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WHO policy dialogue on international health workforce mobility and recruitment challenges: technical report

Amsterdam, 2–3 May 2013

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The World Health Organization (WHO) Regional Office for Europe and the WHO Western Pacific Regional Office organized this policy dialogue on international health workforce mobility and recruitment challenges. The meeting took place on 2–3 May 2013 at the Royal Tropical Institute, a WHO collaborating centre for research, training and development of human resources for health, located in Amsterdam.

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Abbreviations and acronyms

ASEAN	Association of Southeast Asian Nations
BLA	bilateral agreement
CIS	Commonwealth of Independent States
COP	code of practice
CSO	civil society organization
DNA	designated national authority
EPSU	European Federation of Public Service Unions
EU	European Union
HOSPEEM	European Hospital and Health Care Employers' Association
HRH	human resources for health
MOU	memorandum of understanding
WHO	World Health Organization

Executive summary

This report summarizes the key issues and conclusions of a policy dialogue on international health workforce mobility and recruitment challenges held in Amsterdam in May 2013. The meeting was organized by the WHO Regional Offices for Europe and the Western Pacific. The meeting brought together policy-makers from source and destination countries, representatives from intergovernmental and regional organizations, representatives from civil society organizations, health professional employers, private recruitment agencies and academia to debate effective policy mechanisms for the fair and ethical international recruitment of health personnel.

The specific objectives of the meeting were:

- to review current progress in implementing the WHO Code of Practice on the International Recruitment of Health Personnel in the two regions;
- to explore the challenges and benefits arising from the international mobility and recruitment of health workers;
- to share experiences in addressing these challenges including bilateral arrangements, integration of migrant health workers in labour markets of the destination countries and circular migration policies; and
- to facilitate and propose a process of continuous information exchange in order to expand further the evidence base and to inform national and international policies and actions.

Participants in the meeting recognized that developing appropriate and effective policy solutions to human resources for health (HRH) challenges is complex and requires multistakeholder engagement. They agreed that the current global financial and economic crisis has changed the dynamics around the recruitment and mobility of health workers, but not the underlying demographic trends for HRH. In this context, the participants also recognized that the Code, on its own, will not be sufficient in influencing, creating and testing policies to create a sustainable health workforce. It will be effective when used as part of multistakeholder action, rather than as an administrative tool for which the reporting process is the end result.

Participants identified the main HRH challenges as recruitment, retention, skill mix and productivity. They described limitations in the availability of data on HRH as a constraint, but not a reason for inaction. They recognized that data is not evidence and, further, that evidence is not strategic intelligence. WHO recommends using the available data in the best way possible to assist in projecting future scenarios, to influence and engage multiple stakeholders, and to shape policy. There is a related need to identify and promote available promising practices related to the various policy tools and approaches currently in use such as bilateral agreements, the integration of health professionals in destination countries, mutual recognition of qualifications and circular migration.

Five key messages emerged from the policy dialogue.

1. Enhance advocacy efforts to maintain the momentum and raise awareness about the Code.

There is a continued need to raise awareness about the Code. The target audience for this effort at the international level is intended to go beyond the health sector to include other United Nations agencies and high-level political forums such as the G8, the G20 and the World Economic Forum. There is a role for WHO in building alliances with these high-level decision-making groups and their representatives.

Many employers and recruiters, who are major stakeholders in the ethical and effective recruitment of international health personnel, are hardly aware of the WHO Code. Designated national authorities can play a key role in raising awareness and engaging in a dialogue with these stakeholders. These communication efforts can be supported by translating and disseminating the Code.

It is important for WHO to prioritize work on HRH, as the health workforce is a crucial part of the health systems strengthening and universal health coverage agendas. Member States can play an important role in ensuring that HRH is given high priority on the WHO agenda. The current consultations with WHO Member States could help to ensure that strengthening the health workforce and health systems will be part of a focused set of key priorities on the WHO agenda in the coming years.

2. Foster dialogue and build cooperation with stakeholders.

A critical component in supporting implementation of the Code is effective country-level awareness raising and dialogue. This communication can be achieved through multistakeholder country-level dialogues with the aim of exchanging perspectives, values and objectives related to the international mobility and recruitment of health professionals. Such stakeholders would include: various ministries; bilateral partner countries; social partners; trade unions; employer organizations; professional associations; and recruitment agencies from both the public and the private sector. It is important that these stakeholders understand that the Code can serve their interests. The national reporting instrument developed by WHO can be used as a focal point for these meetings, as can the communication tool on macroeconomics and fiscal space which WHO is developing to support mutual understanding between ministries of health and finance.

Existing platforms can also be utilized. Examples in the WHO European Region include the South-eastern Europe Health Network, in which high-level representative of the various ministries of health are involved, and the European Union (EU) Joint Action on Health Workforce Planning and Forecasting, which already brings many of the stakeholders together. The experiences and forums of the Wemos Foundation (Netherlands) programme on implementing the Code in multiple EU countries can also provide an entry point.

The overall objective is to engage various stakeholders in the health sector and beyond (education, finance, labour and foreign affairs), who have different interests and objectives, to agree and implement a unique core set of principles.

3. Identify good practices and expand the evidence base.

There is a need for expanding the evidence base. It was recognized that WHO can play a role in collecting, synthesizing and promoting examples of Code implementation and lessons learnt such as via the WHO web site or other online forums. Member States have the responsibility to provide examples, information and data to WHO so that WHO can perform this dissemination function more effectively.

There is scope to build on the lessons learnt from current initiatives such as the International Labour Organization study on bilateral agreements involving the Philippines, and the assessment of the agreement between Japan and the Philippines by the Japan International Cooperation Agency. These studies could provide the basis for developing a methodology or framework to assess the implementation and impact of efforts to manage migration: to answer the questions of what worked, what did not work, what are the results, for whom and why? Given the limits on available resources to support research and evidence generation, countries should consider maximizing the possibilities of using schools of public health and academic researchers at this stage. The intention is that research questions related to the strengthening of the health workforce will be on the agenda of these institutions. HRH is not a discipline, but rather entails multiple disciplines including economics, migration, sociology and psychology. It would be wise to combine these areas of expertise to develop further the discourse on the health workforce and share knowledge with others who are conducting research on HRH. This dialogue and knowledge sharing can be done through workshops and courses in which multiple disciplines and stakeholders contribute to develop the capacities of researchers and policy-makers in the field of HRH. National, subregional and regional HRH observatories and WHO collaborating centres can also play an important role in strengthening capacities and sharing information.

4. Assess and report on changing trends in health labour markets.

Existing HRH observatories, WHO collaborating centres, the EU and the Joint Action on Health Workforce Planning and Forecasting, the Association of Southeast Asian Nations and the Organisation for Economic Co-operation and Development provide for well-connected networks to collect, analyse, and present data and projections on the quickly changing trends in the health labour market. This information should be made available and used to strengthen knowledge base, perceptions, capacities and technical know-how of decision-makers in the areas of health workforce and the relation of HRH with the macro-economic context.

5. Make use of the need for reform to sustainably strengthen the health workforce.

In the current global economic crisis, health and HRH budgets in many countries are constrained or are declining. The international mobility of the health workforce is changing, but not reducing, and is likely to increase in the coming years. Managing migration in isolation should not be the primary focus of policy solutions. Addressing the causes in the mismatch between the national demand for and supply of health professionals is very important. Moreover, the crisis represents an opportunity to pursue policies and strategies to reform the health sector and the health workforce, in order to create a sustainable health workforce and health system for the future.

Introduction

On 2 and 3 May 2013, the World Health Organization (WHO) Regional Office for Europe and the WHO Regional Office for the Western Pacific, in cooperation with the WHO collaborating centre for research, training and development of human resources for health at the Royal Tropical Institute in Amsterdam, organized a policy dialogue on international health workforce mobility and recruitment challenges. This meeting brought together policy-makers from different ministries in both source and destination countries; representatives from intergovernmental and regional organizations; representatives from civil society organizations (CSOs); health professional employers; private recruitment agencies and academia to debate on effective policy mechanisms for the fair and ethical international recruitment of health personnel.

The specific objectives of the meeting were:

- to review current progress in implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010) in the regions;
- to explore the challenges and benefits arising from international mobility and recruitment of health workers;
- to share experiences in addressing these challenges including bilateral arrangements, integration of migrant health workers in labour markets of the destination countries and circular migration policies; and
- to facilitate and propose a process of continuous information exchange in order to expand further the evidence base and to inform national and international policies and actions.

This technical report summarizes the presentations and discussions that took place during the policy dialogue. These discussions provided a better understanding of the progress made and challenges in implementing the Code and its principle of mutuality of benefits. The meeting provided further recognition of policy mechanisms that may be used to address the challenges and benefits associated with international migration and recruitment of health personnel. It also facilitated a better understanding of models of bilateral agreements (BLAs) that can be put into place to facilitate intercountry cooperation. Annex 1 provides the programme of the meeting. Annex 2 lists 40 participants that took part in the policy dialogue.

Chapter 1 describes the background of this policy dialogue on international health workforce mobility and recruitment challenges. Chapter 2 reviews the current progress in reporting on implementation of the Code. Chapter 3 describes challenges and benefits arising from international mobility and recruitment of health workers. Chapter 4 presents experiences in addressing the challenges related to the international mobility and recruitment of health workers including bilateral arrangements, integration of migrant health workers in labour markets of the destination countries and circular migration policies. Chapter 5 describes the key messages that came out of this policy dialogue, and the concrete next steps that were identified for a process of continuous information exchange in order to expand further the evidence base and to inform national and international policies and actions.

1. Background

The health workforce is a crucial element of the health system in providing quality health services to the population. Qualified health personnel are critical not only for attaining the health-related Millennium Development Goals, but also for the post-2015 development agenda and for achieving universal health coverage.

In 2006, the World Health Report (WHO, 2006) identified 57 countries that were facing a critical shortage of doctors, nurses and midwives. These countries were located mostly in Africa and south-east Asia. More generally, a global shortage of health workers exists, with most countries facing imbalances in their health workforce, both of a geographical nature, and because of skill mismatches, e.g. related to a difference between the competencies or skills needed and the competencies and skill-mix provided by the current health workforce.

