

# WP4 Report

## The applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context



Joint Action Health Workforce  
Planning and Forecasting

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# Report – Version no. 1.0

## The applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context

WP4. Semmelweis University, Health Services Management Training Centre, Hungary

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## The Joint Action Health Workforce Planning and Forecasting

The Joint Action on European Health Workforce Planning and Forecasting is a three-year programme running from April 2013 to June 2016, bringing together partners representing countries, regions and interest groups from across Europe and beyond, including non-EU countries and international organisations. It is supported by the European Commission in the framework of the European Action Plan for the Health Workforce, which highlights the risk of critical shortages of health professionals in the near future.

The main objective of the Joint Action on European Health Workforce Planning and Forecasting (JA EUHWF) is to provide a platform for collaboration and exchange between partners, in order to better prepare Europe's future health workforce. The Joint Action aims to improve the capacity for health workforce planning and forecasting by supporting collaboration and exchanges between Member States, and by providing state-of-the-art knowledge on quantitative and qualitative planning. By participating in the Joint Action, competent national authorities and partners are expected to increase their knowledge, improve their tools, and succeed in achieving a higher effectiveness in workforce planning processes. The outcomes of the Joint Action, amongst other things, should contribute to the development of a sufficient number of health professionals, aid in minimising the gaps between the need for and supply of health professionals equipped with the right skills through forecasting the impact of healthcare engineering policies, and by re-designing education capacity for the future.

This document contributes to achieving this aim by providing a report on the discussion of the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context, including the mapping of best practices.

## Contributors and Acknowledgements

The preparation of this document was led by the Health Services Management Training Centre of Semmelweis University, Budapest, Hungary.

In addition, we would like to highlight the contributions that have been invaluable in preparing the materials reflected on in this document. Within this particular work, we are grateful for being able to count on the knowledge and expertise of associated and collaborating partners who participated in the WHO Code Activity of Work Package 4 and thus contributed to this document.

Our sincere gratitude goes to the following authors from Semmelweis University, Budapest, who directly contributed to this milestone report: Réka Kovács – activity leader, Zoltan Aszalos, Edit Eke, Eszter Kovács, Zoltán Cserhádi, Edmond Girasek, András Wéber, as well as Michel Van Hoegaerden, the Programme Manager of the Joint Action.

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We would like to extend our thanks to all partners engaged in the Joint Action and would like to highlight Michel van Hoegaerden, Lieve Jorens, Tina Jacob and Maria D'Eugenio (Belgian Federal Public Service of Health, Food Chain Safety and Environment; coordinator of the Joint Action) for their leadership and support.

Finally, the financial support from the European Commission is gratefully acknowledged and appreciated. In particular, we would like to thank Caroline Hager and Leon van Berkel from the European Commission DG for Health and Consumers, as well as Antoinette Martiat from the Consumers, Health and Food Executive Agency (CHAFEA).

## Introduction

As the Grant Agreement of the Joint Action on European HWF Planning and Forecasting indicates, an important task of Work Package 4 is “to **initiate a discussion on the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel** (often referred to in this document as “the WHO Code<sup>1</sup>”) **within a European context including the mapping of best practices.**”<sup>2</sup>

### *What is this Report?*

The Report itself - as shown by the figure below - is a **structured report of a descriptive nature about the discussions** organised in the form of **two workshops** in order to gain insights about the views of different stakeholders on the applicability of the WHO Code in the context of mobility of health personnel within the EU, together with mapping good implementation practices of Member States from a wider context.

Its **scope is limited** to introducing the views participants expressed during the discussions, the conclusions they reached, the presentations they put forward about their relevant experiences, and **does not aim to provide a detailed analysis**. While the participants have been requested to provide opinions on a list of statements and to introduce good practices, this report does not aim to propose policy recommendations.

This report is **not a deliverable, but only a milestone** of the Joint Action. Being a milestone signals importance, and at the same time also the ability to feed other deliverables providing analysis, as well as policy recommendations on topics in connection with the issues introduced by this report. Thus the activity is naturally linked to **WP4 deliverable on mobility** and the **report on circular mobility** that Work Package 7 will issue.<sup>3</sup> Furthermore, the report **provides input for Work Package 7** that could extend the findings into sustainability recommendations at policy level, both in relation to circular mobility, and more in general as a **basis for further work** related to the applicability of the Code’s principles within the EU.

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<sup>1</sup> Available at: [http://www.who.int/hrh/migration/code/WHO\\_global\\_code\\_of\\_practice\\_EN.pdf?ua=1](http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf?ua=1)

<sup>2</sup> Grant Agreement Annex Ib. Page 19.

<sup>3</sup> Ibid., p. 20.

## Work Package 4 on data – mobility activity

### WHO Code activity

### WHO Code report

**Work Package 4 (WP4) has its focus on data.** The so-called **mobility activity** of WP4 will explore and summarise the current knowledge on HWF mobility data situation in the EU, focusing on gaps in mobility terminology, data and their availability. It examines the recommendations relevant to existing HWF mobility data, and also investigates the use and development potential and applicability of existing EU and international tools. WP4 examines which mobility indicator(s) could be recommended for international data collection.

#### Activity on WHO Code

"As an expansion to activities related to mobility research, efforts will be made to initiate a discussion on the applicability of the WHO Global Code of Practice on the International Recruitment of Health Personnel within a European context, including the mapping of best practices."

As a JA Milestone, a **report of the discussions will be produced**. This report gives food for thoughts for WP7 activities:

**"based on the results of WP4, WP7 will develop a recommendation on helping a policy making process to go further regarding the application of WHO Code on International Recruitment in the EU."**

## How to read this Report

This report - being a milestone of the Joint Action as explained above - **does not have a special target group or audience**. However, its different parts (knowledge base, Member States' experiences with the implementation of the WHO Code, applicability of the Code's principles within the EU context) contain a series of summaries and descriptions that **can be used by experts or even decision-makers** for different purposes, courtesy of its different Reading Paths.

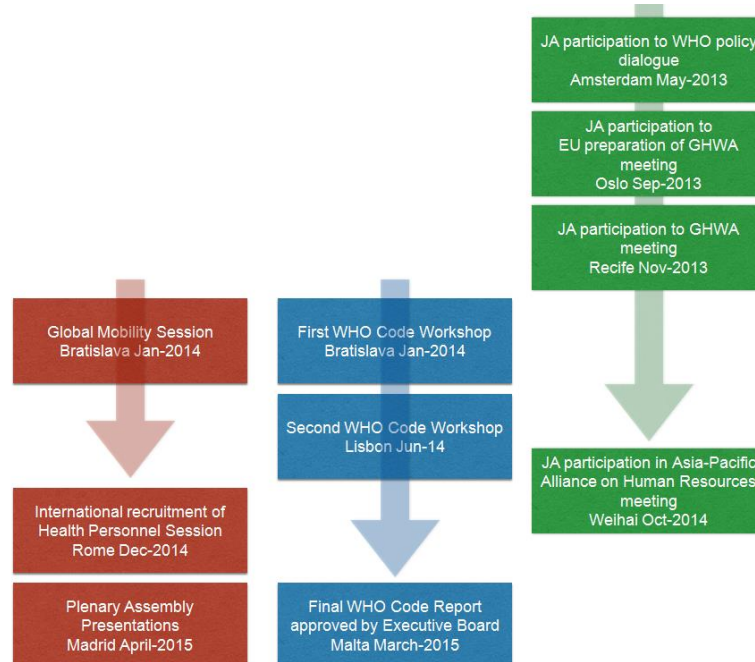
The following **Reading Paths** can help the reader to concentrate on the contents that are of greatest interest to him/her.

