OECD Human Resources in Health Care Project - Update

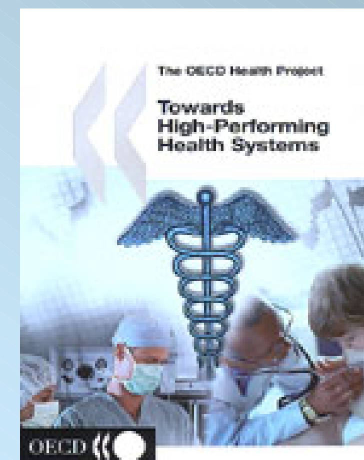
8th International Medical Workforce Collaborative

October 6, 2004, Washington

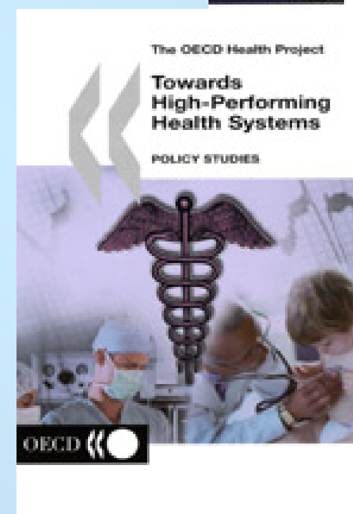
Human Resources in Health Care study as part of OECD Health Project

- OECD Health Project was 3-year project (2001-2004)
- Focus on analysing performance of health systems (including efficiency, effectiveness and equity)
- Culminated in meeting of OECD Health Ministers in May 2004
- Important component was Human Resources in Health Care study (imbalances in doctors & nurses)

OECD Health Project products



- *Towards High-Performing Health Systems*
  - Final Report to Ministers
  - Summary Report
  - Policy Studies (chap. 4: Human Resources)



- *Private Health Insurance in OECD Countries*
- *Health Technologies and Decision Making*
- *Long-Term Care for Older People*

Upcoming OECD Health Working Papers

- “Ensuring an adequate supply of physician services in OECD countries” (by Simoens and Hurst)
- “Tackling nurse shortages in OECD countries” (by Simoens, Villeneuve and Hurst)
- “Skill mix and policy change in the health workforce: Nurses in advanced roles” (by Buchan and Calman)

Objective of study on Human Resources in Health Care

- Identify, compare and evaluate policies across countries for addressing imbalances in the supply and demand of physicians and nurses

Process for OECD study on Human Resources

- April 2002: First meeting with experts from participating countries (20 countries)
- Fall 2002: Policy and data questionnaires sent to countries
- December 2002: Second experts group meeting to review difficulties and interim results from data collection
- April 2003: Deadline for countries to complete questionnaires
- December 2003: Progress report submitted to OECD Ad Hoc Group on Health
- May 2004: First results from Human Resources study summarised for meeting of OECD Health Ministers
- By end 2004: Completing publication of results and dissemination