Additionally, exogenous factors impact labour market dynamics and health workforce mobility. For instance, ageing populations, changing lifestyles and morbidity patterns, and the availability of new technologies lead to increasing demand for services, while the relative size of the health workforce to meet this growing demand is not keeping pace in many countries. These dynamics can lead to a stronger pull for foreign qualified health personnel from more affluent destination countries. As a consequence of the current global financial-economic crisis, some governments are cutting their health budgets, which affect health workers' salaries and can lead to the closure of health facilities. These developments influence the dynamics of the labour market and the mobility of the health workforce. Addressing these types of issues is a priority for Member States and WHO alike.

1.1 The WHO Global Code of Practice

On 21 May 2010 the Code was adopted by the 193 Member States of the World Health Organization to address challenges associated with the international migration of health workers.

The Code promotes voluntary principles and practices, not only for the ethical international recruitment of health personnel, but also for the strengthening of health systems through improved workforce planning, retention and health workforce sustainability. The Code provides a global framework for health workforce development and is relevant for both source and destination countries.

Within this framework of health systems strengthening and human resources development, the WHO Code was designed by Member States as a continuous and dynamic framework for dialogue and cooperation between multiple stakeholders at local, national, regional and global levels.

The Code (WHO, 2010) highlights six principles in relation to the international recruitment of health personnel:

1. ethical international recruitment
2. health workforce development and health systems sustainability
3. fair treatment of migrant health personnel in destination countries
4. international cooperation
5. support to developing countries
6. data gathering and information exchange.

1.2 WHO support in implementing the Code

WHO has provided resources and facilitated various technical meetings and policy dialogues to help countries implement the Code including: the *National Reporting Instrument of the WHO Global Code of Practice on the International Recruitment of Health* (WHO, 2012); the *Draft guidelines for monitoring the implementation of the WHO Global Code* (WHO, 2011a); and the *User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel* (WHO, 2011b). WHO provided input to the report *Innovations in cooperation: a guidebook on bilateral agreements to address health worker migration* (Dhillon, Clark & Kapp, 2010).

WHO continues to work on improving information and knowledge on HRH, and developing tools, policy options, and global recommendations in facilitating and supporting country-level actions. The WHO Regional Office for Europe organized a technical discussion at the sixty-second session of the WHO Regional Committee for Europe in Malta with the aim of promoting debate on effective policy options for strengthening national health workforce and fostering commitment to implement the Code. A package with three resources was presented to the Members States to facilitate implementation of the Code in the European Region (WHO Regional Office for Europe, 2012a-c). As part of the third document, *Action Towards Achieving a Sustainable Health Workforce and Strengthening Health Systems*, various capacity building workshops and policy dialogues have been organized by the Regional Office in the past three years.

The WHO Western Pacific Regional Office faces different dynamics with regard to the international mobility of the health workforce, both within the Region and between the Western Pacific Region and other WHO regions. Its Regional Committee adopted in 2011 the Human Resources for Health Action Framework for the Western Pacific Region (2011–2015) to strengthen HRH capacities in Member States in the Region. Multiple policy dialogues have taken place in the Region, e.g. in the Philippines, Australia, and within the subregional network of the Association of Southeast Asian Nations (ASEAN).

This technical report profiles the Amsterdam policy dialogue on international health workforce mobility and recruitment challenges, which was organized by the WHO Regional Offices for Europe and the Western Pacific (2–3 May 2013), a further example of a WHO activity that contributes to this on-going support.

2. Progress in reporting on Code implementation in the regions

2.1 Designation of National Authorities and reporting

The Code mandated the WHO Secretariat to report periodically to the World Health Assembly on the progress in implementing the Code, on the progress in achieving its stated objectives, and to provide suggestions for improvement. Member States agreed to designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. This Designated National Authority (DNA) reports periodically to the WHO Secretariat on the measures taken, the results achieved, the difficulties encountered, the lessons learnt, and the information and data related to the international migration of health personnel. A key milestone for the Code will be the first report of the WHO Secretariat to the World Health Assembly in 2013 (WHO, 2013), and every three years thereafter. This report will provide a synthesis of the current status of the Code implementation by Member States and a global overview of international health workforce migration, human resources development and health systems strengthening.

In consultation with Member States, WHO established a national reporting instrument for countries and sent them reminders about establishing a DNA and submitting a national report. Considerable variations exist between the regions with respect to reporting on implementing the Code; the WHO European Region is the region in which most countries established a DNA and submitted a report (see Table 1).

Table 1. Status of designating national focal points and reporting in the WHO regions

WHO region	Member States in the region	Member States with critical health worker shortages	Designated national authorities established	Reports received
Africa	46	36	13	1
The Americas	35	5	11	4
South-East Asia	11	6	4	3
Europe	53	0	43	39
Eastern Mediterranean	22	7	8	3
Western Pacific	27	3	6	4
Total	193	57	85	54

In addition, the quality of the reports differ and range from simple reporting with limited information to detailed and in-depth reports from e.g. Finland, Germany, Norway, the Philippines and others (see Box 1).

Box 1. Content of the country reports on implementing the Code

Of the countries that submitted a report to WHO:

- 31 have statistical records on health workers whose initial qualification was obtained in a foreign country (Article 7);
- 31 reported that communication and information sharing took place across sectors on the Code, migration and recruitment (Article 9);
- 23 conduct research in the area of migration (Article 6);
- 11 have a database exists of laws and regulations related to international recruitment (Article 7); and
- 10 have a record of all recruiters authorized to operate in the country (Article 8).

In general, Member States provided limited and incomplete information and evidence to WHO. Therefore, a mismatch exists between reports received from Member States and the commitment to the Code that was unanimously adopted by 193 Member States on 21 May 2010.

2.2 Challenges in implementing the Code

In their national reports, DNAs state that one of the key challenges in implementing the Code is the engagement of multiple stakeholders involved in the decision-making process on health workforce migration and international recruitment. These stakeholders come from different levels in the health sector and from other sectors (education, finance, labour and foreign affairs) and have different interests in respect of the Code. In some countries, the Code was translated to facilitate information sharing within the countries, but for many other countries translation was not seen as a priority.

2.2.1 Leadership and the role and position of the DNA

One reason for this variation could be that there is limited political will at national level to meet the commitments made in the Code. In addition, not all DNAs have the expertise or qualifications in HRH necessary to fulfil their role and are able to set up a platform for cooperation, discussion and dialogue at national level. This variation may be due to a lack of resources available to DNAs and highlights the need to identify individuals who are best qualified and positioned to perform the DNA role. In addition, quite some time has passed between the original nomination of the DNAs and the reporting; in the meantime, a number of the originally nominated DNAs have changed. In some cases, individual follow-up by WHO at regional level has helped to identify a new DNA, but it has not been possible to assist all countries. It is also doubtful whether this follow-up and tracking mechanism is sustainable. It is also the case that strong regional leadership by the European Regional Office and other actors is not being matched by global-level action.

2.2.2 Availability of data

Another challenge noted in the country reports is the lack of coordinated and comprehensive data on health personnel mobility in order to inform policy choices. In addition, the institutional and ministerial capacity to deal with health workforce planning and mobility is often indicated to be weak, even in some countries in the WHO European Region. Countries are also facing difficulties in developing intercountry cooperative arrangements to exchange data and share good practices towards better manage health worker mobility. The focus on reporting may have overshadowed the need for action and innovative cooperation between sending and receiving countries.

During the meeting, several recommendations to improve the national reporting instrument on Code implementation were discussed (see Box 2).

Box 2. Proposals to improve the process and the tools of the national reporting instrument

The meeting participants agreed on recommendations to improve the national reporting instrument.

- Use the national reporting instrument as a tool to raise awareness and facilitate action at national level in order for the instrument to not only provide inputs on Code implementation, but also serve as an output of implementation of the Code.
- Ensure more in-depth information in the country reports, so that countries which invested resources in providing in-depth information for the reporting are not demotivated by the lack of relevant information from other countries.
- Include more open and less closed questions to allow for additional and more in-depth information.
- In addition to the inputs from the Ministry of Health, include inputs from other partners and stakeholders such as other ministries and, in particular, CSOs as the latter are often very involved in stimulating Code implementation.
- Provide feedback to the ministries of health regarding the completeness of their national report to incentivize adequate reporting.
- Introduce an online forum for countries to share evidence and best practices in a more interactive manner.

3. Challenges and benefits arising from international mobility of HRH

The Code aims both to mitigate the negative effects of health personnel migration and to maximize the positive effects on the health systems. Destination countries are encouraged to collaborate with source countries so that both can derive benefits from the international migration of health personnel. It is referred to as the principle of mutuality of benefits.

As was highlighted by multiple participants in their presentations and discussions during the policy dialogue, the international migration of health workers is a complex phenomenon for which multiple stakeholders are responsible in both source and destination countries. Stakeholders from different ministries, different sectors and different levels (local, national, regional and global) are holding diverging (and sometimes conflicting) perspectives, interests and rights. It was recognized that any attempt to manage migration and ensure mutuality of benefits is a challenging task. This challenge is compounded by the fact that the labour market dynamics that are an important driver of the international migration of health personnel vary by region, country and within countries, and change over time, making it hard to predict and manage the challenges and benefits arising from the international mobility of health workers.

3.1 The right to move versus the right to health

Health professionals are free to move to the places where they prefer to work, especially within regions that have agreements on the free movement of labour, as is the case within the European Union (EU), or between countries that have mutual recognition of qualifications such as ASEAN. However, for some countries or for some areas within a country, this freedom to move poses a direct threat to the right to health of the population.