1. **The "Implementation" Path:** for those national experts who are interested in the implementation of certain provisions of the Code or in the improvement of the current scope of implementation, the country cases in Part 2 offer good practices and suggestions ([Part 2. Experiences of Member States relating to the implementation of certain provisions of the WHO Code](#)). A graphic at the end of Part 2 shows the major elements of country examples, while a summary table offers a helping hand in finding which paragraph(s) of the WHO Code is/are implemented by concrete country examples ([Summary positioning of the national cases within the framework of the WHO Global CoP](#)).
2. **The "From theory to practice" Path:** for those who want to gain insight into the essential policy elements relating to the implementation of the Code and

deepen their knowledge through practical solutions, Part 1. ([Part 1. Selected literature, the Joint Action context and the EU environment](#)) and Part 2. ([Part 2. Experiences of Member States relating to the implementation of certain provisions of the WHO Code](#)) can offer a starting point.

3. **The “From understanding EU policy context to acting” Path:** for policy makers of EU countries wishing to understand the specificities of the EU environment and looking for suggestions and ideas offering solutions compatible with EU law for managing mobility, Part 1 that describes the key policy context of the Code ([Part 1. Selected literature, the Joint Action context and the EU environment](#)) together with Part 3 ([Part 3. The applicability of the WHO Code’s principles within the EU context](#)) - which offers 12 issues, 12 discussions and 12 statements - are the most important parts of this document. Statements for the 12 areas are grouped according to their relevance - as evaluated and ranked by the workshop participants ([Summary table of revised statements](#)) - which can help the reader prioritise when reading, and can also offer a clear structure for choosing what is important for his/her context.

### What is the wider Joint Action context of this Report?



This activity joins an intense framework of discussions around the risks created and opportunities offered by the professional mobility of health workers. The picture above indicates the **activities carried out by this Joint Action relating to the WHO Code within the overall framework.**



- In **Red**: the Joint Action team (WP4, WP1 & WP2) organised sessions during both the first Bratislava and second Rome conference of the Joint Action that contributed to this Report. The Report was presented at the March 2015 Madrid Plenary Assembly to all Joint Action partners.
- In **Blue**: the Joint Action team (WP4) organised two workshops with the Partners of Work Package 4, the first one in Bratislava on 30 January 2014 and the second in Lisbon on 16 June 2014. The compiled input collected during these workshops is the basis of the current Report, which was approved by the Executive Board on 5 March in Malta.
- In **Green**: the Joint Action team (WP4 & WP1) participated at international conferences on international HWF recruitment and contributed to this Report with the results of those conferences;

It is also important to mention that the Joint Action collaborated explicitly with the EU-funded project Health Workers for All, led by the Wemos Foundation (a collaborating partner of the Joint Action), whose input and careful review was highly useful for the synchronisation of the content and proposals.

### *How was the activity organised?*

The core work of this activity was carried out within the framework of the **two key workshops**, the first in January 2014 in Bratislava and the second in June 2014 in Lisbon.

The **first workshop** had the following objectives:

- raising awareness among participants in regards to the implementation of the WHO Code, supported by presentations introducing the Code's main principles and experiences from its first implementation round with special focus on ethical recruitment
- provide information on the best practices including measures taken, tools developed by Member States, and EU tools in order to support implementation together with running projects
- examine whether the principles of the WHO Code – with special focus on the principle of ethical recruitment – have relevance in the context of the EU, where the basic principle of free movement and the guiding values and principles of EU health systems like solidarity, equal access to good quality health care and sustainability of health care systems are sometimes in conflict
- facilitate a panel discussion where countries affected by international mobility in different ways have the opportunity to share their experiences on efforts taken in order to maintain or recruit a sufficient health workforce
- engage in an open and constructive dialogue on possible cooperation on training capacities, relevance of ethical recruitment, strategies for preservation and recruitment of health workforce, role of monitoring of intra-EU movements, and the availability of data

The **second workshop** aimed to analyse deeper issues identified to be of great relevance at the first workshop and to continue with the examination of the relevance of the EU context. The discussion was based on previously shared statements related to the key topics identified concerning the implementation of the WHO Code, and in most cases also concerning the applicability of its principles within the EU.

A special method was applied during this process: pro and contra arguments were collected together with possible measures along with their possible policy level implementation and timing. As a next step, the pre-sent statements were reformulated and finally ranked on the basis of importance and feasibility. Another valuable part of the workshop was the introduction of best practices of the Member States concerning the implementation of the WHO Code, which fuelled the discussion on the applicability of EU context.

The activity fulfilled its aim of (1) initiating a discussion on the sensitive topic of the applicability of the WHO Code's principles within the EU context, (2) sharing best practices on the implementation of the WHO Code and thus helping awareness raising. The useful practices introduced at the workshops and the main elements of the discussions based on the pre-sent statements/topics are introduced in this report. The applicability of the results of this activity will be examined by WP7.

## Part 1. Setting the scene – knowledge base

This section contains a **very limited literature review**<sup>4</sup> to set the stage. The activity and the report itself – as already mentioned, however – do not intend to perform any research, but mainly build upon stakeholders' views. We have simply selected publications from WHO and present a stakeholder example about the importance and success of the Code. The section also **introduces the related activities of the Joint Action** itself, and also how Joint Action representatives at different forums communicated about the Code. Finally, the section introduces – based on the presentations at the two workshops – the **international context that the discussion is embedded in**, including how WHO evaluates the first reporting round on the Code's implementation, what the relevant EU-level activities and initiatives of the European Commission are while also providing brief insight into the 'Health workers for all and all for health workers' project and the main aspects of the EPSU-HOSPEEM Code of Conduct on Ethical Recruitment.

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<sup>4</sup> Given the limited scope of this activity, this section only provides very basic reference to literature and relevant JA communication on the WHO Code.

