibility for recruiting in European countries, it would be ethically less justifiable to recruit in countries where shortages already are very acute and threaten the population's access to health care. However, even amongst developing countries there are countries, notably the Philippines, deliberately training nurses for emigration. In addition to the ethical aspects of recruitment in developing countries, question of adequate training as well as cultural and language barriers play a significant role in recruitment decisions.

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**Health sector is liberalizing and the migration of health professionals is becoming easier.**

The current competition for health human resources in which countries are engaged is not an isolated phenomenon and such a rivalry also exists for engineers, managers and other categories of professionals for a long time. As for all these professionals, countries tend to facilitate the admission of foreign health professionals because of their much-sought skills. Even if there are still limitations restraining a total freedom of movement, deliberation about health workers migration within the General Agreement on Trade in Services (GATS) illustrates the will to liberalize this sector in the manner of other economic sectors. The ongoing deliberations concerning the health sector are notably related to

Mode IV, the movement of people. Future effect of GATS is uncertain as it governs the temporary movement of people and there is no generally admitted definition of what «temporary» refers to<sup>36</sup>. By now, commitments of countries to GATS Mode IV are very limited in the health sector, notably because they are concerned by their ability to regulate the entry of health workers<sup>37</sup>.

Given the context of global health human resources shortage and its impact on the population's access to health care in less favored nations, some people question whether the rules of the free market should also be applied to the health sector. The will to liberalize the health sector is underlied by the assumption that opening the service sector to global competition would address health worker shortages, notably thanks to economic and efficiency gains, diaspora remittances and «brain circulation». These are the classical arguments in favor of opening borders to economic migrants. Thus, the negative impacts of health workers migration on the more destitute countries are well-known and the desirability of opening borders is debated. This is a complex discussion which leads some authors to promote a «medical exceptionalism» in the sense that policies which address medical migration should differ from those related to other highly skilled professionals and should be based on moral and ethical grounds<sup>38</sup>. If such a position was adopted, relevant actors would have to define what kind of international recruitment is morally acceptable and which legislative tool, from ethical guidelines to binding law, is more appropriate. On the other hand such calls for a «medical exceptionalism» can be seen as a symptom of the general reluctance in the health sector towards (often necessary) reforms.

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**The question whether migration of health professionals should be treated differently from other professionals is a discussed one.**

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<sup>36</sup> Stilwell, B. and al., 2003: Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges, *Human Resources for Health* 1(8).

<sup>37</sup> Bach, S., 2003: International migration of health workers: Labour and social issues, Geneva, International Labour Office, p.29.

<sup>38</sup> Alkire, S. and Chen, L., 2005: Medical Exceptionalism in International Migration: Should Doctors and Nurses be treated differently? In Tomas, M. and Palme, J. *Migration Regime*. Ashgate Press, p.2-4.

## Question N°3: Is international cooperation the way to resolve the issue?

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**The international migration of health professionals is on the agenda of several international organizations.**

Over the past years, migration of health professionals has gained international attention in two ways. First, there are several processes on international and regional levels aiming a balanced and comprehensive approach to the management of migration (see the Berne Initiative (2005), the Global Commission for International Migration (2005) or the UN High-Level Dialogue on International Migration and Development (2006)). Secondly, there is the WHO's work in favor of the development of a code of practice on the international recruitment of health workers. Such a code would be «the first international instrument on health worker recruitment developed with a worldwide scope applicable to both source and destination countries»<sup>39</sup>. In this avenue of enquiry, we will concentrate the discussion on the elaboration of the WHO code of practice.

The code of practice on the international recruitment of health workers was requested by a resolution adopted by the World Health Assembly in 2004 entitled «International migration of health personnel: a challenge for health systems in developing countries». Five years later, the drafting of the WHO code of practice is still in progress. Yet, it is already known that countries will have to express their view on dispositions related to the international recruitment practices, the mutuality of benefits, the national health workforce sustainability or the data gathering<sup>40</sup>. Provisions related to recruitment practices may protect the migrant health workers; they also may restrict recruitment from states experiencing critical workforce shortages. Mutuality of benefits principle pleads for an appropriate balance between the interests of source and destination countries. In this perspective, the code may promote bilateral agreements. It could also recommend some type of compensation and/or international cooperation. Then countries will have to decide whether the concept of national health workforce sustainability should be included in the code and if so, how is the concept defined and implemented. Concerning data gathering, the type and scope of the data collected and the mechanisms to allow information exchange will have to be defined. Data gathering has been considered as an essential step to inform policies. It also appears to be the most accepted practice that would endorse the WHO in its coordination role.