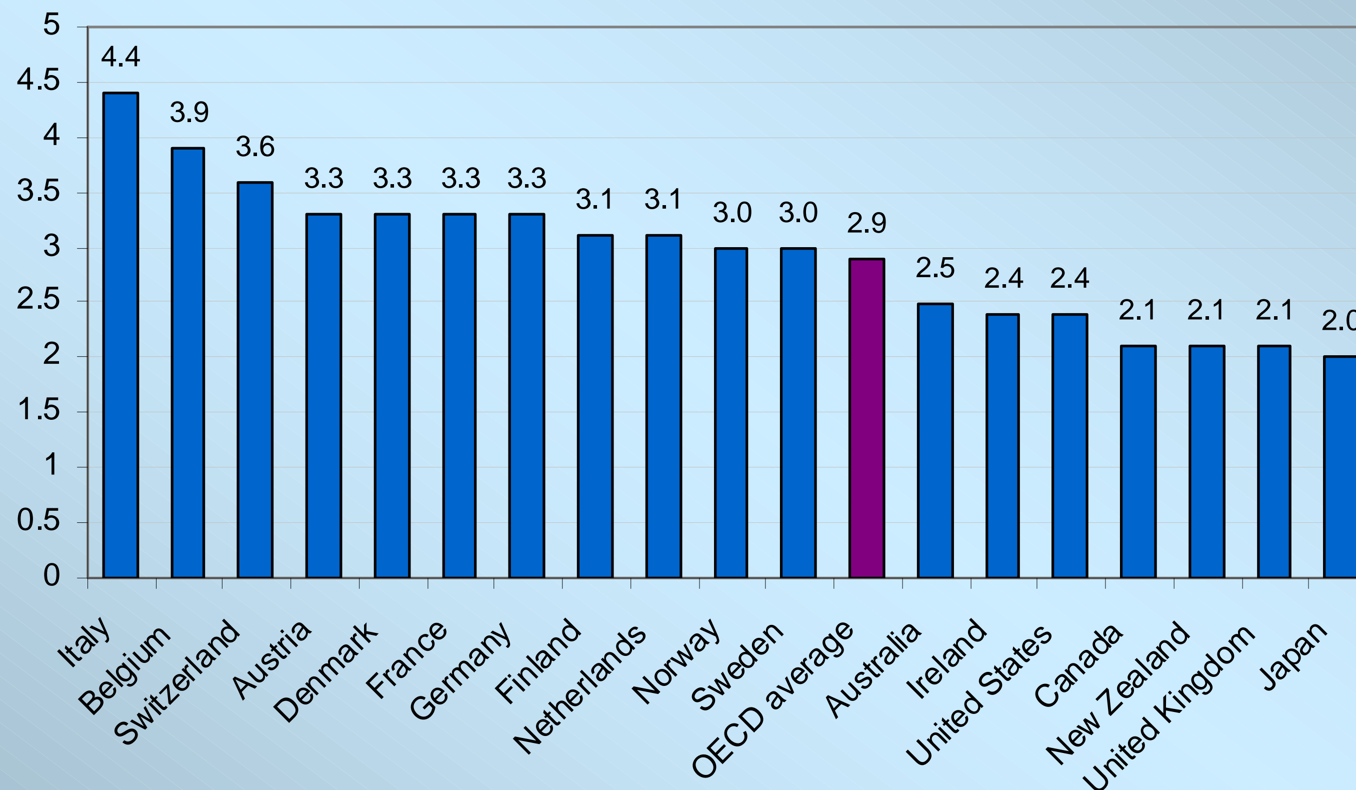
Framework for supply and demand of doctors and nurses

Scope of data collection in Human Resources study

- Demographic characteristics (number of doctors and nurses, proportion of women, age, foreign-trained)
- Breakdown by type of doctors/nurses, type of contracts, public/private sectors
- Activity levels (working hours)
- Remuneration and working conditions

Also used data from Eurostat and *OECD Health Data*

Variations in doctors per 1000 population, 2002



1) Belgium, Denmark, France, Ireland, Netherlands and New Zealand include physicians working in industry, administration and research.

2) Finland, Ireland, Netherlands and New Zealand provide the number of physicians entitled to practise rather than only those practising.

3) Norway reports full time equivalents (FTE) rather than headcounts.

Source: ***OECD Human Resources in Health Project*** and ***OECD Health Data 2004***.

Current or projected shortages of doctors

- Evidence of current shortages of doctors in some countries at least in certain regions (e.g., UK, Canada)
- Shortages expected to worsen in many countries because of higher demand (population ageing, higher expectations) and lower supply (workforce ageing)
- Countermeasures needed