## **Messages from literature on the importance and success of the Code**

The **WHO** in its 2014 publication ***Migration of health workers - WHO Code of practice and the global economic crisis***<sup>5</sup> outlined the following:

- The Code is an ambitious step in the evolution of what has become known as global health diplomacy. It seeks to redress the imbalances among health workers around the world by raising important issues of human rights, including access to health, equity and social justice.
- In the context of migration, the Code encourages “receiving” countries to consider the impact of their policies and actions on the countries from which health workers migrate. Crucial to the success of the Code is the willingness of countries to implement it, which in turn depends largely on national and international dialogue and cooperation, including the exchange of information and data.
- The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. It is a multilateral framework for tackling shortages in the global health workforce.
- The Code emphatically does not aim to stop migration, but rather to guide countries to address some of the aspects of health workforce migration that may have a detrimental impact upon countries, and particularly source countries.
- Foreign-trained doctors and nurses make up a significant share of the health workforce in the major English-speaking destinations; these flows do not seem to have been strongly affected so far by the global economic crisis and are expected to remain strong in coming decades as aging populations further increase the demand for health services.
- While some governments have actively recruited foreign health professionals in the past, they can receive large inflows even without actively or deliberately recruiting them.

The publication ***WHO policy dialogue on international health workforce mobility and recruitment challenges: technical report***<sup>6</sup> draws attention to an additional specific issue about HWF mobility, which also has high relevance to the discussions presented in this report: “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) ... 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.”

<sup>5</sup> Available at: [http://www.who.int/hrh/migration/14075\\_MigrationofHealth\\_Workers.pdf?ua=1](http://www.who.int/hrh/migration/14075_MigrationofHealth_Workers.pdf?ua=1)

<sup>6</sup> Amsterdam, 2–3 May 2013, available at: <http://www.euro.who.int/>

#### **Indicative numbers on the Global implementation and success of the WHO Code:**

“As of March 2014, 85 countries have designated a national authority [to the national-level monitoring of the implementation of the WHO Code], three-quarters of which are based in the ministry of health, the others in institutes of public health, health authorities, health boards and HRH observatories. At least 56 countries, mostly in Europe, have completed and returned their National Reporting Instruments. These countries represent more than 80% of the world’s population living in destination countries, and a minority of the known source countries. Overall, 37 countries have taken steps towards implementing the Code. Already, 33 have reported taking actions to communicate and share information on health-worker recruitment, migration issues and the Code among relevant ministries, departments and agencies.”<sup>7</sup>

To show an example from a different **stakeholder’s view**, we would like to highlight how the Standing Committee of European Doctors (CPME), an associated partner of the Joint Action, has reflected on the intra-EU migration of the health workforce: “Within the European Union, we have also seen targeted recruitment campaigns between member states. This of course is a legitimate part of the rules on free movement but care should be taken not to damage the healthcare infrastructure of another Member State through thoughtless recruitment strategies.”<sup>8</sup> Furthermore, CPME, in its response to the GREEN PAPER on the European Workforce for Health,<sup>9</sup> suggests the following: “a European policy should be developed in order to assist and to help Member States to plan sufficient local training capacity to face their needs. By establishing common standards towards educating, funding and supporting their respective national healthcare needs, the “financially motivated” migrations within the European Union should be kept to the level where free movement (a fundamental right) is the only factor driving migration. Relying unduly on external recruitment should be thus eliminated. CPME thinks that the best way to prevent these “brain drain” situations within the EU is to establish common standards on high quality training and CPD for health professionals on one side and to invest in proper working conditions and remuneration on the other side.”<sup>10</sup>

#### **The Joint Action context - key communications on the Code**

##### **International conferences**

The **Joint Action on Health Workforce Planning and Forecasting** has repeatedly drawn attention to the importance of the WHO Code: in the **Feasibility Study of the**

<sup>7</sup> MIGRATION OF HEALTH WORKERS: The WHO Code of Practice and the global economic crisis, Introduction available at: [http://www.who.int/hrh/migration/14075\\_MigrationofHealth\\_Workers.pdf?ua=1](http://www.who.int/hrh/migration/14075_MigrationofHealth_Workers.pdf?ua=1)

<sup>8</sup> Available at: [http://cpme.dyndns.org:591/adopted/2007/CPME\\_AD\\_Brd\\_170307\\_027\\_EN.pdf](http://cpme.dyndns.org:591/adopted/2007/CPME_AD_Brd_170307_027_EN.pdf)

<sup>9</sup> Available at: [http://cpme.dyndns.org:591/adopted/2009/CPME\\_AD\\_Brd\\_140309\\_034\\_final\\_EN.pdf](http://cpme.dyndns.org:591/adopted/2009/CPME_AD_Brd_140309_034_final_EN.pdf)

<sup>10</sup> *Ibid.*: Section on On 4.3 Training and 4.4 Managing mobility

**Joint Action on Health Workforce Planning and Forecasting**, the WHO Code is mentioned among the most important elements of its international policy context.<sup>11</sup>

Among the official international presentations on the results of the Joint Action, during the Consultation on **Human Resources for Health for high income countries in Oslo, Norway**, in preparation for the Third Global Forum on Human Resources for Health,<sup>12</sup> the Joint Action representative<sup>13</sup> put forward that

- “the JAHWF is the main EU initiative to implement art. 6 & 7 of the Code - enhancement of data collection, forecasting & planning.”

This presentation also underlined that

- “the implementation of the CODE is ethically undisputed but at the EU level it must be aligned with the EU philosophy of free mobility of persons, goods and services.”<sup>14</sup>

At the **3rd Global Forum on Human Resources for Health in Recife**, the Joint Action representative underlined that the Joint Action and the WHO Code have some identical objectives, especially in the area of HWF data collection: “Today there is need to ... increase the capacity of forecasting and planning all through the countries of this world. At least basic data gathering and scenario building is possible in the coming year, as strongly recommended by the WHO code. We, EU countries and the many partners joining us, applied to do that in our region, and to share our findings with everyone.”<sup>15</sup>

The **3rd Global Forum**<sup>16</sup> issued the *The Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage*.<sup>17</sup> This document

- reaffirms the importance of the WHO Global Code
- recognises “the need to revise these commitments in light of new developments, with a view to progressing towards universal health coverage” (par. 4).
- underlines that “the HRH agenda transcends national borders: geographical maldistribution and international migration affect low-, middle- and high-income countries, in some cases hindering the provision of even essential health services and the attainment of universal health coverage... 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.” (par. 8 and 9).

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<sup>11</sup> Commission Feasibility Study, 2.3.2 International Policy Context

<sup>12</sup> WHO-OSLO, 5 September 2013

<sup>13</sup> In Oslo and in Recife alike, the Joint Action was represented by Michel Van Hoegaerden, Programme Manager of the Joint Action.

