International normative and legal framework, model agreements, and codes of practice on bilateral and multilateral arrangements for mobility of health professionals: Core issues

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Available at: https://works.bepress.com/piyasiri_wickramasekara/26/
International normative and legal framework, model agreements, and codes of practice on bilateral and multilateral arrangements for mobility of health professionals: Core issues

Presentation at the ILO DWAB/DOH Training Course on: “Challenges and opportunities of bilateral and multilateral arrangements for the mobility of health professionals and other skilled migrant workers”

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Structure of presentation

- Key messages
- What is special about health worker migration
- Modalities of HW mobility
- Normative foundation: international instruments
- Model agreements
- Codes of practice
- Way forward
Key messages

- Health workforce crisis is a global phenomenon which requires cooperation at all levels – bilateral, regional and global.
- Health worker migration poses special problems in the context of rights to health & freedom of mobility.
- Most of the principles and guidelines for development of BLAs & MOUs can be found in international instruments.
- While a soft law instrument, Codes have raised global awareness of ethical considerations as a mainstream issue.
- WHO Code of Practice is a good foundation for countries to build upon in developing sustainable health systems and ethical recruitment.
- It is important to identify core principles and criteria which should go into any BLA or multilateral agreement while providing for additional and country specific provisions as needed.
Case for multilateral and bilateral cooperation

- Human resource crisis in health: shortage of health workers to achieve highest attainable health standards and universal health coverage

- Ethical considerations in health worker migration – brain drain, inequitable distribution
  - They are scarcest where they are most needed, especially in poorest countries. WHO

- Fiscal burden - most health professionals educated at public expense
  - Africa lost $2.2 billion due to doctor migration. Reverse transfer or perverse subsidy.

- Issues in fair treatment of migrant health workers in foreign countries: exploitation & discrimination
What is the health human resource crisis?
Are there grounds for assuming ‘medical exceptionalism’ (Joint Learning Initiative - JLI)?

- Related to right to life: health workers save lives.
  - As a matter of life and death, policies to address medical migration should adopt “medical exceptionalism” based on moral and ethical grounds (Alkire & Chen, JLI).
- **Fatal flows** compared to other movements (Chen & Bufford).
- Human capital formation—longer gestation period compared to IT sector.
- Health workers generally need to be on site to provide services;
- Outsourcing difficult
- Few feedback effects (vicious cycle – Phil Martin)
International focus on HW migration

- International Council of Nurses: Global Nursing Review Initiative
- Trade union movement: Public Service International (PSI)-UNISON-project on health worker migration
- Commonwealth Secretariat: code of practice on recruitment of health workers 2003
- European Commission: Communication (2005 (642)
  - EU strategy for action on the crisis in human resources for health in developing countries
- 2006 Global Health Workforce Alliance (GHWA) – Kampala Declaration 2008
- 2007 Ethical Globalization Initiative & Health Worker Migration Policy Initiative
- WHO - World Health Assembly – 2010 code of practice
- Post-2015 Development Agenda and universal health for all
  - Sustainable Development Goal 3. proposed - Attain healthy life for all
- 2013 Third Global Forum on Human Resources for Health, 10-13 November 2013 | Recife, Brazil- Racife Declaration
.. challenges persist: investment in HRH remains low; fundamental discrepancies exist between health worker supply and demand; HRH planning is often weakened by uncoordinated interventions on single issues, focusing on an individual cadre or illness and not on prevention; and the adoption and implementation of effective policies remains uneven. As a consequence, severe HRH shortages, deficiencies in distribution and performance, gender imbalances and poor working environments for health workers remain matters of major concern.

In particular, international migration of health personnel has reached unprecedented levels in the past few decades. Addressing this issue in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel in an effective and ethical manner is truly a shared global priority.

The Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage, Third Global Forum on Human Resources for Health, 10-13 November 2013 | Recife, Brazil.
Crisis goes beyond shortages and migration

- In the recent past, much attention has been given to the most acute manifestations of the health workforce crisis, namely, the health workforce shortages in the so-called “crisis countries” and migration. However, there is now increasing awareness that the crisis cannot be reduced to these two dimensions, important though they are. The health workforce crisis is a global, multidimensional challenge.

- WHO 2013. The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs, A66/25.
INTERNATIONAL NORMATIVE FRAMEWORK ON MIGRATION AND RIGHT TO HEALTH
International protection regime for migrant workers

- General human rights instruments of the United Nations
- Core Conventions of the ILO on child labour, freedom of association, discrimination and forced labour
- Migrant-specific instruments
  - ILO instruments – C97 and C143
  - United Nations - ICMW
- Other relevant ILO labour standards: Domestic work, OSH, social security, Private Employment Agencies, etc.
# ILO Core Conventions on labour rights

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<tr>
<th>No.</th>
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<th>Ratifications Sept 2014</th>
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<td>Freedom of Association and the Protection of the Right to Organize Convention, 1948 (No. 87)</td>
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# UN Universal Human Rights Treaties

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<td>ICMW</td>
<td>International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families</td>
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<td>CPED</td>
<td>International Convention for the Protection of All Persons from Enforced Disappearance</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
<td>13-Dec-06</td>
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Migrant Specific standards

- Migration for Employment Convention (revised), 1949 (No. 97) (49 ratifications)

- Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143) (23 ratifications)

- 1990 International (UN) Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW) 47 ratifications.

ILO Nursing Personnel Convention, 1977 (No. 149)

- Article 2(1) Member States ‘shall adopt and apply... a policy concerning nursing services and nursing personnel... to provide the quantity and quality of nursing care necessary for attaining the highest possible standard of health for the population.’

- Article 2(2) ‘In particular, it shall take the necessary measures to provide nursing personnel with:
  - (a) education and training appropriate to the exercise of their functions; and
  - (b) employment and working conditions, including career prospects and remuneration, which are likely to attract persons to the profession and retain them in it.’

- Reinforces the need to improve working conditions in the health sector for better retention of health workers. This includes protecting the rights of health workers and implementing other relevant international labour standards.
Main principles in ILO Migrant Conventions

- Contain international good practices achieved through tripartite negotiation.
- Covers the whole migration process including emigration, immigration and transit.
- Principle of non-discrimination and equal treatment with national workers.
- Respect for basic human rights of all migrant workers (regular and irregular).
- Principles for regulating migrant worker flows and ensuring protection.
- Consultations with social partners on policies.
- Principle of cooperation between States.
ILO Multilateral framework on labour migration

- **Objectives:**
  - Better governance of migration; protection of workers and promoting development linkages:
  
  - A framework of nonbinding guidelines and principles to serve as a tool kit for guiding migration policies in countries based on all UN and ILO instruments

- **Relevant Guidelines**
  - Guideline 2.3. promoting, where appropriate, bilateral and multilateral agreements between destination and origin countries addressing different aspects of labour migration, such as admission procedures, flows, family reunification possibilities, integration policy and return, including in particular gender-specific trends;
  
  - 15.7. adopting measures to mitigate the loss of workers with critical skills, including by establishing guidelines for ethical recruitment;
  
  - 15.8. adopting policies to encourage circular and return migration and reintegration into the country of origin, including by promoting temporary labour migration schemes and circulation-friendly visa policies;
Human Rights and Right to Health
Human rights involved in health worker migration

- There are three main human rights commonly at stake in international health worker migration:
  - **Right to health** (affecting individuals in countries of origin and destination),
  - **Rights in the workplace or labour rights** (for health workers),
  - **Right to leave a country** (for health workers)

Cutting across all of these, **non-discrimination and equality**.