There are multiple dynamics that can make health workers want to leave their posts to work in another country or in another region within the country. In countries with shortages of and relatively high salaries for health personnel, such as Finland, health professionals (especially doctors, but also nurses), to a large extent, can dictate their working conditions such as their interest to work only in the south of the country during winter or their willingness to work only in certain shifts. The differences in salaries for health workers are an important driver of the mobility of health personnel to higher-salary countries. Swedish doctors, for example, can work in Qatar, Saudi Arabia or the United Arab Emirates for a few months per year in order to receive high salaries and pay little or no taxes. Focus group discussions with health workers in Lithuania showed that health workers did not compare their salaries to those of health workers abroad, but to the salaries of other professionals in their country. For example, doctors, who used to earn salaries similar to those of lawyers, are now reported to be considering migrating to neighbouring countries in order to earn what they perceive as a fair salary. Other reasons for individual health workers to move abroad can be related to e.g. differences in working conditions, living conditions, access to training and career opportunities, the medical infrastructure and which services they are legally allowed to provide, or corruption in the health sector.

3.2 The health sector is an economic driver, as is migration

The health sector is a large provider of employment in countries, and migration of health workers in the global labour market is an important factor in ensuring the supply of labour to this sector. In addition to relieving unemployment, migration can provide benefits to the source country in terms of remittances and in terms of newly acquired skills and competencies by migrants who return to their country.

Health care provides employment for around 10% of the EU workforce. It is one of the most innovative sectors and could drive the creation of new jobs (European Health Forum Gastein, 2010). During the economic crisis of 2008/2009 and beyond, global employment levels in the health sector, unlike other sectors, have continued to increase in spite of some countries cutting their health budgets, closing down hospitals and reducing budgets available for HRH salaries in response to the crisis. Compared to the same period in 2008, employment in health services registered an overall increase of 2.3%.[1]

Migration can be an economic driver in the sense that unemployed health workers will move to try and gain employment in areas or countries where they are needed and where vacancies exist, making sure that the supply goes where there is a demand and making more optimal use of the skills available. This migration may prevent HRH from working in health sector jobs for which they are overqualified, or prevent skills being wasted due to HRH moving to non-health sectors within their countries.

Another benefit from the mobility of health personnel is that it can provide health professionals with the opportunity to upgrade their skills and competencies. Migrants can return to their source country with the skills acquired from working abroad. Finally, migrants working abroad can bring a substantial stream of revenues in the form of remittances to their source countries. For example, remittances from overseas Filipino workers provide about 10% of the Philippines' gross domestic product.

3.3 The dynamics of the health labour market cannot be left to market forces alone

The demand for additional health workers in most destination countries is likely to continue because of ageing of the domestic workforce and demographic-driven increase in demand. Governments need to intervene with the relevant push and pull factors by putting in place policies, regulations and incentives to ensure the right people are in the right place at the right time to ensure the right to health of the population.

[1] Based on the International Labour Organization short term indicators of labour markets, which are only available in some countries. The 2.3% increase in employment in the health sector is based on the data that was available from selected countries: Australia, Austria, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Chile, China (Macao Special Administrative Region and Taiwan), Colombia, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kazakhstan, Korea, Rep. of, Latvia, Lithuania, Luxembourg, Malta, Mauritius, the Netherlands, New Zealand, Norway, Peru, Poland, Portugal, Romania, the Russian Federation, Slovakia, Slovenia, South Africa, Spain, Sweden, Switzerland, Thailand, Turkey, the United Kingdom and the United States.

Government intervention is necessary due to three characteristics of the health labour market.

1. In the health labour market the real demand is the health needs of the population. This demand is not always equalled by the willingness or ability to pay at the level of the individual or at the level of the health system.
2. Even if the health system is able to provide a sufficient quantity of labour, it does not automatically imply that this labour is equitably distributed to match the health needs, or has the right skills-mix to address the health needs of different groups in the population.
3. Even if the right number of health care providers with the right skills is available at the right place, the health system has to be able to provide a supportive work environment including the availability of equipment and supplies in order to ensure the performance of HRH.

The European Commission projects the shortage of health professionals in the EU to be around 1 million by the year 2020 if nothing is done to adjust production and retention measures (European Health Forum Gastein, 2010), and this shortage is likely to reach 2 million if other employees in the health care sector are included. The EU projects that nurses will be number one on the list of occupations with job vacancies in Europe. The extent to which the EU and other high-income countries, such as the United States or the countries of the Cooperation Council for the Arab States of the Gulf,[2] will resort to international recruitment of personnel will depend on whether they share a language, culture, curriculum or a system of recognition of professional qualifications with other countries. The pull will be larger when these countries are geographically close or easy to travel to and from, already have a migrant community in the destination country, and have relatively easy entry into the destination country.

This mobility can be seen in the countries of the Commonwealth of Independent States (CIS).[3] Except for Belarus, the Russian Federation and Kazakhstan (since 2012), these countries do not share a common labour market. Yet, significant international mobility and recruitment of health professionals is taking place in this region, especially on a temporary basis, and with the Russian Federation as a major destination country in spite of the current economic crisis. The attractiveness of the Russian Federation depends not only on a strong demand for health personnel and higher salaries than in other CIS countries, but also on the absence of a linguistic barrier; the personal, social and cultural ties that remain between the CIS states and the Russian Federation; geographic proximity; and the automatic recognition of health worker diplomas obtained before 26 December 1991. Furthermore, people can often move between countries without a visa and there are other regulations that simplify access to the national labour markets in CIS countries.

3.4 Sustainable health systems as a first priority

Ideally, active international recruitment is a last resort for countries experiencing a problem with the supply of HRH. Options of a first resort are increasing the training, improving retention and productivity, improving the skills mix and flexibility (or effective use) of the health workforce at national level.

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[2] The Cooperation Council for the Arab States of the Gulf consists of Bahrain, Qatar, Kuwait, Oman, Saudi Arabia and the United Arab Emirates.

[3] The Commonwealth of Independent States was established in 1991 and includes Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

International mobility and recruitment are part of a bigger picture in which dynamics of the health labour market and other push, pull, and retain factors play a role in the decision of individual health workers on whether or not to migrate to work abroad. Managing migration is not a sustainable solution to a systematic disconnect between health workforce supply and demand. Countries should ask themselves: "What is causing this mobility of the health workforce and what can be done to retain health professionals in the health sector after graduation?"; "What kind of health system and health workforce do we want for the future?"; and "Do we really need doctors and nurses to provide services to the growing population with noncommunicable diseases, or can we think of alternative models in which support groups, volunteers or new cadres play a bigger role?" Examples of countries that are thinking of alternative care models are Finland (see Box 3), the Netherlands and Norway (see Box 4).

Box 3. International mobility and recruitment is part of a bigger picture: the example from Finland

Finland is experiencing the fastest ageing of its population in the EU and is ranked fourth on the list of countries in the world with rapidly ageing populations. In the coming years, about 50% of the country's workforce (including the health workforce) will retire. Aware of the future lack of skilled personnel, the health sector started to prepare for international recruitment of health personnel on a larger, more organized scale. The process involved meetings including the Ministry of Social Affairs and Health, the Ministry of Education, trade unions, organizations of employers, professional associations and the big municipalities. During the meetings, stakeholders discussed whether they really needed to recruit foreign health professionals, especially in the longer term. It was recognized that recruitment does not solve the underlying problem of structural and growing shortages in the current set-up of the health system. The stakeholders have now started preparing shorter and longer term proposals to reduce the shortage of health personnel in the country. These longer term proposals include changes in service delivery models for elderly care; changing the structure of the health workforce; focusing more on healthy lifestyles and prevention; and making use of unemployed people within the country such as immigrants. These policy options will be presented to the new government after the elections in 2015. However, policies, such as reducing the training of health assistants in elderly care from the original three years to one or two years, have caused a lot of unrest and opposition from e.g. professional associations. It requires a lot of political will and political entrepreneurship to prepare the health system and the health workforce for the future. Countries can make use of the current economic crisis and the need to reduce the health budget in realizing these structural changes in the health sector.

3.5 Rapidly changing health labour market dynamics: the need for intelligence

Due to limited availability of real-time data and forecasting methodologies, an over-reliance on point-in-time measurements to inform policies and strategies often exists in countries.

The dynamics of the health labour market change rapidly and are sensitive to changes in e.g. the economic and political context. The global economic crisis has impacted push factors and pull factors in both source

and destination countries. For example, within the EU the crisis changed mobility patterns, but has not constrained overall mobility of the health workforce. Migration outflows from countries, such as Bulgaria, Estonia, Hungary and Romania, have increased while migration trends in Ireland and Portugal reversed from recruitment of foreign health personnel to outflow of the health workforce. Other countries, such as Poland, see their migrant workforce returning.

At the same time, this crisis offers opportunities to change the provision of health services, for instance, by using the need for efficiencies to refocus care from tertiary and secondary level to primary level. This shift in turn changes the type of service providers needed in the future. For example, a shortage of 400 000 health workers in the Netherlands was predicted a few years ago, but since the government introduced policies to stimulate the production and employment of carers in long-term and elderly care, these projections are no longer accurate.

Many countries need to improve their capacity to collect, analyse and use accurate data to provide a political narrative that convinces policy-makers to undertake action. Only with accurate and real-time data and projections of future scenarios can governments ensure that scaling up training of health professionals will have the expected impact, and that future graduates will be able to find a job in their home country.

Australia, Finland, the Netherlands, New Zealand, Norway, the United Kingdom and the United States are examples of countries that have an information system in place that can provide these data and intelligence and produce forecasts. However, as in many countries, the information that is available often covers doctors and nurses (as these health professionals need to be registered), but not the lower level cadres. The EU project Joint Action on Health Workforce Planning and Forecasting has been set up to harmonize the language and methodologies used, to develop expertise and increase the number of countries within the EU that collect accurate data and undertake adequate planning of the health workforce.

3.6 Ethical recruitment

Ethical recruitment and effective integration of migrant health workers in the destination country are needed to ensure the safety and welfare of the migrant and quality of care provided by foreign-trained health workers.

A challenge related to the international recruitment of health workers is ensuring that migrants are not exploited or treated unfairly, especially when they are migrating undocumented. Ethical recruitment is important not only to ensure the rights and welfare of the migrant, but also to ensure that the recruitment, deployment and integration are effective, retaining them in the health system and maximizing their integration and productivity.