<sup>14</sup> par 4. Available at: [http://www.euhwforce.eu/web\\_documents/131128-WP4-WP7-CODE-OSLO\\_V1\\_0.pdf](http://www.euhwforce.eu/web_documents/131128-WP4-WP7-CODE-OSLO_V1_0.pdf)

<sup>15</sup> Quoted from the preparation work for the panel activity in Recife, 10 November 2013

<sup>16</sup> Available at: [http://www.who.int/workforcealliance/forum/2013/3gf\\_outcomes/en/](http://www.who.int/workforcealliance/forum/2013/3gf_outcomes/en/)

<sup>17</sup> Available at: <http://www.who.int/workforcealliance/forum/2013/globaldocument3gf12Nov2013.pdf?ua=1>

In the *Call to Action* section of the Declaration, participants of the Forum, including various EU governmental and non-governmental institutions<sup>18</sup> commit to:

- “use the WHO Global Code of Practice on the International Recruitment of Health Personnel as a guide to strengthen investment in the health of our peoples through stronger health systems and human resources.” (par. 13. ii)
- “working together, through bilateral, sub-regional and regional arrangements and other approaches and use the Global Code of Practice on the International Recruitment of Health Personnel as a reference to better manage migration of health personnel for the benefit of both source and destination countries.”

This Declaration demonstrates the strong international interest in and dedication to the application of the WHO Code for a better management of the international migration of the health workforce. Nevertheless, this statement should be mitigated at EU level as – apart from the JA representative – only 7 EU member states<sup>19</sup> attended the Recife Global Forum, and among those only Ireland gave a commitment<sup>20</sup>.

During the **8th Conference of the Asia-Pacific Alliance on Human Resources for Health**,<sup>21</sup> the representative of Joint Action<sup>22</sup> underlined that

- the implementation of the Code in relation to the recruitment from non-EU countries is a priority for the European Region.
- while the European Union is an area of free movement of persons, another principle, the principle of “equal access to healthcare for all EU citizens” is also an aim at EU level, which can be challenged by the free intra-EU movement of health professionals.
- since 2004, 13 countries joined the EU resulting in distortions in the availability of sufficient adequately trained health professionals in some countries or regions – due to flows from lower income countries to higher income countries.
- the question is to be raised whether the WHO Code’s principles can be applied for the intra-EU mobility of health professionals and how?<sup>23</sup>

### The Joint Action conferences

The two Joint Action conferences (Bratislava and Rome) also had mobility sessions which can be introduced from the WHO Code perspective.

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<sup>18</sup> Available at: [http://www.who.int/workforcealliance/members\\_partners/member\\_list/en/](http://www.who.int/workforcealliance/members_partners/member_list/en/)

<sup>19</sup> Germany, France, UK, Ireland, Portugal, Finland and Italy

<sup>20</sup> Available at: [http://www.who.int/workforcealliance/forum/2013/hrh\\_commitments/en/](http://www.who.int/workforcealliance/forum/2013/hrh_commitments/en/)

<sup>21</sup> Available at: <http://www.mbedcraft.com/aaah/>

<sup>22</sup> Réka Kovács, Work Package 4, Ministry of Human Capacities and Semmelweis University, Hungary

<sup>23</sup> Available at:

[http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/14\\_reka\\_parallelsession\\_3\\_global\\_migration\\_kovacs\\_eka\\_european\\_example.pdf](http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/14_reka_parallelsession_3_global_migration_kovacs_eka_european_example.pdf)

The **Bratislava Conference of the Joint Action**<sup>24</sup> offered various presentations and discussions with relevance for the WHO Code. The participants of the *Panel discussion hosted by representatives of various countries and a recruitment agency*<sup>25</sup> were asked the following questions:

- How can you plan future health workforce needs in a context that facilitates the mobility of qualified health workers?
- Can planning methodologies take into account rapidly changing mobility trends?
- How does international recruitment affect the planning of the health workforce?
- What are your views on the WHO Global Code of Practice on the International Recruitment of Health Personnel?

The answers provided by the panellists verified the close relationship between questions of mobility, health workforce planning and the relevance of the WHO Code.

During the *Global Mobility and Triple Win Migration Session*,<sup>26</sup> a presentation on Africa stated that the loss of a sizeable number of highly skilled health professionals from African countries impacted the functioning of the already weak health systems. Furthermore, in countries such as Zimbabwe and Cameroon, the extent of migration of health professionals has made it necessary for non-qualified personnel to perform duties that are normally beyond their scope of practice.<sup>27</sup>

Another presentation, *“Migration in Health Care Professions - The Triple Win® Approach”*<sup>28</sup> discussed how the German institute IEGUS - beginning with the initial approach of “circular migration” finally developed the approach of a “Training and Development partnership” - thereby creating synergies between migration and development, called Triple Win-Migration. Within this cooperative framework, foreign health professionals (nurses) are recruited and trained according to their language skills (in the country of origin). The project management provides support in connection with their transfer to Germany (recognition of qualifications, residence and work permit) and provides an intercultural training) The foreign nurses have the opportunity to work in German healthcare facilities and are (further) educated in geriatric and elderly care. The foreign health personnel will be actively supported to utilise work experience gained abroad for the benefit of their home country. With this approach, (1) source countries will win knowledge (skilled workforce), (2) Germany will win labour and gains from cultural

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<sup>24</sup> Held on 29 January 2014 in Bratislava, available at: <http://euhwforce.weebly.com/140128-joint-event-bratislava.html>

<sup>25</sup> Moderated and chaired by Gilles Dussault, Professor at the Institute of Hygiene and Tropical Medicine, Medical University of Lisbon.

<sup>26</sup> Moderated by Linda Mans, Wemos Foundation

<sup>27</sup> Presentation *“Austerity and mobility of health workers in Eastern & Southern Africa”* by Yoswa M Dambisya, University of Limpopo, EQUINET HRH Programme of Work, available at: [http://www.euhwforce.eu/web\\_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129\\_BOSESSION3\\_EQUINET.pdf](http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_EQUINET.pdf)

<sup>28</sup> By Dr. Grit Braeseke, Head, IEGUS Institut GmbH, available at: [http://www.euhwforce.eu/web\\_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129\\_BOSESSION3\\_3WIN.pdf](http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_3WIN.pdf)

diversity, and (3) migrants will win job opportunities (in both destination and source countries) and skills. This approach is based on the guiding principle of par. 5.1. of the WHO Code: "... the health systems of both source and destination countries should derive benefits from the international migration of health personnel".

The presentation by Health Workers for All, "*Terre des hommes - Help for Children in Distress*"<sup>29</sup> underlined that at the end of the day, the most important part of the WHO Code is arguably Article 3.6. from the *Guiding Principles*: "Member States should strive, to the extent possible, to create a sustainable health workforce ... that will reduce their need to recruit migrant health personnel." Considering that the per capita coverage with health workers is ten times higher in Germany than it is in Vietnam, recruitment should be done with great care from countries such as Vietnam. Furthermore, the presentation underlined that the lack of nurses in Germany is a home-made problem that calls for a domestic solution.

