Mobility of Health Professionals:
Source Countries Perspectives (Asia)

WIAD (Wissenschaftliches Institut der Ärzte Deutschlands)

Scientific Institute of the German Medical Association

Bonn, Germany

Funded by

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Asian Source Countries Perspective : Presentation Outline

- Source Countries Perspectives (Asia)
- Case Study results from India, the Philippines and Australia
- Key findings
- Key Recommendations
- Research Questions for Micro Phase

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Source Countries Perspective (Asia)

- Asia covers approximately 30% of world's total land area with an estimated 4.10 billion inhabitants, or 60% of the world's population.

- In the project covers Asia and the Pacific represented by selected countries in their Asian region:
  - Australia – Pacific Countries
  - India – South Asia
  - Philippines – Southeast Asia

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Source Countries Perspective (Asia)

- Countries in Asia and the Pacific have reached high levels of prosperity but millions of its inhabitants still suffer from poverty and poor health.
- These conditions further compounded by increasing trend of health worker emigration to first world nations.

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Source Countries Perspective (Asia)

- Reported 76,104 emigrant health professionals (nurses, doctors, dentists, and pharmacists) to the European Union (EU) states from 49 Asia and Pacific countries ;
- There were 395,716 health worker emigrants from 58 Asia and Pacific nations to the whole world in the same year.

(Dumont and Zurn,2007)

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Case Studies on India, the Philippines, and Australia

- Key sources of health professional migrants from Asia to European Union nations;
  - India leads with close to 20,000 migrant health professionals in the EU;
  - The Philippines comes in second with 11,294 migrants in EU countries.
  - Australia ranks 6th with an estimated 4,000 migrant health professionals in the European Union.

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Case Studies on the Philippines, India and Australia

Philippines –

- Major source country of health professionals and leads all Asian countries in the number of migrant professionals world-wide with close to 130,000 health professionals abroad;
- Most of these migrants or 85% were reported to be nurses while 16,000 or 12.1% were noted to be physicians.

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Case Studies on the Philippines, India and Australia

- **India** ranks second with an estimated 86,000 health professionals world-wide. Unlike the Philippines, India mostly sends out physicians, which make up about 65% of all their health professional migrants; with nurses only comprising 26% of all their migrant health professionals

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Case Studies on India, the Philippines, and Australia

- **Australia** is a transit country – both a destination and source country .
- Biggest proportion (70%) of all health professionals going to EU countries from the country were found to be Australian;
- But foreign health professionals comprise a proportion of the Australian workforce where :
  - 1% was reported to have come from China,
  - 0.8% from Vietnam,
  - 0.7% from India,
  - 0.6% from the Philippines and 0.5% from Malaysia.
  - The rest came from Europe (England and Italy) and New Zealand (2)

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Case Studies on the Philippines, India and Australia

- **Australia** ranks 11th among all countries with health professional migrants worldwide although classified as a developed country;
- About 4,500 or (64% of all HRH migrants) Australian nurses and 2,000 (28% of all HRH migrants) Australian physicians were reported to be migrant health professionals worldwide in 2001;
- Knowledge of emigration from Australia is limited as it reflects only data obtained from the exit card when leaving Australia.

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Key Findings

1. Emigration of health professionals seems to be driven by external demand of destination countries as well as by existing conditions or situations in source countries (such as poor work conditions and low pay) and destination countries (promise of better compensation and career opportunities) that facilitate HRH migration;
2. While all types of health workers have the opportunity to emigrate, nurses and doctors seem to constitute the bulk of health professional migrants

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Key Findings

3. Currently available data on the mobility of health professionals showed that source countries may have information on temporary and permanent health professional migrants, but data on the same migrants when they arrive in destination countries are not available. Such may include placement, entry, citizenship, licensure/ certification and retention. Particularly data on circular migration especially on re-entry are not available.

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Key Findings

4. There are limited data on the emigration of skilled health professionals especially in India and Australia;
5. Policies that facilitate migration management that will define the scope , rate and scope of outmigration , official and non-official recruitment practices, especially re-entry and circular migration are not available;
6. There seems to be more available information on immigration policies of destination countries. These seem to be better implemented also.

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Key Findings

7. Practices of the private sector in the recruitment and deployment of health professionals are varied. In the absence of strict regulation and/ or government- to-government agreements and guidelines, private recruitment agencies are predisposed to exact higher fees and exploit those being recruited. Market based and government recruitment modes and experiences are observed but they are not adequately documented.

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Key Recommendations

1. It is important that policy development center on how to make mobility of health professionals mutually beneficial for both source and destination countries;

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Key Recommendations

2. Policy instruments that need to be discussed are bilateral and multilateral agreements that will contextualize the conditions of mobility across countries. The EU may want to consider multilateral agreements if the EU will want to maximize the potential efficiency and effectiveness of HRH mobility to, from and within the EU. Otherwise, bilateral agreements between countries in exchange may be encouraged.

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Key Recommendations

3. From a source country perspective, facilitation of temporary HRH migration through bilateral agreements seem to provide most promise to ensure that the development needs of source countries as well as the efficiency needs of destination countries are met.

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Key Recommendations

4. The need to ensure a mutually beneficial arrangement will also promote ethical recruitment and employment of health professionals which is a global concern currently especially among OECD destination countries.

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Key Recommendations

5. Proposed areas for further studies include the following:

- Return and circular migration of health professionals from the EU
- Utilization of remittances by migrants
- Mutual recognition of skills and expertise of health professionals

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Proposed Areas for further Studies (cont’d)

- Components of the information system that can be shared between source and destination countries to promote mutually beneficial strategies
- Investments needed and may be made as part of ethical recruitment agreements between countries
- Market based and government recruitment modes

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THANK YOU VERY MUCH!

MARAMING SALAMAT PO!