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**A WHO code of practice on the international recruitment of health workers is in progress.**

This code is not intended to be a binding legal instrument albeit it is acknowledged that it would represent persuasive moral imperatives<sup>41</sup>. For example,

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<sup>39</sup> WHO, 2009: A World Health Organization code of practice on the international recruitment of health personnel. Background paper, p.5.

<sup>40</sup> Ibid, p.5-9.

<sup>41</sup> Pagett, C. and Padarath, A. 2007: A review of codes and protocols for the migration of health workers. EQUINET Discussion Paper 50, p.30.

member countries would probably be urged to publish a national report at periodic intervals to communicate progress. This transparency would encourage countries to make an effort to achieve the defined objectives.

At the moment, discussions have shown strong divergences among some states on whether and how the issues mentioned above should be incorporated in a code of practice. This can be explained by the contradictory interests between countries. In this regard, it is not surprising that the issue first appeared on the international scene at the initiative of some developing countries affected by the emigration of their health professionals. Moreover, it also may be difficult to achieve coherence within countries between their training, recruiting, migration and foreign policy because of their contradictory interests. Immigration policy and human resources for health policy are primarily determined by factors such as national economic interest or national welfare but less by the specific interest of other countries; while development cooperation policy tries to support the interests of developing countries. This diversity of policy fields concerned makes it difficult for countries to determine their national position on proposed provisions of the code and explains the delay in the elaboration of the WHO code of practice.

The migration of health professional has made the shortage of health workers a global issue which concerns most of the countries, either as importing country or as exporting country or even as both. As a global issue, a global answer is required, involving both source and destination countries. Still it is not clear which type of regime will be more able to meet the challenges posed by these international movements and what would be the role of international organizations such as WHO. Indeed, as the WHO draft code suggests, bilateral or, to a certain extent, plurilateral agreements may constitute a more operational instrument for countries to «formalize their commitments to mutually agreeable policies and practices on health worker migration»<sup>42</sup>. To date, several experiences have been conducted, some of them quite successful. For example, the agreement signed by the UK and the Philippines sets out in detail the requirements placed on the Philippine Overseas Employment Administration (POEA) and the National Health Service (NHS, UK) to ensure transparency and eliminate potential for abuse<sup>43</sup>. It notably establishes the various fees in charge of the employer (initial application, entry visa application, initial airfare to the UK, etc.).

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**Consensus on a code of practice appears difficult to achieve because of the divergence of interests between and within the States.**

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**There are different ways to manage the migration of health professionals.**

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<sup>42</sup> WHO, 2009: A World Health Organization code of practice on the international recruitment of health personnel. Background paper, p.5.

<sup>43</sup> Bach, S. 2003: International migration of health workers: Labour and social issues. Geneva, International Labour Office, p.23.

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**The outcome of the WHO process remains uncertain.**

The multilateral scene has allowed the health workers migration issue to come into the spotlight. At this stage, the most tangible effect of the ongoing process for an international code of practice is probably that it has initiated a reflection within countries about the international migration of health workers and their position within this system. Yet, it is difficult for now to predict which kind of cooperation will take place between affected countries and what will be the role of the WHO code of practice. Due to the various contradictory interests at stake, it may be difficult to attain consensus on very ambitious objectives. In this perspective, bilateral agreements may be preferred to actually manage health workers flows.

## Conclusion

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This working paper only tackled some of the issues among the many raised by the international migration of health professionals. Indeed, it appears that this phenomenon questions the Swiss practices on several political areas and institutional levels. That is why Switzerland has launched in 2008 a coordination process between the relevant federal departments and the cantonal health ministers conference with the aim of discussing the different points of view on the migration of health professionals. This process allowed to shed light on the situation in Switzerland: the strong reliance of the Swiss health system on the foreign health workforce, the scattering of the competencies regarding the training, the granting of residence and work permit linked to the needs of the economy or the autonomy of the employers in terms of recruitment. However, this overview rather demonstrates the specific interests of each actor rather than achieve coherence between them. Thus, the answers of Switzerland to the questions raised by brain drain are still to be defined but according to current knowledge and trends in the availability of health care personnel, Switzerland has the following options for the future so as to avoid serious shortages: increase domestic training of personnel, import more trained personnel, switch work responsibilities and tasks between the medical professions, increase the work productivity of medical professions, or a combination of all the above.

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**Switzerland has launched a coordination process between the relevant federal departments and the cantonal health ministers conference.**