The *Country cases on the international recruitment of health personnel* section of the **Rome Conference of the Joint Action**<sup>30</sup> also offered various presentations with relevance for the WHO Code. The issues presented in these country cases (concerning Moldova, Germany and Ireland) were also put forward by country representatives in depth at the WHO Code workshops, therefore they are presented in Part 2 of this document. At the Rome Conference, the presentation "*Policy/guidelines for the ethical international recruitment of health staff, Finland*"<sup>31</sup> underlined that international recruitment is a very new phenomenon in Finland: systematic processes have been implemented in recruiting small groups of nurses from EU/EFTA and the Philippines. Awareness of the future situation – a lack of skilled personnel – is the reason and motivation for both the public and private sector to prepare for international recruitment on a larger scale. At the same time, international recruitment is only a small part of the solution. Instead, the attractiveness of the healthcare professions should be improved and the healthcare sector should be more productive, partly through the improvement of the leadership and management, and also through a full reliance on modern technology. Innovative services should be introduced, and prevention as the responsibility of citizens should be more emphasised.

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<sup>29</sup> Presentation by Heino Güllemann, available at: [http://www.euhwforce.eu/web\\_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129\\_BOSESSION3\\_TDH.pdf](http://www.euhwforce.eu/web_documents/JAHWF-CONFERENCE-1-BRATISLAVA/DOCUMENTS/140129_BOSESSION3_TDH.pdf)

<sup>30</sup> Rome Conference of the Joint Action: 4-5 December 2014, available at: <http://euhwforce.weebly.com/141204-rome-conference.html>

<sup>31</sup> Presentation by Ulla-Maija Laiho, Ministry of Employment and Economy, Finland, available at: [http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/5dec\\_slides\\_laiho.pdf](http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/5dec_slides_laiho.pdf)



### *The WHO perspective – Implementation of the WHO Code: results of the first round of reporting*

(Section based on a presentation by **Dr. Galina Perfilieva**, WHO Europe<sup>32</sup>)

The WHO Code is built on overarching principles and mechanisms, including the ethical recruitment of health personnel from developing countries, the fair treatment of migrants, and the role of international cooperation and dialogue. The implementation of the Code started with the establishment or appointment of designated national authorities and the first report on the basis of the WHO National Reporting Instrument. The following two questions are of special importance with regard to the experiences of implementation:

- while some countries are committed to ethical recruitment, at the same time they have no influence on private actors pursuing completely different practices;
- the mechanisms to assess the benefits and risks of employing migrant health workforce as well as the equal treatment of internationally recruited professionals is missing.

The top challenges for implementation identified by reporting countries are as follows:

- difficulty in engagement of multiple stakeholders (national, sub-national, public and private sector) in efforts concerning migration and recruitment of health personnel;
- lack of coordinated and comprehensive data on health personnel migration;
- lack of shared understanding between stakeholders at the national level on health workforce needs, planning, migration, etc. and the differences in interests;
- weak national capacity to deal with health workforce issues and to mobilise and coordinate stakeholders;
- development of inter-country cooperation in exchanging data, sharing tools and good practices to better manage the health workforce.

WHO monitors the progress of the WHO Code Implementation in the European WHO region, fosters the process by producing supporting documents (roadmap, policy briefs and toolkit), supports countries in order to better manage the mobility of health professionals (e.g. the project in Moldova) and facilitates inter-regional collaboration and policy dialogue on health workforce migration (Amsterdam workshop, May 2013). The key directions for future strategy measures to advocate for the implementation of the WHO Code are the following:

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<sup>32</sup> Presentation at the WHO Code Workshop in Bratislava - 30 January 2014. The section - and other similar parts of this document - only summarises what has been said by the presenter.

- enhance advocacy to maintain momentum;
- foster dialogue and build cooperation with stakeholders at country level;
- identify good practices and expand evidence base;
- assess and report on changing trends in the health labour market;
- make use of the need for healthcare reform to sustainably strengthen the health workforce.

### The EU environment



\* Cohesion and Structural Funds 2014-2020, Leonardo da Vinci, Erasmus, Erasmus+, Health for Growth Programme 2014-2020

### EU activities in the field of health workforce policy

(Based on presentations by **Caroline Hager**, EU Commission - DG SANCO<sup>33</sup>.)

The **European Commission Action Plan for the EU health workforce**<sup>34</sup> sets out areas for European action to address health workforce shortages in many EU Member States. The Action Plan - within many other areas for action - aims to strengthen the EU's response to the ethical recruitment of healthcare professionals from outside the EU

<sup>33</sup> Presented at the Bratislava and Lisbon Workshops on the WHO Code.

<sup>34</sup> COMMISSION STAFF WORKING DOCUMENT on an Action Plan for the EU Health Workforce, Strasbourg, 18.4.2012, SWD(2012) 93 final

within the context of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Starting with the **global dimension**, we have to mention that in the context of developing countries, in order to reduce push factors, the EU also provides significant EU funding assistance through the European Development Fund (EDF) to build HRH capacity in countries in a HWF crisis. This funding will be increased under the new financial framework of 2014-2020. Among projects aiming to manage migration in developing countries are HRH observatories, a health workforce mobility-project in Moldova, and the project “*Health Workers for All*” coordinated by the Wemos Foundation.

The EU has also adopted legislation and mechanisms such as the **Blue Card Directive**<sup>35</sup> and **Mobility Partnerships** to address issues of global migration, especially movements from non-EU to EU countries.

The **Blue Card Directive**<sup>36</sup> adopted in 2009 aims to facilitate fast-track procedures for highly skilled workers from non-EU countries for special residence and work permits as well as legal rights in the country in which they want to work. The Directive also provides for an option to reject these applications on ethical grounds, in order to limit brain drain.

The Progress Report prepared by the Commission in May 2014<sup>37</sup> provides a rather disappointing picture about the application of the Directive: only some 15,000 Blue Cards have been issued, out of which 14,000 were by Germany alone, followed by a few hundred issued by Luxembourg and France. Furthermore, of the countries that reported on their application of the Directive, only 8% provided a breakdown by profession. Therefore, it is not yet possible to make comments on the migration of HWF facilitated by the Blue Card system. While various countries (BE, CY, DE, EL, LU and MT) introduced in their legislation that applications for the Blue Card may be rejected on ethical grounds, none of the country reports mentioned such a case.