Integrating health workers – who have a different language, different culture, different training and come from a different health system – into the destination health system can also pose a challenge to the quality of care and safety of the patient in the destination country. To ensure the safety and welfare of the migrant and quality of care by foreign-trained health workers, four key dimensions to integrate foreign-trained health workers should be taken into account.

- Professional integration includes registration, accreditation, licensure, training and examinations for clinical and/or language skills.
- Integration in terms of immigration requirements relates to visa status (education) and the acquisition of residency and language skills.
- Integration at the workplace relates to an introduction or orientation to the new work environment, equal access to career development and other opportunities, and a workplace where the co-workers are prepared for the integration of a foreign-trained colleague.
- Integration of workers and their families is the need for personal support, an element which often receives the least attention but is most critical in ensuring that migrant health workers are productive because their broader needs are taken into account and they feel at home in the destination country. Examples of support are the ability to practice their religion; knowing how public and private services function such as housing, children's education, insurance schemes, health services, bank accounts and telephone contracts; and knowing where to obtain these services.

3.7 Engaging multiple stakeholders with varying perspectives and interests

The challenges and benefits related to the international mobility and recruitment of health personnel show that different rights, perspectives, values and interests need to be balanced. This balance requires participation of all stakeholders involved and political commitment and leadership.

As described previously, organizing this dialogue in itself and realizing agreements between stakeholders within the country poses a major challenge to DNAs in implementing the Code. The different stakeholder interests involved in the international mobility of health professionals poses a politically sensitive subject that can make it hard to engage politicians and to secure long-term political commitment. But in times of crisis, political and legal barriers often prove easier to overcome. In order to have political commitment at the highest level to address the issue of international mobility of the health workforce, a need exists in many countries to maintain the momentum through advocacy and awareness raising.

CSOs, the media, and the strategic use of data, evidence, forecasting models and scenarios can play an important role in changing the mindsets of politicians and in providing them with a rationale for action. The information provided to politicians needs to be simple and comprehensive, and focus on triggers that are within the political sphere in which the politician has influence and focuses on the shorter term. The media can also showcase malpractices to stimulate parliamentary questions and debate.

Another problem related to the Code is that ministries of health are not always able to perform the role of gatekeeper to implement its provisions. Active involvement is needed from the ministries of health, education, labour and foreign affairs and from grassroots professionals: employer's organizations, trade unions, professional organizations and recruitments agencies. This multistakeholder collaboration can be more difficult in a context where experiences with participatory processes and starting a dialogue between multiple stakeholders and helping them work together are relatively limited.

Box 4. Multisectoral discussions to address gender and the health workforce in Norway

Intense discussions in the Government of Norway preceded its decision to implement the WHO Code. Since then, stakeholder discussions took place in 2011 and 2012, and another one will take place in September 2013. The decreasing ratio of people who are active in the workforce versus people who depend on health services requires the building of domestic and municipal nursing capacities and discussions involving the question of how to make the training of HRH more aligned with the demands of the health labour market.

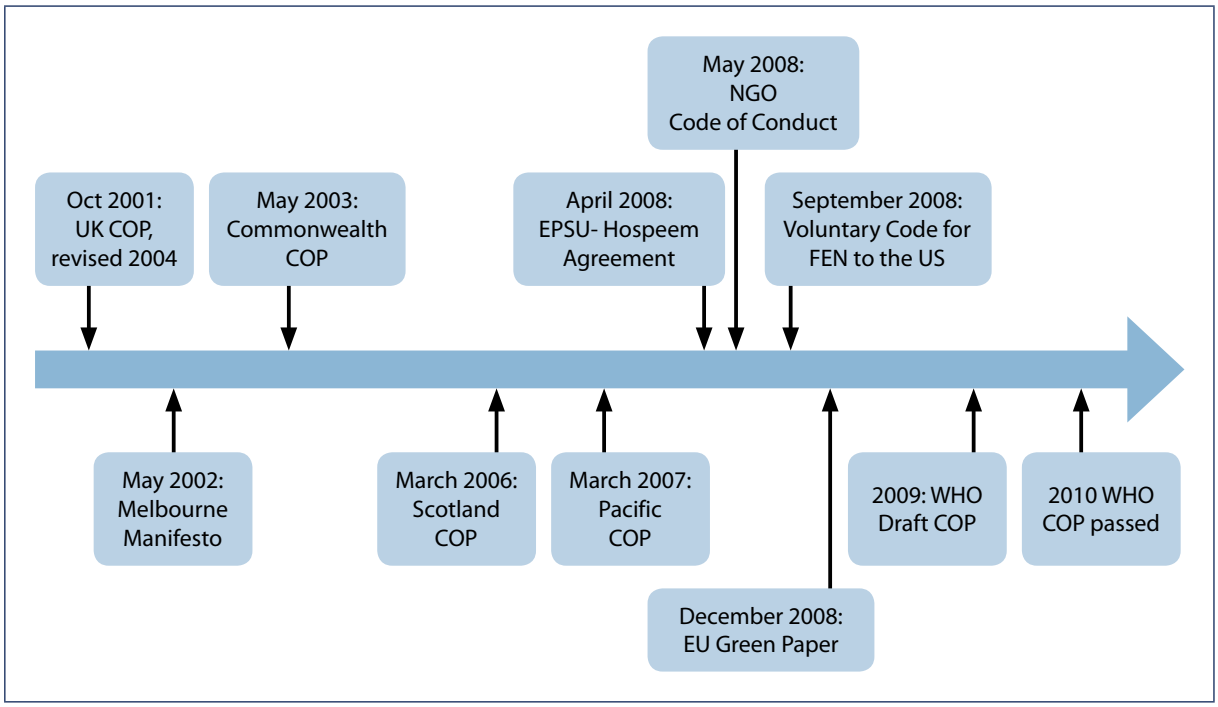
As in many countries, the health workforce in Norway is to a large extent made up of women, which is one of the factors behind part-time employment being as high as it is. For every nurse trained, 50% will be active due to part-time working. The Government of Norway has instructed hospitals to reduce the number of staff employed on a part-time basis, as some nurses wish to work full time. But it cannot force this shift to full-time work due to the agreements and provisions at municipal level. As a result, negotiations are now taking place between municipalities and hospitals to address the needs of female health workers. When 10% of the health workforce can get the full-time job they want, there will be a significant increase in the productivity of the health workforce.

4. Experiences in addressing these challenges

The Code emphasizes the importance of strengthening health systems and the health workforce of each country in order to tackle health workforce shortages and to ensure self-sustainability. The Code also highlights the need to address the challenges arising from the mobility of the health workforce, and proposes arrangements for cooperation between countries with regard to the international recruitment of health personnel. Such bilateral, regional and/or multilateral arrangements could include measures that allow source countries to benefit from international recruitment, for example, through support for training, access to specialized training, technology and skills transfer and the support of return migration, whether temporary or permanent. In the same vein, the Code encourages the circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.

Globally, many activities have been implemented in compliance with the Code. Ethical recruitment standards and codes of practice are gaining momentum and new BLAs are still being developed. At national level, innovations are taking place in strengthening the health workforce and the health system towards self-sustainability in both source and destination countries. Some examples outside the European and the Western Pacific Regions are Ethiopia's health extension programme and Rwanda's national health workforce plan. In destination countries, development assistance to health workforce strengthening and to the production of new health workers is on the agenda. Fig. 1 provides an overview of codes of practice (COPs) developed in the last decade to address the international mobility of health personnel.

Fig. 1. Codes of practice to address health workforce mobility



4.1 Bilateral agreements

The WHO Code of Practice Article 5.2 states:

> Member States should use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. Such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures.

BLAs are often agreed between neighbouring countries and/or between countries with different income levels, between which a flow of health workers exists. The aim is to work together in a more effective way to manage the flow of health personnel between their countries. BLAs can take many forms, varying from a one-page memorandum of understanding (MOU) to a legal document. They can also serve varying interests or objectives to manage migration, from limiting the number of health personnel that can be recruited from a country to protecting the rights of migrants to facilitating migration of health personnel between the countries. Codes can be developed specifically for the health workforce, or can address the health workforce as part of broader agreements on the migration of labour between countries.

Examples of early BLAs are the agreement between the United Kingdom and South Africa; the MOU between the Philippines and the United Arab Emirates; the MOU between Namibia and Kenya; and the France and Senegal "Accord on Concerted Management of Migratory Flows". The early, 20th century agreements tended to be developed largely in a unilateral way and to serve mainly the objectives of the destination country in addressing labour shortages, protecting post-colonial relations or facilitating broader economic integration. Objectives for the source countries are to ensure better living and working conditions for migrant workers, promote advancement of skills of their health workers or relieve unemployment in their country. Examples are the BLAs between the Philippines and the United Arab Emirates or the BLA between the Philippines and Saskatchewan, Canada.

The 21st century BLAs tend to be developed with more collaboration between the source and destination countries. The objectives are focused towards facilitating labour mobility and the social protection of migrants and take a broader view of migration and its benefits for development. Challenges related to "brain drain" are addressed more explicitly and incorporates the shared responsibility of source and destination country, as well as of migrant workers to maximize benefits and mitigate harm of migration. Examples are the agreements between France and Senegal, between France and Benin, between Spain and Morocco/West Africa, and between the Philippines and Bahrain.

Examples of innovative practices that can be found in these BLAs are:

- promotion of joint ventures and investment in health facilities, such as training hospitals and research institutions (Philippines and Bahrain);
- support for improved education and training for young people through contributions/donations from companies that employ workers under the MOU (Philippines and Saskatchewan);
- collaborative study of projects to support human resource development (Philippines and Manitoba, Canada);
- facilitated admission to health-related courses at academic institutions (Namibia and Kenya); and
- greater use of specialized training institutions (Sudan and Saudi Arabia).

Based on a review of the various BLAs, the Health Worker Migration Policy Advisory Council developed two models of BLAs with the aim of clarifying the potential form and content that a BLA could take in comprehensively addressing the challenge of mobility and international recruitment of the health workforce, and to serve as a guide for those countries, particularly developing ones, interested in developing BLAs.