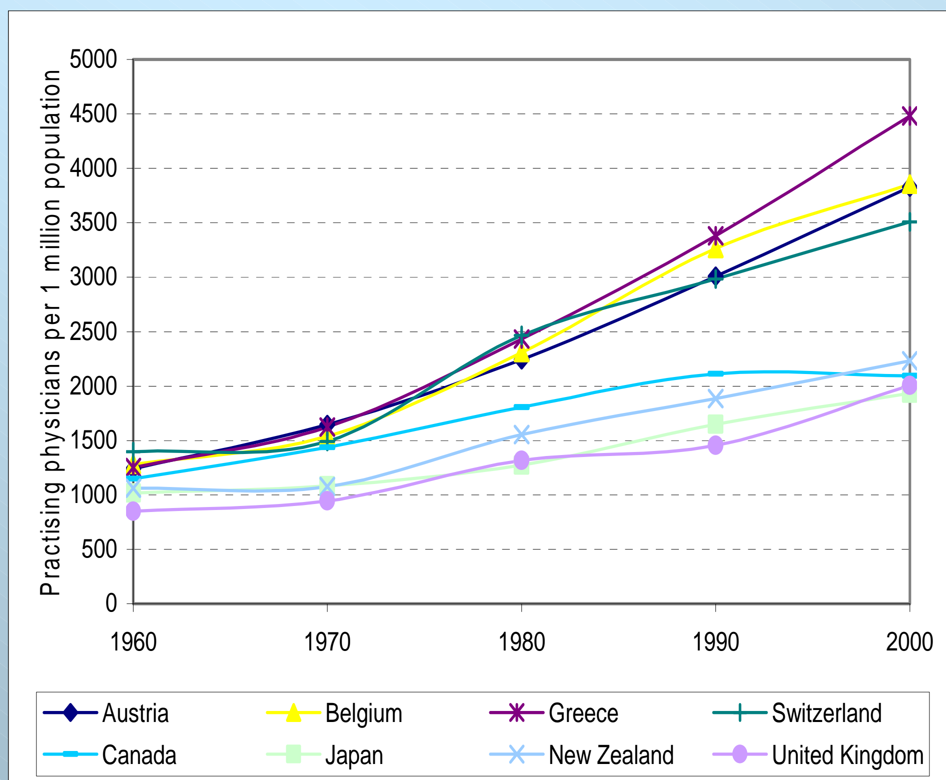
Policies to tackle looming shortages

- Domestic training rates
- Recruitment and retention
- International migration
- Skill mix changes
- Raising productivity

Domestic training rates

- Main reason some countries face shortages of health professionals (and may be net recruiters) lies in their domestic markets
- One of the main factors seems to be the extent to which countries have restricted number of places in medical schools
- Different path between countries which have controlled rates of entry to medical schools with those that have left entry more to market mechanisms
- Still, both types of country seem to have experienced cycles of boom and bust in training programmes – likely due to lags in training
- Need for better forecasting to inform planning/market mechanisms

Impact of planning and market regimes on physician density



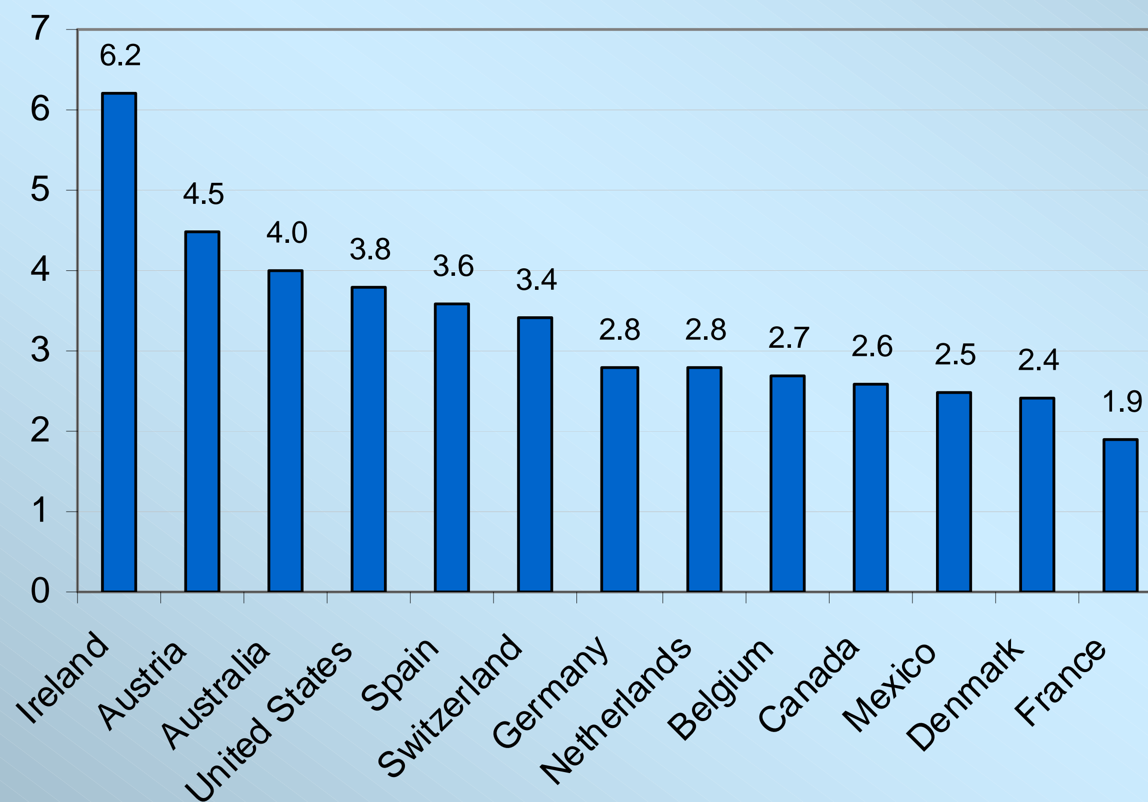
Countries that don't or recently started to regulate medical school intake