The Commission recognises that the Blue Card initiative is a long-term process that is still in an early stage, and it is too soon to draw conclusions about the impact of the EU Blue Card on attracting highly qualified migrants to the EU. As a Communication of the Commission on the Implementation of the Blue Card Directive states: “the Commission is concerned about flaws in the transposition, the low level of coherence, the limited set of rights and barriers to intra-EU mobility.... The Commission will increase its efforts to ensure that the Directive is correctly transposed and implemented across the EU. Three years after the deadline for the transposition of the Directive, it is high time to put it to

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<sup>35</sup> Council Directive 2009/50/EC of 25 May 2009 on the conditions of entry and residence of third-country nationals for the purposes of highly qualified employment

<sup>36</sup> More information on this Directive, available at: [http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/immigration/work/index\\_en.htm](http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/immigration/work/index_en.htm)

<sup>37</sup> Available at:

[http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/work/docs/communication\\_on\\_the\\_blue\\_card\\_directive\\_en.pdf](http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/immigration/work/docs/communication_on_the_blue_card_directive_en.pdf)

full use. In order to achieve this, the Commission will organise meetings with MSs and, where necessary, make use of its powers under the Treaty.”<sup>38</sup>

**Mobility partnerships** are tailored to specific needs and list initiatives to manage mobility between partners such as Moldova, Georgia, Armenia, and Cape Verde. These mobility partnerships are dependent on initiatives by Member States and they consist of non-legally-binding frameworks and aim to manage and monitor migration patterns between the EU and individual countries. These partnerships aim to establish a comprehensive cooperation framework combined with visa facilitation and readmission agreements. The EU-Moldova Mobility Partnership (SIMP) aims to minimise the negative effects of migration and harness the benefits for development purposes from diaspora members residing in the EU, including promoting temporary and permanent return of skilled migrants and investors through various legislative and operational measures with a strong focus on health workers.

In cooperation with **DG Home, the Commission department responsible for migration, DG Sanco** issued a **query** at the end of December 2013 on ethical recruitment of HWF via the **EU Migration Network** to collect information on the management of migration in the EU.<sup>39</sup> The 18 country reports provided detailed evidence only from DE, NL, PT, FR, PL, UK. However, we could gain some insight into how different countries implement ethical recruitment in the health sector for third country nationals; if they develop bilateral or multilateral agreements on international recruitment of health personnel, and whether they have any guidelines, policy or other tools to facilitate circular and temporary migration that would minimise negative and maximise positive impacts of highly skilled immigration on developing countries. The different forms of circular migration, such as internships, training exchange, etc. currently applied are therefore also presented in this report.

What we could learn from the above report is that immigration policies are still the traditional mechanism for managing international migration flows, and circular migration is little developed and does not have a clear definition. Bilateral agreements focus on facilitating labour mobility/recruitment/social protection rather than on managing migration, and there are large variations between countries on the types of agreements. However, as bilateral agreements have a decisive role, health issues have to be incorporated into Partnership Agreements (improved policy coordination is needed).

**Mobility of health professionals within the EU** has been highlighted as a challenging and complex issue with little data available. Two European research projects also

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<sup>38</sup> COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL on the implementation of Directive 2009/50/EC on the conditions of entry and residence of third-country nationals for the purpose of highly qualified employment (“EU Blue Card”) Brussels, 22.5.2014 COM(2014) 287 final

<sup>39</sup> The Report *Ad-Hoc Query on ethical recruitment of third country health workers Requested by COM on 18th December 2013* is available on the DG Home website, available at: [http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european\\_migration\\_network/reports/docs/ad-hoc-queries/economic-migration/525\\_emn\\_ahq\\_ethical\\_treatment\\_31jan2013\\_%28wider\\_dissemination%29.pdf](http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/ad-hoc-queries/economic-migration/525_emn_ahq_ethical_treatment_31jan2013_%28wider_dissemination%29.pdf)

underlined this complexity: the **Prometheus study**<sup>40</sup> and the **Mobility of Health Professionals (MoHProf)** study.<sup>41</sup>

At the EU level and within the free movement context, where as a consequence of the economic crises new mobility patterns occurred, there are no easy solutions. In order to mitigate negative effects of mobility Member States should maximise the use of European funding instruments: the **Cohesion and Structural Funds 2014-2020** could be used for investments in jobs in the healthcare sector; the EU programmes **Leonardo da Vinci** and **Erasmus**, and the latter's successor **Erasmus+** support cross-border education and training projects; the proposed **Health for Growth Programme 2014-2020** proposes to help Member States develop tools and mechanisms at the EU level to address shortages of resources and to facilitate the uptake of innovations in healthcare.<sup>42</sup>

It is important to mention that the **agreement of the social partners EPSU and Hospeem** on the ethical recruitment of health professionals exists within this EU-level mobility context (see the last part of this chapter).

In order to support the exchange of practices, improve data and information availability, the Joint Action activities on mobility data, the **EU study on effective retention measures** and the **OECD study on education and training capacities of doctors/nurses** are in the pipeline to offer ideas to manage mobility at the EU level.

#### Health workers for all project

(Based on presentations by **Linda Mans**, Wemos Foundation<sup>43</sup>)

The project '*Health workers for all and all for health workers*' (Health workers for all, HW4All) is a European civil society initiative that contributes to a sustainable health workforce worldwide.<sup>44</sup> The project involves organisations from eight EU countries<sup>45</sup> and also offers an online collaboration platform.<sup>46</sup>

The project focuses on the WHO Code implementation and is strongly aware that Europe needs to be part of a solution to the global HWF problems rather than a source of the problem itself. To mitigate the brain drain of health workers from low- and middle-income countries in an interdependent global workforce market, it is necessary to shed light on the interdependencies between shortages of health workers in the South and the

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<sup>40</sup> More details on this study available at: <http://www.euro.who.int/en/about-us/partners/observatory/activities/research-studies-and-projects/prometheus>

<sup>41</sup> Available at: <http://www.mohprof.eu>

<sup>42</sup> Further information available at: [http://ec.europa.eu/health/workforce/policy/index\\_en.htm](http://ec.europa.eu/health/workforce/policy/index_en.htm)

<sup>43</sup> Presented at the WHO Code Workshops at Bratislava and Lisbon

<sup>44</sup> Available at: <http://www.healthworkers4all.eu>

<sup>45</sup> Countries and organisations involved in the project are Germany, Belgium, the Netherlands, the United Kingdom, Italy, Spain, Romania, Poland, WHO/Europe, European Forum for Primary Care, European Public Health Alliance, Health Workforce Advocacy Initiative, WHO – Global Health Workforce Alliance, Action for Global Health in Europe, and Regional Network for Equity in Health in East and Southern Africa (EQUINET).

<sup>46</sup> Available at: <https://interact.healthworkers4all.eu/display/PUB>

increased demand for health workers within Europe. As a result of the Treaty of Lisbon that facilitates mobility of employees within the EU, as well as more stringent EU migration policies, attention has also shifted towards internal imbalances within the distribution of health workers in the EU. In the context of the economic crisis in Europe, for example, countries are competing to attract scarce health professionals.

Since only a limited number of people working on health workforce issues are aware of the Code, one of the first steps required is general awareness raising of its existence and principles, as well as the initiation of a dialogue at the national and then at the EU level. To support this initiative, the Code was translated into various national languages. Other steps consisted of coordinated action to exchange data, policy tools, good practices and understanding – and most importantly – creating connections among all different stakeholders in health workforce policies and practices.