Lord Nigel Crisp, Health Worker Migration Global Policy Advisory Council Member, Former Director of the United Kingdom National Health Service, says, "We have a vision of a world abundant in opportunities to work and train abroad, rich in the exchange of ideas and expertise in the pursuit to further global health, and where every country also has a safe minimum number of trained health workers."

4.1.1 The Philippines

In 2011, an estimated 10.5 million Filipinos were working overseas, of which over 40% were working on temporary contracts mainly in Saudi Arabia, United Arab Emirates, Singapore, Hong Kong and Qatar. Between 2008 and 2012 annually, 17 000 to 22 000 health professionals, mainly nurses, left the country to work abroad (according to Philippine Overseas Employment Administration).

The Philippine Government actively pursues bilateral, regional and multilateral agreements, arrangements and dialogue in order to protect the overseas Filipino workers before, during and after employment until their reintegration in the Philippines. In the experience of the Philippines it is not always possible to forge BLAs with destination countries. In that case alternative options, such as technical committees and liaising with foreign embassies, are used to manage migration as well as possible. Another problem is that BLAs are not always monitored, well implemented or respected. An example of a BLA that has been proactively implemented is the agreement between the Philippines and the western provinces of Canada (Alberta, British Columbia, Manitoba and Saskatchewan).

Even though the Philippine Government plays an active role in managing migration, overseas Filipino workers still encounter problems when they migrate, e.g. in relation to recruitment malpractices (such as overcharging of recruitment fees or illegal recruitment), to employment (such as violations of the contract, confiscation of passports or travel documents, or when a migrant worker violates the laws and regulations of the destination country) and with regard to professional skills (such as a mismatch between the skills of the migrant and the skills needed for the job).

Lessons learnt from the Philippine experiences are that more attention should be paid to the formulation of implementing guidelines and regular reviews of agreements (e.g. through the establishment of review committees). In addition, BLAs could include more provisions to ensure that the Philippines benefit from international recruitment of the health workforce through enhanced human resource development (e.g. through support or access to training, the transfer of skills and support of return migration).

4.1.2 The Republic of Moldova

After the economic crisis in the mid-1990s, the Republic of Moldova experienced a massive outflow of the labour force. A decade later, the social and political stability in the country were restored, but the labour force continues to struggle as working-age people leave the country due to discrepancies in living

standards between the Republic of Moldova and its surrounding countries. In response, the country entered into negotiations of BLAs with several countries, e.g. Hungary, Italy, and Poland.

Under "agreements of social protection of migrants", the Republic of Moldova and the destination country ensure that migrant workers are treated equally and enjoy the same social rights and obligations as national residents. The agreement guarantees that social insurance contributions of migrant workers and their families are being paid in the destination country and enhances the transferability of social benefits between countries.

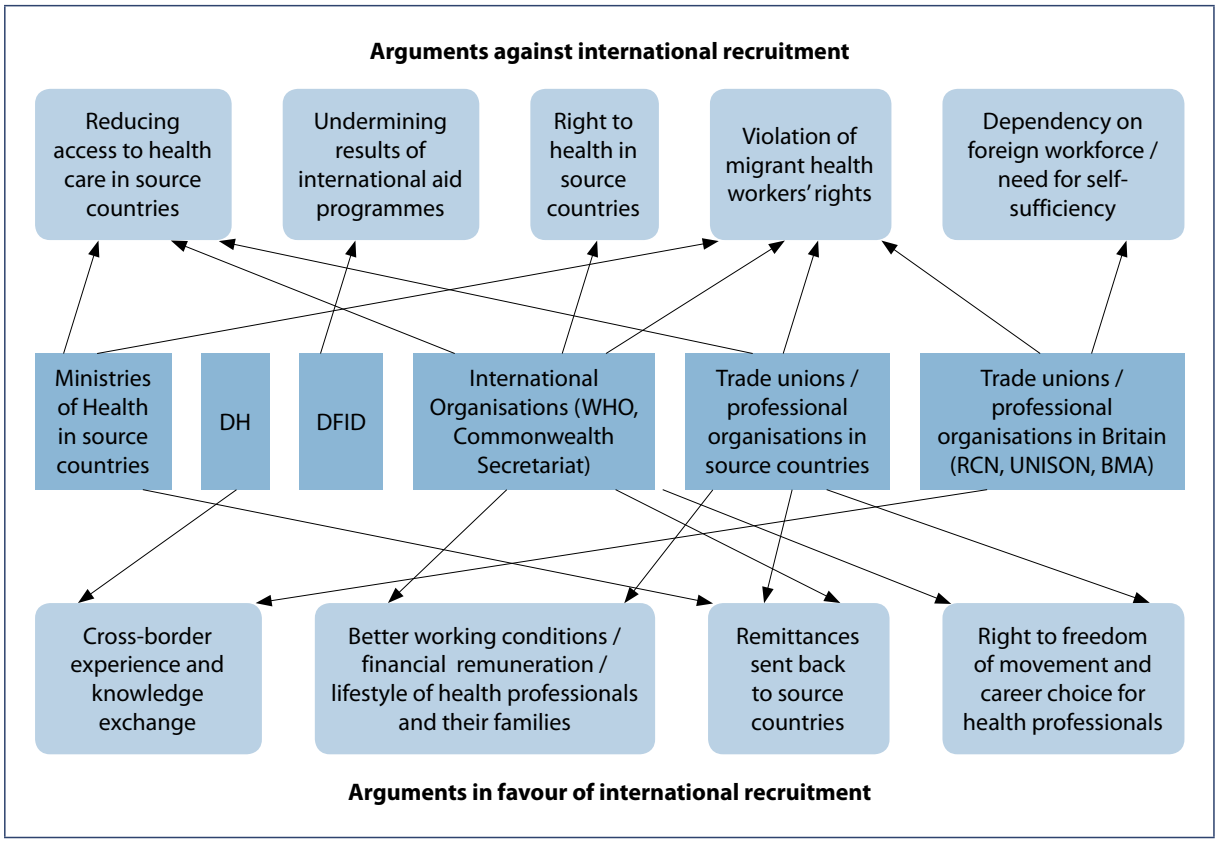
Under "agreements on labour migration", the Republic of Moldova and the destination countries agree on arrangements to ensure the equal treatment of migrant workers at the workplace; the right of migrant workers to be a member of trade unions or associations; the exchange of migration data that is of mutual interest; pre-selection and pre-departure courses related to the language, culture, development of competencies and professional skills; arrangements for circular migration and the facilitation of reintegration of migrants. However, this development is relatively new and limited implementation experiences have provided few lessons learnt.

The experiences of the Republic of Moldova showed that migration is a sensitive issue, that citizens need to be convinced of its benefits and that ensuring internal political support for migration is hard. In addition, collaboration from destination countries is not always easy to get. The presence of an international framework can facilitate the negotiation process and it is important to evaluate the effect of the BLA on the target beneficiaries.

4.1.3 The United Kingdom

As a recipient country, the United Kingdom also has experience negotiating BLAs, starting in the early 2000s with BLAs with China, France, Germany, India, Indonesia, Italy, the Philippines, South Africa and Spain. The reason that these BLAs came into existence was that the United Kingdom decided to expand the National Health Service in the late 1990s. In order to ensure the supply of the newly needed doctors and nurses, the country invested in national training and used active international recruitment as a way to rapidly scale up the workforce. After criticism from national stakeholders in source countries, notably South Africa, the United Kingdom entered into negotiating BLAs with source countries of health professionals and developed a national code on international recruitment. The implementation of the BLAs with India, the Philippines, South Africa and Spain was most visible. These BLAs covered mainly nurses, although some were later extended to cover doctors as well. Fig. 2 shows an overview of the stakeholders in the United Kingdom and their arguments against or in favour of international recruitment.

Fig. 2: Stakeholders in the United Kingdom and their arguments against or in favour of international recruitment



The experiences showed that it is difficult to monitor and regulate the practices of private health providers and private recruitment agencies. The competitiveness of public health care providers can be hampered, when the recruitment practices of only the public sector are regulated. In addition, BLAs have implications in terms of time, manpower and the administrative burden at the level of the national authorities, which may limit their interest to enter into these agreements.

4.1.4 Lessons learnt

The examples from the Philippines, the Republic of Moldova and the United Kingdom show that BLAs can have some or all of the following functions:

- a measure to respond to criticisms of recruitment practices from within or outside of the country;
- a diplomatic instrument to promote peace, stability, security and good international relations;
- a framework for communication and collaboration;
- the ability to provide a constructive and mutually beneficial framework maximizing benefits and minimizing costs of migration which can:
  - restrict active recruitment (e.g. United Kingdom–South Africa and United Kingdom–some regions in India);
  - facilitate entry and employment access of qualified workers (e.g. United Kingdom–Spain and United Kingdom–Philippines);
  - increase legal migration and employment;

- promote ethical recruitment practices by employers and recruitment agencies, prevent illegal exactions and exorbitant fees from the workers and minimize illegal recruitment and trafficking;
- ensure pre-selection and pre-departure courses related to the language, culture, development of competencies and professional skills;
- ensure greater compliance to terms and conditions of employment;
- ensure equal treatment of migrant workers at the workplace;
- ensure the right of migrant workers to be a member of trade unions or associations;
- ensure fair and speedy settlement of employment disputes;
- enhance social protection and the transferability of social benefits between countries;
- ensure arrangements for circular migration and the facilitation of reintegration upon return; and
- ensure the exchange of data on migration that is of mutual interest.

However, these countries encountered several challenges related to negotiating and implementing BLAs. First, the destination country is not always willing to enter into an agreement with a source country. Second, fully implementing and monitoring a BLA may present significant challenges. The compliance of the private sector with BLAs is a challenge as recruitment often still takes place via other channels such as the private sector or other legal or illegal pathways. This lack of compliance to the BLA limits its scope and impact. One important factor is determining if the BLA is the only "legal" route for recruitment, or if it just one of several routes. Currently, there is a lack of evidence on the impact and sustainability of BLAs, which makes it hard to determine whether the required investments in time and human resources, and the administrative burden resulting from a BLA are compensated for by the outcomes.