Countries that regulate medical school intake

Graduation Rates

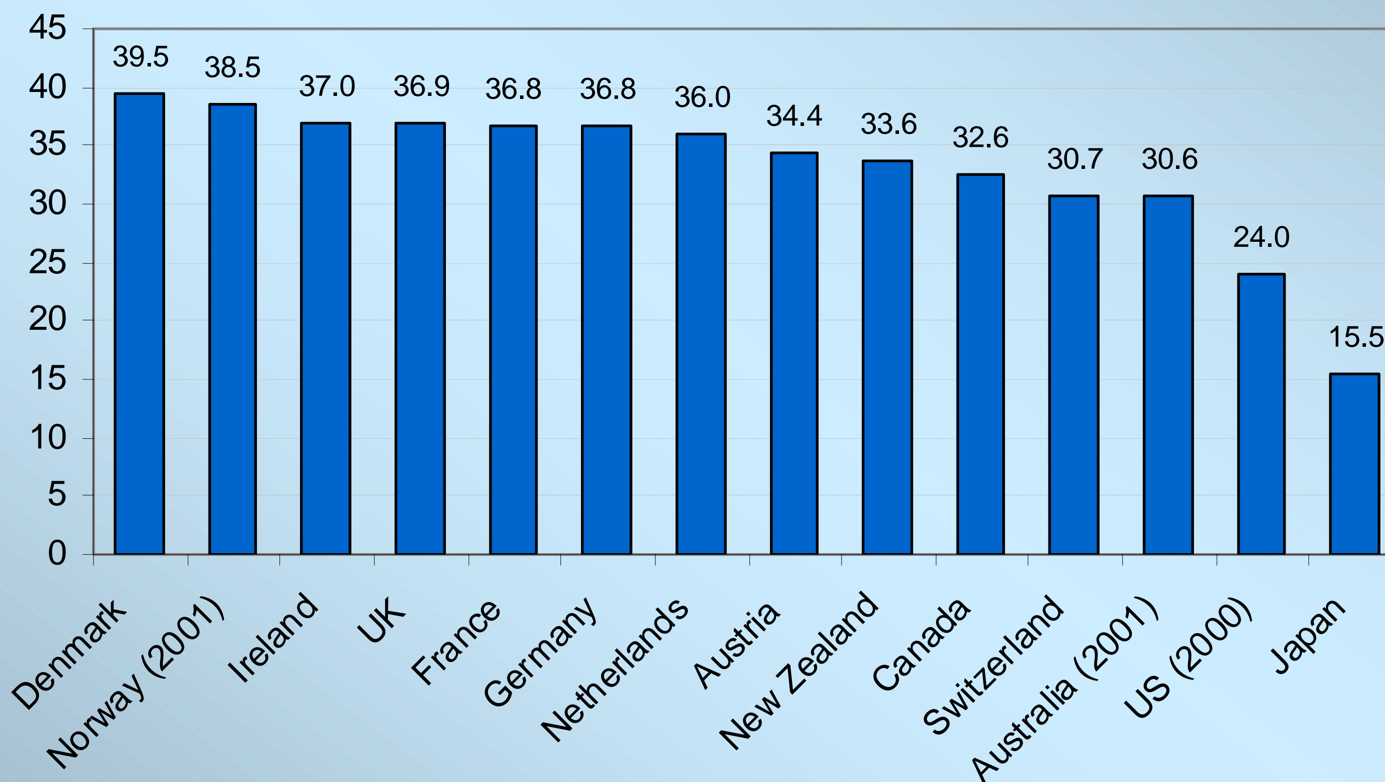
- Many OECD countries are not training enough doctors to compensate for the outflow into retirement.

Newly graduated doctors as % of all doctors, 2000



Source: *OECD Human Resources for Health Care Project*.