Mesquita and Gordon 2005.
Right to health

- International Covenant on Economic, Social and Cultural rights:
  - ‘The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ (Article 12(1))
  - Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. (Article 2(1))
- Group specific protections:
  - ICERD, CEDAW, CRC, ICRMW, ILO C97 and C143
Right to freedom of movement

- Universal Declaration of Human Rights, Article 13 (2):
  Everyone has the right to leave any country, including his own, and to return to his country.

- International Covenant on Civil and Political Rights, Article 12:
  (2) Everyone shall be free to leave any country, including his own
  (3) The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect... public health or morals... and are consistent with the other rights recognised in the present Covenant.
  Restrictions must be the least intrusive means and must be proportionate to the interest to be protected (Human Rights Committee General Comment 27)

Balancing of human rights -1

- Freedom of movement for migrant workers versus
- Right to health of population in origin countries (and destination countries)

All human rights are equal and there can be no trade-off between rights.

Everyone has the right to the enjoyment of the **highest attainable standard of physical and mental health** (ICESCR, Article 12(1))

The right to health includes: availability, accessibility, acceptability and quality of health facilities, goods and services (Committee on Economic, Social and Cultural Rights, General Comment 14)
Balancing human rights -2

- Individuals have the right to leave any country, including their own, in search of better opportunities, but health workers trained with public resources have obligations as defined by individual countries.
- Nothing in this code should be interpreted as impinging on the rights of health workers to migrate to countries that wish to admit and employ them.
- (WHO code of practice on the international recruitment of health personnel).
Mechanisms for cooperation in health worker migration
Mobility of health workers

- Unilaterally:
  - Individuals decide to migrate
  - Destination countries introduce migration channels for health workers under skilled migration schemes, points-based schemes, etc.
- Trade-related agreements:
  - As part of regional economic integration: European union free mobility of labour; other regional economic communities; ASEAN free flow of skilled labour target by 2015. Mutual Recognition Arrangements. For health professionals
- Multilateral agreements
  - WTO General Agreement on Trade in Services (GATS) Mode 4 – Movement of natural persons as temporary service providers
- Bilateral agreements and MOUs
- Codes of practice for ethical recruitment
Free/Liberalised labour mobility areas around the world

Free/Liberalised labour mobility areas:
- Nordic Common Labour Market, 1954
- EU, 1968
- Trans-Tasman Travel Arrangement, 1973
- EEA, 1994
- COMESA, 2001 - not implemented
- EU-Switzerland, 2002
- EFTA, 2002
- MERCOSUR Agreement on free Movement of Persons and Residence, 2002

Partial Liberalisation of International Labour Mobility:
- ECOWAS, 1979 – not fully implemented
- CARICOM Single Market and Economy, 1989
- NAFTA, 1994
- CIS, 1994 (date refers to the signature of the Agreement in the Field of labour Migration and Social Protection of Migrant Workers - agreement is being implemented on a bilateral basis)
- SADC, 1997 Protocol on the Facilitation of Movement of Persons - not implemented
- Andean Community of Nations, 2003
- ASEAN Community, 2015

Note: Unless otherwise specified, dates refer to the year of first implementation of provisions for the liberalisation of workers’ movements

Source: Chaloff, OECD.
Model agreements for mobility of health professionals
ILO Model Agreement on Temporary and Permanent Migration for Employment, including Migration of Refugees and Displaced Persons