4.2 Recognition of qualifications

A major motivation for health workers to migrate and one that helps their effective integration into a destination country's health system is that their professional qualifications are recognized by the destination country.

4.2.1 The EU

Based on the 1989 EU Directive on a general system for the recognition of higher-education diplomas (which was supplemented in 1992), the EU Directive on recognition of professional qualifications was developed in 2005, came into force in 2007 and has been amended several times. The Directive covers 800 recognized professions, including 7 health professions. Sixty per cent of all requests for recognition of qualifications come from health professionals. The professional qualifications of doctors, nurses, midwives, dentists and pharmacists are automatically recognized within the EU, due to the establishment of EU minimum training requirements.

Currently, the EU is reviewing the need to update these minimum training requirements. It is also reviewing the possibility to enhance patient safety by improving information sharing between countries

and authorities within the EU on health professionals facing professional or criminal charges in the country where they work.

Applications take place with the regulatory authority in the destination country. In spite of the Directive, this process remains long and poses a large administrative burden on potential migrant health professionals. Some countries are still posing barriers to the inflow of foreign-trained health professionals, for example, by requiring language skills tests before issuing a permit. Recognition within the EU is based on professional skills and not on language skills. Countries should be able to require language tests, but only after qualifications are recognized and there is considerable doubt with regard to language fluency.

It is harder for health workers from third countries to obtain recognition of their professional qualifications. The respective EU Member State can recognize qualifications on a case-by-case basis. Only after three years of professional experience in an EU Member State are professionals from third countries allowed to provide services within other EU Member States.

4.2.2 ASEAN

ASEAN[4] has developed the Asian Framework Agreement with the objective to facilitate the movement of professionals and skilled labour within the ASEAN Member States in order to improve the efficiency and competitiveness, capacity and supply, and distribution of services within and outside ASEAN.

As part of this framework, countries have established a mutual recognition agreement that applies to medical practitioners (doctors, nurses and dentists) and specialists, with the objective to facilitate mobility of medical practitioners within ASEAN; exchange information and enhance cooperation in respect of mutual recognition of medical practitioners; promote adoption of best practices on standards and qualifications; and to provide opportunities for capacity building and training of medical practitioners.

Foreign medical professionals may apply for recognition in the destination country. Their qualifications are recognized and validated when they have been active in their profession in their home country for at least five continuous years, have complied with the requirements for continuous professional development and have not violated any professional or ethical standards.

The mutual recognition agreement, however, does not reduce, eliminate or modify the rights, power and authority of each ASEAN Member State. It is the right of the national professional medical regulatory authorities to regulate the qualifications, impose additional requirements or assessments, monitor and assess compliance, and take necessary actions if compliance has not been met. Adoption, implementation, exchange of information, and review of the agreement on mutual recognition (every five years) are being discussed within the ASEAN Joint Coordinating Committee on Medical Practitioners. Every profession (doctors, nurses and dentists) has its own committee, which convenes on a regular basis.

Through these committees, countries agree upon and discuss the national roadmaps to implement the agreement, learn about and understand each country's needs and requirements, and exchange information on regulatory practices within the countries. Future plans include the exchange of information on assessing medical, dental and nursing schools, and on specialist training.

[4] The countries involved are Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam.

4.2.3 Lessons learnt

The experiences from the EU and the ASEAN show that mutual recognition of professional qualifications can lead to better and more efficient regulation of health professionals practicing in the destination country. It also facilitates the mobility of health professionals between countries. However, it requires a lot of exchange and cooperation between countries before automatic recognition of professional qualifications is truly implemented. So far, limited information is available with regard to implementation experiences.

4.3 Circular migration

Many ideas, but no single definition, exist on the concept of circular migration. Two examples of definitions are:

- " … a form of migration that is managed in a way allowing some degree of legal mobility back and forth between two countries…" (European Commission, 2007); and
- " ... temporary movements of a repetitive character either formally or informally across borders, usually for work, involving the same migrants. ... it can be distinguished from permanent migration (for settlement), and return migration (one trip migration and return), ... " (Wickramasekara, 2011).

According to the WHO Code of Practice Article 3.8, "Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries."

The definitions show that circular migration can be difficult to distinguish from temporary migration. Stakeholders who are in favour of circular migration view this form of migration as a "triple-win" for destination countries (which receive a steady supply of skilled or unskilled occupation labour without integration costs, given the temporary stays of circular migrants), for source countries (which benefit from the inflow of remittances and enhanced skills upon return), and for the individual migrants (for which the expansion of circular migration programmes increases the opportunities for safer, legal migration and an easier return to a workplace and family in the home country).

Counterarguments are that circular migration can be a way to reduce the social and political costs of migration, restrict worker rights and entitlements (such as pension benefits and health insurance), and that, in reality, the costs of the re-migration process are not likely to be fully recovered by migrants. Other risks could be that the short duration of contracts affects migrants' capacity to contribute back home and the potential for unethical recruitment practices. The fact that the employer can decide who can return from a renewed contract weakens the power of employees.

Overall, there is a lack of examples and evidence on the impact of circular migration of health professionals, which makes an assessment of the balance of costs and benefits of this type of model very difficult to undertake.

One example is derived from focus group discussions with doctors and nurses from the Republic of Moldova working in Romania under the BLA between the two countries. Discussions showed that many

of the 650 Moldovan doctors registered with the College of Physicians in Romania would like to build an association of Moldovan doctors in Romania that communicates and collaborates with the Government of the Republic of Moldova. These health professionals indicated their willingness to provide temporarily services across the border in the Republic of Moldova, as is the case with health professionals from Bulgaria and Hungary that work in Romania. Conditions can be established to facilitate these health professionals in rendering services in their home country on the basis of circular migration schemes. An example of a current barrier for circular migration or reintegration in the Republic of Moldova is that the Republic of Moldova does not recognize specialist qualifications received in Romania by Moldovan medical doctors.

The Republic of Moldova aims to facilitate reintegration of health professionals in the national health system once they decide to return to their home country, but no real experiences are available to date. As the country is still struggling with the impacts of economic reforms, it is not in the position to actively call on migrants to return (which is being done by the Government of Malaysia). The Republic of Moldova is working with those migrants who want to return home by listening to their needs and those of their families. An example is that health professionals who have successfully reintegrated in the Moldovan health system can serve as an example for other migrant health workers to return.

In spite of the interest in the concept of circular migration, the limited reported experiences with this form of migration make it hard to establish an evidence base on its implementation and outcomes.

4.4 Engaging with multiple stakeholders with varying perspectives and interests

A major challenge in implementing the Code is the engagement of multiple stakeholders involved in the decision-making process on health workforce migration and international recruitment. The Philippines developed its own national reporting mechanism for the implementation of the Code, which was used to raise awareness among stakeholders and to bring all stakeholders in the country together for a dialogue on the international mobility of health personnel. The HRH Network in the Philippines brought together various members of the government involved in HRH: trade unions, recruitment agencies, national and local public hospitals, private hospitals and professional associations.

The different sectors had different perspectives on the challenges of international mobility of the health workforce. The health sector was concerned with the disruption of service delivery, retention and social protection. The labour sector was concerned with unemployment and fair labour practices. The Ministry of Finance and Economics was concerned with the inflow of remittances due to overseas workers. Representatives from academia and professionals were concerned with regulations, international standards and recognition of competencies. Others were concerned with migration and labour policies, etc.

4.5 Engaging with the private sector

The policy dialogue in the Philippines showed that it was possible to merge the perspectives of various stakeholders and to reorient them towards common positions related to the provisions of the Code. Private recruitment agencies within the country are also looking to collaborate.

Collaboration is important, as there is a need to regulate private sector recruitment to make sure that recruitment agencies adhere to the principles of the Code and apply ethical standards. In the Philippines, an important contextual factor could be that international mobility and international recruitment of health workers generate a lot of work and that the recruitment agencies are very active.

Currently, the Dutch CSO Wemos Foundation is implementing a three-year project in eight EU countries on facilitating the implementation of the Code, in collaboration with other national CSOs. Experiences with the process in the Netherlands showed that the contact and exchange with recruitment agencies were not hard to establish, but ensuring their engagement and undertaking joint action proved more difficult and took time, as this is not the primary mandate of private recruitment agencies. Contacts were sometimes lost and the involvement of recruiters seemed to follow the influx of foreign health workers in the Netherlands. Recruitment agencies seemed more active and more willing to cooperate when recruitment was high.

During the WHO policy dialogue in Amsterdam, a Dutch recruitment agency provided an example of a recruitment company that had never heard of the Code. In order to establish ethical and effective recruitment practices, they considered their own experiences with the international recruitment of health personnel: what went wrong and what went well? They established a training and integration program to ensure effective recruitment practices in which every aspect of the recruitment, employment and integration process are based on their best practices.

In 2008, the Dutch association of health care organizations (*Brancheorganisaties Zorg*) established a voluntary Quality Mark for Foreign Workers Recruitment Agencies (*Keurmerk Bemiddelingsbureaus Buitenlandse Werknemers*). This Quality Mark only applies to Dutch recruitment agencies and, therefore, does not cover foreign recruitment agencies hired by Dutch health care providers to recruit health personnel from other countries. So far, the Quality Mark has not yet been requested by Dutch agencies.

The European Hospital and Healthcare Employers' Association (HOSPEEM), coordinates the views and actions of national employer associations operating in the hospital and health care sector. In 2008, HOSPEEM and the European Federation of Public Service Unions (EPSU) signed a code of conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector to be followed up and implemented by HOSPEEM and EPSU members within next three years.

Specialized health professionals represent a significant value to employers in the health sector. In the Netherlands, the Ministry of Health annually allocates € 1 billion for hospitals to provide specialist training to post-graduate medical doctors. Specialist training on average takes 6 years at a cost of about € 150 000 per trainee per year. Nursing specialist training, e.g. for nurses who are going to work in intensive care units or the operating theatre, have an average duration of 2 years at a cost of € 30 000 per trainee per year.