Share of women in physician workforce, 2002

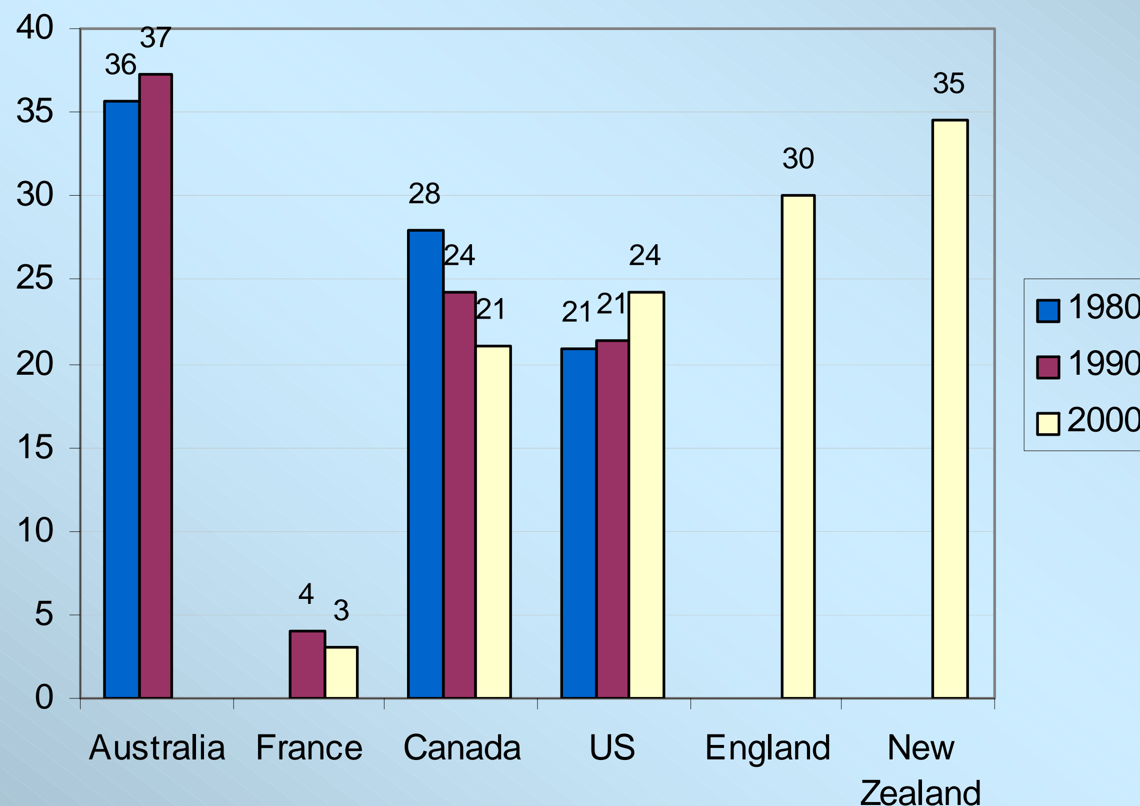


Source: ***OECD Human Resources in Health Care and OECD Health Data 2004***.

International migration

- International movement of health professionals might help reduce shortages in receiving countries
- But there are many barriers to such movement despite agreements by EU, NAFTA, Nordic countries
- Presumably, private benefits exceed private costs for people migrating
- However, social costs may exceed social benefits if there is a permanent 'brain drain' from poorer countries to richer countries
- Solutions may include greater domestic self sufficiency, ethical recruitment, temporary migration, financial compensation.