- Annex to the ILO Recommendation R86, accompanying the Migration for Employment Convention, 1949 (No.97)
- Comprehensive instrument covering the complete migration cycle
- Checklist on comprehensiveness of provisions and quality of content.
- Most principles seem to be still valid.
- Widely used in the 1950s and 1960s by European governments, but the new generation in Asia has not used it much.
- Myth – that ILO has identified 24 basic elements of a BLA.
- Recently, ILO has provided policy advice based on the Model Agreement for the drafting of bilateral labour agreements between Georgia and France, Armenia and the Russian Federation, Costa Rica and Nicaragua, and Moldova and Italy.
- Standard employment contracts can draw upon Art. 22
| Article 1: Exchange of Information | Article 16: Settlement of Disputes |
| Article 2: Action against Misleading Propaganda | Article 17: Equality of Treatment |
| Article 3: Administrative Formalities | Article 18: Access to Trades and Occupations and the Right to Acquire Property |
| Article 4: Validity of Documents | Article 19: Supply of Food |
| Article 5: Conditions and Criteria of Migration | Article 20: Housing Conditions |
| Article 6: Organization of Recruitment, Introduction and Placing | Article 21: Social Security |
| Article 7: Selection Testing | Article 22: Contracts of Employment |
| Article 8: Information and Assistance of Migrants | Article 23: Change of Employment |
| Article 9: Education and Vocational Training | Article 24: Employment Stability |
| Article 10: Exchange of Trainees | Article 25: Provisions Concerning Compulsory Return |
| Article 11: Conditions of Transport | Article 26: Return Journey |
| Article 12: Travel and Maintenance Expenses | Article 27: Double Taxation |
| Article 13: Transfer of Funds | Article 28: Methods of Cooperation |
| Article 14: Adaptation and Naturalization | Article 29: Final Provisions |
| Article 15: Supervision of Living and Working Conditions | |
ASPEN Model Agreements for Health Worker Migration

- **Objectives**
  - Highlight potential of bilateral agreements to address the challenges associated with HWM;
  - Promote the WHO Code of Practice on the International Recruitment of Health Personnel;
- **Procedure**
  - Review of text of existing instruments and normative frameworks
  - Draw upon existing good practices on content and process
  - Development of Model Bilateral Agreements.
Structure & Content of ASPEN model

- **Preamble**: refers to health worker shortage and guiding principles
- **Objectives**: Promote ethical practices, return & reintegration, fair treatment & development benefits of migration
- **Structure**
  - Recruitment standards
  - Employment standards
  - Migration and development provisions
  - Dispute Resolution system
  - Monitoring and implementation
ASPEN: Two models

Model Bilateral Agreement I
- Targeted at countries that utilize bilateral agreements for health personnel recruitment and admission purposes, specifically aiming to address the negative effects of health worker migration (South Africa, UK)
- Text based almost exclusively on existing practice.
- Links to recommendations presented in the WHO COP.

Model Bilateral Agreement II
- For those that utilize selective, non-discriminatory admission policies as well as decentralized recruitment policies (Australia, Canada, USA)
- Relevant also for those that recognize the extent of the problem and the importance of international cooperation but unsure as to the precise steps forward.
- Based on the US-China Climate Change MOU
- More emphasis on dialogue and cooperation
Comments

- Promotion of France’s agreements as good practice model – can be questioned.
- No information on ASPEN models are being used in actual agreements
- Broad stakeholder support, especially from social partners and civil society needed to promote it along with WHO COP
Codes of Practice for ethical recruitment - 1

- Non-binding and voluntary
  - ‘active recruitment must be undertaken in a way that seeks to prevent a drain on valuable human resources from developing countries’
  - Forbids active recruitment of health workers from developing countries without a bilateral agreement (list of at risk countries).
- The Melbourne Manifesto, 2002
  - Encourages rational workforce planning
  - Recruitment should be characterised by integrity, transparency and collaboration and an MOU must be signed before one country recruits from another
  - Promotes incentive programs for health workers to work in rural or remote areas
- 2003 Commonwealth Code of Practice
- Pacific Code of Practice
- EPSU – HOSPEEM Code of Conduct
Codes of Practice - 2

- **Commonwealth Code of Practice for International Recruitment of Health Workers, 2003**
  - Balances the right of health workers to seek employment in other countries with their responsibilities to the country where they were trained
  - Discourages targeted recruitment from countries with shortages
  - Safeguards the rights of recruits and working conditions in destination countries
  - Promotes dialogue between developed and developing countries and bilateral agreements
  - Suggests ways to minimise the impact of health worker migration on origin countries: eg compensation or reparation