In order to make optimal use of these resources, the EPSU-HOSPEEM code of conduct adheres to principles of registration and data collection; workforce planning; equal access to training and career development; open and transparent information about hospital vacancies across the EU; fair and transparent contracting; registration, permits and recognition of qualifications; proper induction, housing and standards of living; equal rights and non-discrimination; promoting ethical recruitment practices and freedom of association.

In 2012, a joint evaluation report on the use of this instrument was developed by the social partners in the 27 member countries of the EU. The following success factors were found for dissemination and implementation of the EPSU-HOSPEEM code of conduct: translation; joint steering committees; seminars or meetings with members of trade unions and employers organizations, public authorities at national and local level; and information on the Internet, a user guide and other forms of assistance. One of the challenges in implementing the EPSU-HOSPEEM code of conduct was that the agenda of the social partners often addresses multiple sectors and issues, which can influence the discussions on this code.

Working with employers and managers of the health workforce is important, especially within the EU where the government has no role in providing work permits and where registration and licensing is done by professional associations. The professional associations play an important role in the mobility and recruitment of the health workforce and help provide accurate and up-to-date data on the health workforce and the labour market.

One of the twelve principles of the EPSU-HOSPEEM code of conduct is freedom of association. Once a migrant worker starts working in the destination country, professional associations can play a role in protecting migrant workers from discrimination in pay or working below levels of qualification and in supporting them to achieve equal opportunities to ensure that migrants contribute to the provision of quality health care in the country. This mechanism to enhance ethical recruitment and effective integration needs to be explored further.

4.6 Integration

The recruitment process can be ethical (by respecting the rights and ensuring the welfare of the migrant) and effective (by ensuring that maximum use is made of the labour provided by the migrant in the destination country). In order to be ethical and effective, the integration of migrant health workers needs to be facilitated in the destination country in terms of legal status, professional skills, qualifications, regulations, workplace environment, colleagues, personal and family life. Integration is not achieved once migrant workers have arrived in the country, but once they feel comfortable and at home in the new country and at the new workplace.

However, this ethical and effective integration can be hampered by the often long and complex process of recruitment, employment and integration that involves many steps and multiple responsible agencies and authorities. Table 2 shows an example of the steps a nurse from the Philippines or from an EU country takes before receiving a visa and being registered as a nurse in the United Kingdom (legal and professional integration). Foreign health workers can encounter many difficulties in navigating through different authorities, registers and agencies for these services and can easily get lost within the various systems.

Table 2. Steps in the legal and professional integration in the United Kingdom of nurses from the Philippines or an EU country

Steps in the international recruitment process for legal and professional integration	Philippines	EU
1. National Health System Trust appoints recruitment agency; country selected	•	•
2. Agency advertises or uses networks to generate interest	•	•
3. Selection process agreed by Trust/agency	•	•
4. Trust (and agency staff) interview in country	•	•
5. Trust selects nurses	•	•
6. Agency gives names to the United Kingdom Nurses and Midwives Council (NMC)	•	•
7. NMC sends applicant packs to the nurses	•	•
8. Nurses send completed packs back to agency	•	•
9. Professions Regulating Commission (Philippines) sends verification of qualifications to the agency	•	
10. Agency sends completed pack to NMC	•	•
11. NMC issues letter detailing period of adaptation (if required) or that application is accepted/declined	•	•
12. Agency sends NMC letter/information to United Kingdom immigration	•	
13. United Kingdom immigration reviews application and may issue a permit	•	
14. Permit sent to the recruitment agency	•	
15. Agency sends permit to British Embassy in country	•	
16. British Embassy verifies identity of nurse	•	
17. British Embassy issues visa	•	
18. Philippines Overseas Employment Administration issues final clearance and exit visa	•	
19. Agency books flight	•	•

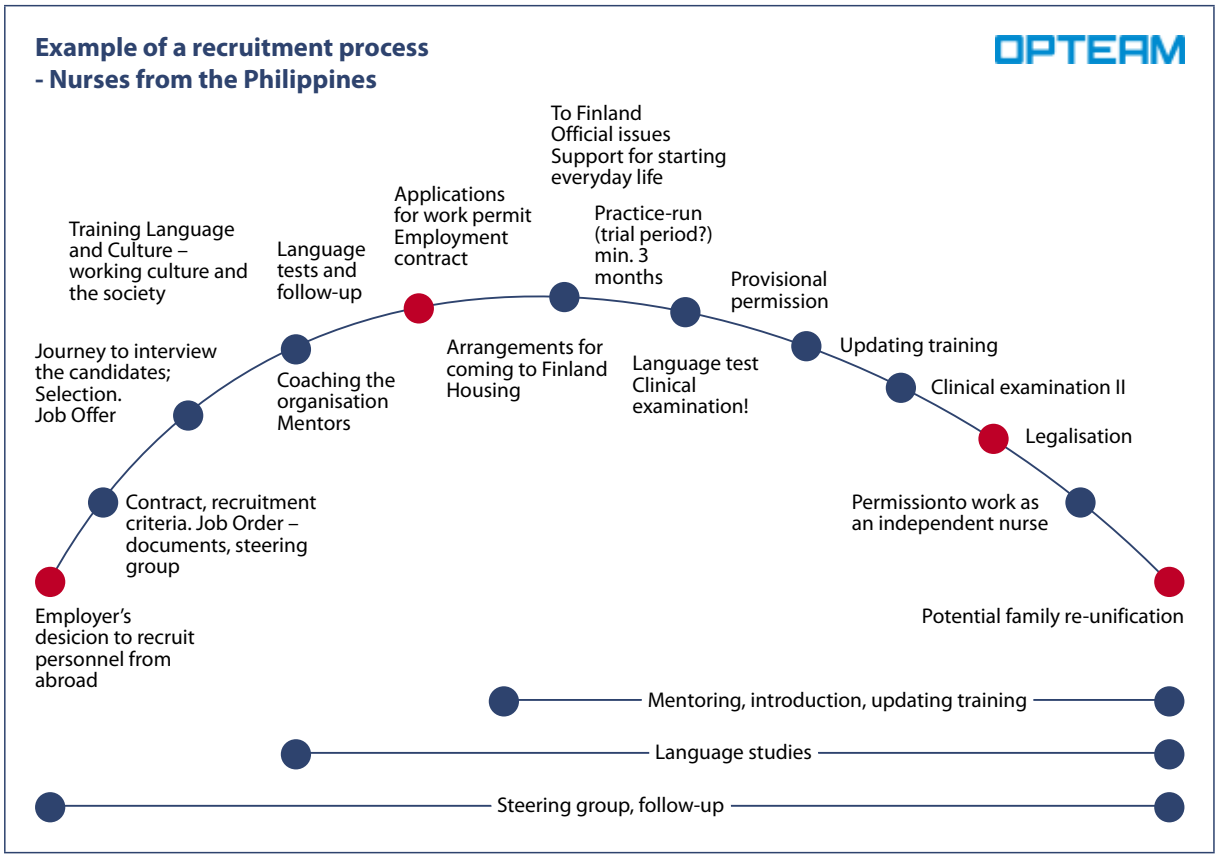
Table 2. (contd)

Steps in the international recruitment process for legal and professional integration	Philippines	EU
20. Nurses arrive in the United Kingdom	•	•
21. Nurses undertake NMC specified period of adaptation/Overseas Nurses Programme	•	
22. Nurses admitted to NMC register	•	•

The fact that this process can take up to a year can make a health professional decide to migrate through non-formal channels, which is the fastest route with the least steps. Furthermore, without a well-organized integration trajectory, it may be easy to recruit foreign health personnel, but not to retain them.

In Finland, the recruitment agency OPTEAM reconstructed the steps that a nurse from the Philippines has to take to integrate into a country, taking into account workplace and personal integration (see Fig. 3). The Dutch recruitment agency T&S Care presented a similar process with substantial attention paid to professional, workplace and personal integration, which showed the important gatekeeper role of employers and recruiters in ensuring ethical and effective integration of health professionals in the destination country.

Fig. 3. Steps in the legal, professional, workplace and personal integration of a nurse from the Philippines in Finland



In order to facilitate this integration process, the United States has established voluntary pre-screening programmes in source countries to screen health personnel willing to migrate on their eligibility to migrate to the United States. The screening decreases the number of unnecessary applications. Norway is piloting a program in India and the Russian Federation which provides information to potential migrants at the Norwegian embassies. In the United Kingdom, there is a one-point entry national registration process for health professionals, and Australia has recently moved from a registration process involving multiple states to one involving a single national authority.

5. Conclusions

The participants at the WHO policy dialogue on international health workforce mobility and recruitment challenges came from both source and destination countries, national and regional levels, multiple ministries, CSOs, health employers' organizations, recruitment agencies, research communities and knowledge institutes. During the meeting, it was reinforced that the health workforce is complex, but dynamic. The economic crisis has changed the dynamic, but not the underlying demographic trends for HRH. The participants recognized that the Code in itself is necessary but not sufficient in influencing, creating, and testing policies to create a sustainable health workforce. The Code will be effective when used as part of multistakeholder action, rather than as an administrative tool for which the reporting process is the end result.

The main HRH challenges in all countries are the recruitment, retention, skill mix and productivity of the health workforce. Limitations in the availability of data on HRH will remain, but are not a reason for inaction. WHO recommends using the available data in the best way possible to forecast future scenarios and to influence and engage the multiple stakeholders that are needed for action, while recognizing that data is not evidence and that evidence is not strategic intelligence. The available good and promising practices with regard to BLAs, integration of health professionals in the destination country, mutual recognition of qualifications, circular migration and engagement of multiple stakeholders can be used as a call to action.

Five key messages were highlighted during the policy dialogue on implementing the Code.

5.1 Enhance advocacy efforts to maintain the momentum and raise awareness of the Code

There is a continued need to raise awareness about the Code. The target audience for this effort at the international level is intended to go beyond the health sector to include other United Nations agencies and high-level political forums such as the G8, the G20 and the World Economic Forum. There is a role for WHO in building alliances with these high-level decision-making groups and their representatives.