The dialogue initiated by HW4All has covered various items of discussion in EU countries. The following are some of the key points of national level discussions:

- United Kingdom: the contradiction between providing international aid for the strengthening of health systems in lower and middle income countries and the active or passive recruitment from the same countries,
- Italy: the impact of austerity measures on HWF resulting in a growing emigration of health workers;
- Belgium: a need for awareness raising about the Code and especially about its principles for the recruitment and retention of the domestic health workforce;
- Germany: the need for decent working conditions for nurses and the Germany-Philippines bilateral agreement about the recruitment of nurses;
- Spain: the importance of collecting data on HWF migration to follow the impact of austerity measures and the resulting unemployment and emigration from the public health sector;
- The Netherlands: the need for sustainable health workforce policies and the consequences of the informalisation of care that has resulted from the increased migration of care workers;
- Romania: the need to develop an intra-EU compensation mechanism, including greater transparency and programmes dedicated to countries that lose health personnel in favour of countries with higher GDP and hence higher budget allocations for health;
- Poland: in 2014 the government adopted a new law on healthcare services, which allowed paediatricians and physicians (specialists in internal medicine) to open primary health care practices. This change, which was the result of public consultations, should lead to better access to primary health care, especially for children.

National level discussions also explored the challenges of providing decent working conditions to immigrant health workers of both EU and non-EU origin, which should be

equal to what is provided to domestic health professionals. These and other issues are covered by 16 case studies that are published via the online collaboration tool.

The HW4All project has now issued a Call for Action<sup>47</sup> to European decision-makers and Member States and is collecting endorsements. It requests that:

1. countries implement long-term HWF planning and training strategies that result in self-sustaining national health systems;
2. Member States do not cut investments in their health workforce due to austerity, but rather invest in their HWF as a way to accelerate economic recovery;
3. countries should also respect the rights of EU or non-EU migrant workers;
4. thinking and acting should be done coherently at the national, EU and global level in terms of recruitment, fiscal policy and development: coherence is required between the development cooperation policies and domestic health policies and practices of European Union Member States with regard to the strengthening of the health workforce in countries with a critical shortage of HWFs.

### The EPSU-HOSPEEM Code of Conduct on Ethical Recruitment

(Based on the presentation by **Elisa Benedetti**, HOSPEEM<sup>48</sup>)

Recruitment and Retention issues have been part of the HOSPEEM (European Hospital and Healthcare Employers' Association) and EPSU (European Federation of Public Service Unions) work programme since 2006 when they established the Hospital Social Dialogue Committee with funding from the EU Commission. This Committee was set up to work on the topic of Recruitment and Retention for "identifying common position [*sic*] for cross-border recruitment of hospital personnel" (EPSU-HOSPEEM work programme 2006-2007) and its aim was to inspire dialogue between employees and employers.

HOSPEEM and EPSU signed the *Code of Conduct on Ethical Recruitment* on 7 April 2008, which focuses on intra-EU mobility. This Code of Conduct has various similarities with the *WHO Code* approved in 2010. The twelve key principles and commitments the EPSU-HOSPEEM Code proposes are as follows:

1. High-quality healthcare, accessible for all people in the EU
2. Registration and data collection
3. Workforce planning
4. Equal access to training and career development
5. Open and transparent information about hospital vacancies across the EU
6. Fair and transparent contracting
7. Registration, permits and recognition of qualifications
8. Proper induction, housing and standards of living

<sup>47</sup> Available at: <https://interact.healthworkers4all.eu/display/CTA/European+Call+to+Action>

<sup>48</sup> Presentation from the WHO Code Workshop in Lisbon

9. Equal rights and non-discrimination
10. Promoting ethical recruitment practices
11. Freedom of association
12. Implementation, monitoring and follow up

In line with the above, it is assumed that healthcare is a fundamental human right and should be equally accessible, affordable and based on solidarity principles. From that another principle has been derived, which is also partially presented in the WHO Code: Commitments towards employers and employees have both been established (e.g. fair and transparent contracting, correct information sharing, etc.).

The Code of Conduct on Ethical Recruitment was assessed within the framework of a Joint Evaluation from the perspective of its application by the Social Partners of EPSU<sup>49</sup> and Hospeem<sup>50</sup>, i.e. by the affiliated partners of these organisations in the EU27, and the report was finally adopted on 5 September 2012. It revealed that only eight affiliated members had made use of the Code.<sup>51</sup> Good examples include the Netherlands, where the Code was used and implemented, for it was highlighted by the Employers' and Trade Unions' joint report.

The quick dissemination and implementation of the Code was mainly due to its translation to various languages<sup>52</sup>, Joint Steering Committees including both employers and employees, seminars or meetings with members of trade unions and employer organisations, public authorities at the national and local level, internet-based dissemination, publication of a user guide, and other forms of assistance.

While the EPSU-HOSPEEM Code contains beneficial solutions for both sending and receiving countries, the question arises as to **why only a limited number of EPSU and HOSPEEM affiliated members (employers and/or trade unions) make use of this instrument**. The possible causes for this are the following:

- Prolonged freeze of collective agreements (e.g. in Italy at this time). The Code should be implemented via collective agreements, and the lack of said agreements prohibits the active steps of implementation;
- A lack of cross-border recruitment in some countries, i.e. no immigration (of any quantitative importance at least - e.g. the Baltic states);
- Lack of formally agreed translation of Code (e.g. Lithuania);
- Other priorities

<sup>49</sup> Affiliated members of EPSU, available at: <http://www.epsu.org/r/6>

<sup>50</sup> Affiliated members of HOSPEEM, available at: <http://hospeem.org/about/members>

<sup>51</sup> HOSPEEM is represented by the NHS in the UK, and since the NHS has its own Code of Conduct, the implementation of the EPSU-HOSPEEM Code was evaluated in the UK.

<sup>52</sup> 35 languages as of January 2014



## The views of EPSU-HOSPEEM members with regard to cross-border recruitment and retention

### Issues:

- Tackling present and future shortages of healthcare professionals. In specific areas there is a significant dependence on migrant workers, which causes uncertainties in planning.
- Recognition of professional qualifications which is currently in developed into the implementation phase.
- For emigration countries: attractiveness of the national labour market to increase retention of skilled staff.
- Role of Social Partners as gatekeepers for ethical recruitment.

### Challenges:

- Making the best use of limited financial resources. Better use of national workforce resources. Countries view their migrant HWF as invested money outflow.
- Improved and easier cross-border recognition of professional qualifications
- Induction and efficient use of migrant health workers (e.g. language skills, training). Need for language training as a precondition for migrant healthcare workers to start working.
- Increasing the representation of migrant workers (i.e. by promoting trade union membership).
- For emigration countries: an urgent need to improve working conditions, convergence of wages towards the EU average and improvement of the quality of public services.