- **General issues**
  - Non-binding; no sanctions for breaches; no incentives for compliance
  - Lack of research and data to monitor progress, and migration outside the Commonwealth.
2010 WHO code of practice on the international recruitment of health personnel

- Voluntary global code adopted on 20 May 2010 by 63rd World Health Assembly: Successful global health diplomacy. 2nd Code
- to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel
- (3) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments
- 3.4 Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries.
Key Principles of the Code of Practice

- Right of all to highest attainable standard of health
- Non-binding and voluntary
- Promotion of ethical recruitment practices
- Achieving balance between rights of origin & destination countries & workers
- Fair labor practices for foreign educated health workers on par with national workers
- Increased efforts from all countries, developed and developing, to meet their own health workforce needs
- International cooperation and support for health system strengthening in less developed countries
- Expects operationalisation of the Code mainly through bilateral agreements
- Robust monitoring procedure with designated national authorities and periodic (every 3 years) national status reports
Progress: WHO’s review

- March 2014: 85 countries had designated a national authority.
- 37 countries have taken steps to implement the Code; 56 countries, mostly in Europe, have completed the National Reporting Instrument: low response from others
  - NRI- a self-assessment of compliance with the Code
- But Africa, Asia poor response.

Challenges
- Engagement of multiple stakeholders - state and non-state actors needed to promote the Code
- Comprehensive data on health workforce and health worker migration not available
- Global economic crisis has not affected health worker migration.
- Partnering with Civil Society crucial for success.

Other evaluations of COP

Angenendt, S., et al. (2014), Center for global Development.

- Contradiction in the Code between Articles 3 and 5: the principle of freedom of movement of health workers & Article 5.1 stipulates that “Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.”
- The Code does not clearly define “critical shortages” of health workers. Governments require a clear definition if they are to implement the Code.
- The potential of temporary and circular migration schemes and innovative training partnerships would go much more to implement the WHO Code’s prescription.


- The challenges associated with international mobility of health workers are too complex to be solved by one instrument, the Code, and it is insufficient to solve the shortages and inequitable distribution of health workers present in low-income countries.
Empirical impact evaluation of code in Australia, Canada, UK and USA

- 42 key informants from across government, civil society and private sectors were surveyed:
  
- 60% of respondents believed their colleagues were not aware of the Code, and 93% reported that no specific changes had been observed in their work as a result of the Code. 86% reported that the Code has not had any meaningful impact on policies, practices or regulations in their countries.

- Conclusions: This suggests a gap between awareness of the Code among stakeholders at global forums and the awareness and behaviour of national and sub-national actors. Advocacy and technical guidance for implementing the Code are needed to improve its impact on national decision-makers.

Evaluation of Code implementation in East & Southern Africa: Equinet study

- For regional stakeholders - Main HRH concerns were: issues of internal migration (rural to urban and public to private) and absolute shortages of health professionals. **Not overseas migration as 10 years before.**
- **African concerns** - elements, especially on compensation and mutuality of benefits, were not included in final code.

- **Main massages from the study:** ESA countries have not made much progress in implementing and monitoring the Code, or using it in their engagement in global health diplomacy, and that the Code remains largely unknown in the region.
- **Major barriers to implementation of the Code:** lack of preparedness, poor mobilisation at country level, overburdened HR departments, and lack of national champions to drive Code implementation and reporting.
- A major obstacle is the lack of a clear focal point or responsible authority dealing with the Code. South Africa – little interest in the Code.
- **Way forward to promote the Code:** appoint designated authorities; more WHO leadership; Support of regional organisations; Civil society mobilisation.

Way forward

- Post-2015 Development Agenda
  - Universal health Coverage
  - SDG: Attain healthy life for all
- Countries should take long term vision to promote self-sufficiency in HRH, retention and return, and beneficial exchanges.
- International instruments and WHO COP should be promoted through bilateral and other agreements, and legislative and regulatory reform, and civil society engagement.