Foreign-trained physicians as % of all practising physicians



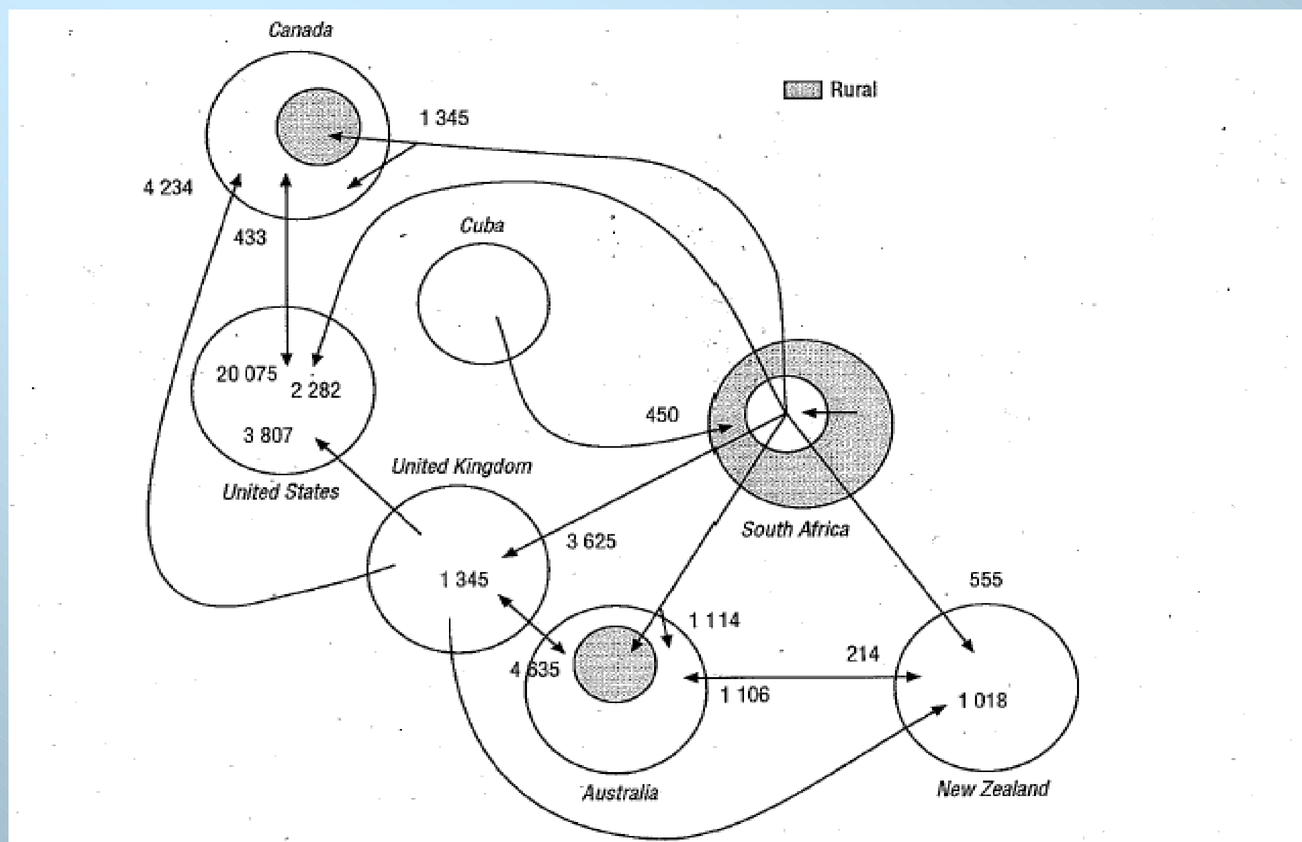
1) Data for England relate to physicians in the National Health Service.

Source: ***OECD Human Resources in Health Care Project***.

South African Case Study

		Practitoners (Doctors, dentists, pharmacists)	Nurses and midwives
Registered in South Africa	1996	38,119	177,520
	2001	46,130	172,338
New graduates	2001	1,420	8,167
Proportion intending to practice abroad	2001	42%	
Unfilled Vacancies	2001	4,222	32,734
South African Born Practising in Australia, Canada, US, NZ, UK	2001	8,921	6,884
UK recruitment, South African nurses	1998-1999		599
	1999-2000		1,460
	2000-2001		1,086
	2001-2002		2,114

Principal axes of international mobility of health professionals (by country of birth)



Main message

- Cross-border migration is just one aspect of normal movements in labour markets
- Excessive rates of movement indicate a “malaise” in domestic training rates or employment conditions
- The aim of domestic training programmes should be to encourage retention for a reasonable number of years, not prevent movement.

Improving skill mix

- Many studies in the US and UK on using nurses in ‘extended’ roles for pre-diagnosed patients (e.g. treating minor illness in primary care, midwives for low risk delivery, follow-up of cardiovascular patients)
- Evaluations suggest nurses can provide care equivalent to that provided by doctors and preferred by patients
- Cost-effectiveness remains unclear
- OECD Working Paper to be released in late October (Buchan and Calman)