Many employers and recruiters, who are major stakeholders in the ethical and effective recruitment of international health personnel, are hardly aware of the WHO Code. Designated national authorities can play a key role in raising awareness and engaging in a dialogue with these stakeholders. These communication efforts can be supported by translating and disseminating the Code.

It is important to prioritize work on HRH in WHO as the health workforce is a crucial part of the health systems strengthening and universal health coverage agendas. Member States can play an important role in ensuring that HRH is given high priority on the WHO agenda. The current consultations with WHO Member States could help to ensure that strengthening the health workforce and health systems will be part of a focused set of key priorities on the WHO agenda in the coming years.

5.2 Foster dialogue and build cooperation with stakeholders

A critical component in supporting implementation of the Code is effective country-level awareness raising and dialogue. This communication can be achieved through multistakeholder country-level dialogues with the aim of exchanging perspectives, values and objectives related to the international mobility and recruitment of health professionals. Such stakeholders would include: various ministries; bilateral partner countries; social partners; trade unions; employer organizations; professional associations; and recruitment agencies from both the public and the private sector. It is important that these stakeholders understand that the Code can serve their interests. The national reporting instrument developed by WHO can be used as a focal point for these meetings, as can the communication tool on macroeconomics and fiscal space which WHO is developing to support mutual understanding between ministries of health and finance.

Existing platforms can also be utilized. Examples in the WHO European Region include the South-eastern Europe Health Network, in which high-level representative of the various ministries of health are involved, and the EU Joint Action on Health Workforce Planning and Forecasting, which already brings many of the stakeholders together. The experiences and forums of the Wemos Foundation (Netherlands) programme on implementation of the Code in multiple EU countries can also provide an entry point.

The overall objective is to engage various stakeholders in the health sector and beyond (education, finance, labour and foreign affairs), who have different interests and objectives, in agreeing and implementing a unique core set of principles.

5.3 Identify good practices and expand the evidence base

There is a need for expanding the evidence base. It was recognized that WHO can play a role in collecting, synthesizing and promoting examples of Code implementation and lessons learnt such as via the WHO web site or other online forums. Member States have the responsibility to provide examples, information and data to WHO so that WHO can perform this dissemination function more effectively.

There is scope to build on the lessons learnt from current initiatives such as the International Labour Organization study on bilateral agreements involving the Philippines, and the assessment of the agreement between Japan and the Philippines by the Japan International Cooperation Agency. These studies could provide the basis for developing a methodology or framework to assess the implementation and impact of efforts to manage migration: to answer the questions of what worked, what did not work, what are the results, for whom and why? Given the limits on available resources to support research and evidence generation, countries should consider maximizing the possibilities of using schools of public health and academic researchers at this stage. The intention is that research questions related to the strengthening of the health workforce will be on the agenda of these institutions. HRH is not a discipline, but rather entails multiple disciplines including economics, migration, sociology and psychology. It would be wise to combine these areas of expertise to develop further the discourse on the health workforce and share knowledge with others who are conducting research on HRH. This dialogue and knowledge sharing can be done through workshops and courses in which multiple disciplines and stakeholders

contribute to develop the capacities of researchers and policy-makers in the field of HRH. National, subregional and regional HRH observatories and WHO collaborating centres can also play an important role in strengthening capacities and sharing information.

5.4 Assess and report on changing trends in the health labour market

Existing HRH observatories, WHO collaborating centres, the EU and the Joint Action on Health Workforce Planning and Forecasting, the Association of Southeast Asian Nations and the Organisation for Economic Co-operation and Development provide for well-connected networks to collect, analyse, and present data and projections on the quickly changing trends in the health labour market. This information should be made available and used to strengthen knowledge base, perceptions, capacities and technical know-how of decision-makers in the areas of health workforce and the relation of HRH with the macro-economic context.

5.5 Make use of the need for reform to sustainably strengthen the health workforce

In the current global economic crisis, health and HRH budgets in many countries are constrained or are declining. The international mobility of the health workforce is changing, but not reducing, and is likely to increase in the coming years. Managing migration in isolation should not be the primary focus of policy solutions. Addressing the causes in the mismatch between the national demand for and supply of health professionals is very important. Moreover, the crisis represents an opportunity to pursue policies and strategies to reform the health sector and the health workforce, in order to create a sustainable health workforce and health system for the future.

5.6 Upcoming events for advocacy on implementation of the Code

The Code provides an opportunity for awareness raising towards actors at country and international level to assume their responsibilities in ensuring a sustainable health workforce. Countries can provide WHO and other stakeholders with information, best practices and knowledge to be translated into action. Events for global-level advocacy on implementing the Code in 2013 are:

- the Sixty-sixth World Health Assembly on 20–28 May in Geneva, Switzerland;
- the Sixty-sixth World Health Assembly panel discussion, Health workforce competencies: time to think out-of-the-box (co-hosted and co-organized by Belgium and Brazil), on 20 May in Geneva, Switzerland;
- the Sixty-sixth World Health Assembly meeting, WHO Global Code of Practice on the International Recruitment of Health Personnel: Stoking up the fire for Code implementation, on 22 May in Geneva, Switzerland;

- the Workshop on Health Professional Education in the WHO Western Pacific Region on 10–12 June in Manila, Philippines;
- the High-level Consultation and Review of the Implementation of Health Systems Strategies in the WHO Western Pacific Region on 22–24 July in Manila, Philippines;
- the High-Income Countries Consultation on Human Resources for Health for the 3rd Global Forum on Human Resources for Health on 4–5 September in Oslo, Norway;
- the Sixty-third session of the WHO Regional Committee for Europe on 16–19 September in Izmir, Turkey;
- a conference on health systems, including a session on human resources for health, marking the progress made since the Tallinn Charter: Health Systems for Health and Wealth was adopted on 17–18 October in Tallinn, Estonia;
- the Sixty-fourth session of the WHO Regional Committee for the Western-Pacific on 21–25 October in Manila, Philippines;
- the thirty-fifth anniversary of the Declaration of Alma-Ata on 5–6 November 2013 in Almaty, Kazakhstan;
- the Third Global Forum on Human Resources for Health on 10–13 November in Recife, Brazil; and
- the Ministerial conference on the prevention and control of noncommunicable diseases on 10–12 December in Ashgabat, Turkmenistan.

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Annex 1. Programme

Thursday, 2 May 2013

Welcome and opening

Objectives and scope of the meeting
by Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

Introductions by participants

Overview of issues on international health worker mobility and developments
by Gulin Gedik, Team Leader, Human Resources Development, WHO Regional Office for the Western Pacific
and
Galina Perfilieva, Programme Manager, Human Resources for Health, WHO Regional Office for Europe

Session 1. Challenges faced in international health workforce mobility and recruitment

Global challenges of international health workforce mobility and recruitment
by Peggy Clark, Health Worker Migration Global Policy Advisory Council, Aspen Institute, United States

Health labour market challenges and implications
by Christiane Wiskow, International Labour Organization, Geneva

Crisis and EU enlargement effects on health system performance
by Matthias Wismar, European Observatory on Health Systems and Policies, Brussels

Health workforce mobility in the CIS countries
by Olga Chudinovskikh, Director, Centre of Demographic Policies, Russian Federation

Discussion (Facilitated by Mihály Kökény)

Thursday, 2 May 2013 (contd)

Session 2: Mechanisms to address challenges and enhance benefits of international health workforce mobility and recruitment

EU response to health workforce challenges: policies and actions
by Caroline Hager, European Commission Directorate-General for Health and Consumers

EU Joint Action on Health Workforce Planning and Forecasting
by Michel Van Hoegaerden, Joint Action on Health Workforce Planning and Forecasting, Federal Public Service Health, Belgium

Civil society engagement
by Remco van de Pas and Linda Mans, Wemos Foundation, Netherlands

Multistakeholder policy dialogue at country level
by Kenneth Ronquillo, Department of Health, Philippines

Country approach to reducing the pull effect of health workers
by Otto Christian Rø, Norwegian Directorate of Health, Norway

Discussion (Facilitated by Hans Kluge)

Session 3: Bilateral labour agreements: introduction and country experiences

Introduction to bilateral agreements
by Peggy Clark, Health Worker Migration Global Policy Advisory Council, Aspen Institute, United States

Bilateral labour agreements: the case of the Philippines
by Ms Liberty Tesorero Casco, Philippine Overseas Employment Administration

Analysis of the recipient country experience: the case of the United Kingdom
by Evgeniya Plotnikova, University of Edinburg, United Kingdom

Experience of the Republic of Moldova: challenges and successes
by Victor Lutenco, Director, Bureau for Diaspora Relations, Republic of Moldova

Discussion (Facilitated by Marjolein Dieleman)

Friday, 3 May 2013

Session 4: International recruitment and integration of migrant health workers

EPSU-HOSPEEM code of conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector and follow-up
by Tjitte Alkema, Secretary-General, HOSPEEM, Netherlands

Integration of migrant health workers in destination countries
by Jim Buchan, Specialist Adviser, Health workforce Australia

International recruitment is only a part of the solution: the case of Finland
by Ulla-Maija Laiho, Ministry of Employment and the Economy, Finland

Recruitment Agency T&S Care
by Linda den Teuling, Operations Manager, Netherlands

Discussion (Facilitated by Gulin Gedik)

Session 5: Recognition of qualifications and other actions

EU Directive on the recognition of qualifications.
by Caroline Hager, European Commission Directorate-General for Health and Consumers

Case of Bulgaria
by Todorka Kostadinova, Dean, Medical University of Varna

Mutual recognition arrangement
by Dr Zabedah Baharudin, Ministry of Health, Malaysia

Circular migration
by Christiane Wiskow, International Labour Organization, Geneva

Discussion (Facilitated by Marjolein Dieleman)

Session 6: Mutual benefits and solidarity: conclusions and priority actions

Discussion (Facilitated by Jim Buchan and Hans Kluge)

Annex 2. List of participants

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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