### A useful practice: Implementation of the EPSU-HOSPEEM Code in the Netherlands

A joint trade union, the *Organisation for Social Partners in Hospitals* (StAZ) was formed in the Netherlands as a collaboration of employer and employee organisations in the Dutch hospital sector.<sup>53</sup>

The StAZ Board found the EPSU-HOSPEEM Code highly important and referred it for implementation to the special StAZ Europe working group. The dedicated meetings of this group, the **translation** of the Code into Dutch as well as the **evaluation** of the Code in light of legislation and initiatives by Dutch authorities, in addition to initiatives taken by social partners, significantly contributed to the implementation of the Code.

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<sup>53</sup> Available at: <http://www.staz.nl/europe>

#### Results:

- Principles of the Code integrated in a **collective agreement 2011-2014**
- The Code and evaluation grid is **accessible** to stakeholders in Dutch and English and is posted on the **StAZ website**<sup>54</sup>
- Clear **overview of measures/gaps** in relation to the implementation of Code
- **Certification scheme** and agreement on **blacklisting of recruitment agencies** not complying with ethical recruitment practices and publication on StAZ website
- **Long-term objective:** a database for comparable data and information on migration and migrant health workers

At the EU level, several Codes of Conduct have been developed and applied by various organisations. To support the integration of these processes, HOSPEEM is eager to negotiate with other stakeholders (i.e. governments, regulatory bodies, trade unions etc.) to establish collaboration with the EU Commission.

## Part 2. Experiences of Member States relating to the implementation of the WHO Code

This section includes an overview of the experiences of four countries regarding the implementation of the Code among those who reported considerable initiatives to WHO: Finland, Ireland, Germany and Moldova. Since the Code has high expectations of countries, the implementation of all its Articles requires long-term and ongoing dedication. These country cases demonstrate well the efforts these countries have made with different levels of success on the path towards implementing the Code. The descriptions of the country cases are based on presentations by the representatives of these countries at the WHO workshop in Bratislava, January 2013 and Lisbon, June 2013.

### *Implementing the WHO Code – the Irish experience*

(Based on the presentation by **Professor Ruairí Brugha**, Division of Population Health Sciences, Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland<sup>55</sup>)

The WHO Code is partially a document discussing international health workforce recruitment, but it is also about HWF training and retention. If national health systems were able to meet their own health workforce needs through training and retaining the health professionals they need, there would not be a need for international recruitment, thus the Code would be less relevant.

Ireland is committed to implementing the WHO Code, a commitment that is reinforced by

<sup>54</sup> Available at: <http://www.staz.nl/europe>

<sup>55</sup> Presented at the WHO Code Workshop in Lisbon

its high reliance on foreign-trained health professionals from low- and middle-income countries. In 2008, Ireland was the biggest recruiter of foreign-trained nurses and the second biggest for doctors (in % terms) among OECD countries. Between 2000 and 2008, the percentage of registered foreign-trained doctors increased from 12% to 35% and between 2000 and 2006, more than 50% of all nurses registering in Ireland were non-Irish, primarily from the Philippines and India.

The peak in registration for foreign-trained doctors was in 2009, when it reached 36.3% and consisted predominantly of non-EU nationals, but it also included doctors trained in Poland and Hungary. In 2010, 33% of doctors trained outside of the EU were from South Africa, most of whom were serving in Ireland only for shorter periods of time as locum doctors (i.e. they were circular migrants).

Ireland has increased its training capacity and now produces sufficient graduates in medicine and nursing to meet its health workforce needs, in response to national policy recommendations that aimed for national self-sufficiency. Nevertheless, Ireland is experiencing recruitment and retention challenges across the public healthcare system. Despite adequate numbers of training positions for nursing and medical students, emigration has increased; for example half of the medical students who graduated in 2011 left the country. Emigration is facilitated by health degrees being highly portable qualifications globally.

The training of nurses in Ireland is now through a degree programme, which may have contributed to a higher rate of emigration. Cuts in salary levels, especially for entry-level consultants and a public sector recruitment embargo from 2009 to 2014, which reduced the availability of new posts for nurses – both precipitated by the economic downturn – contributed to health professionals emigrating.

Research on foreign-trained nurses and doctors in Ireland suggests that many have come to view Ireland as a “staging post” to which they migrate and from which they plan to move on to work in other high income countries such as the United States, Canada, Australia or the UK. Some foreign-trained doctors have encountered difficulties in accessing posts in Ireland that offer formal postgraduate training, which is necessary for career progression. Without access to training opportunities, these doctors look to opportunities in other countries. However, given the lack of exit data, beyond verification data on nurses, it is not possible to accurately estimate the destination countries of both foreign and Irish-trained doctors and nurses who leave Ireland.

The Irish experience demonstrates the need for health workforce data collection to ‘track’ trainee health professionals as they progress through training to permanent posts and/or emigrate to other countries. Based on the Irish experience, national health workforce research programmes need to analyse and identify the factors that determine why a country does not retain the health professionals it trains. The Doctor Emigration Project is a new research project which will track and obtain information about emerging patterns of health professional mobility from up to 900 doctors in training posts in

Ireland, 20% of whom qualified as doctors outside of Ireland. Some of these will have emigrated between mid-2014 and mid-2015.

Any solution to a national HWF crisis will require a multi-pronged response. Ireland is implementing a series of recommendations aimed at retaining the doctors it trains, emanating from a strategic review of medical training and career structure undertaken during 2013-2014. It now also offers a structured migration/training route for doctors from Pakistan whereby they can come to Ireland to obtain two years of postgraduate specialty training, matched to their needs, which is accredited by their training college in Pakistan. At the same time these doctors are also serving local needs in Ireland. There are ongoing discussions with other countries with a view to extending this cooperation to other low- and middle-income countries who wish to avail themselves of postgraduate training opportunities in Ireland.

#### ***Implementing the WHO Code - the German experience***

(Based on presentations by **Melanie Boeckmann**, University of Bremen and **Meiko Merda**, IEGUS – European Institute for Healthcare Research and Social Economy<sup>56</sup>)

From the perspective of the international mobility of health workers, Germany is a receiving country. Key strategy points of the WHO Code are implemented as follows:

- National responses to health workforce shortages: image campaign, discussions on fair wages and work-life balance as well as on the recognition of foreign qualifications. Inter-ministerial cooperation.
- Focus on the fair treatment of migrants. Health personnel from abroad are hired, promoted and remunerated on the basis of objective criteria such as levels of qualification, professional experience and degrees of professional responsibility - on the same basis as the domestically-trained health workforce. Migrant health professionals enjoy the same opportunities as domestically-trained health workers to extend their professional education, obtain new qualifications and achieve career progression.
- In June 2013 the general framework for the migration of nurses from non-EU countries was established with the reform of the "Beschäftigungsverordnung". In November 2013 the revision of this piece of legislation implemented a provision of the WHO Code: according to § 38 only the German Federal Labor Market Authority is authorized to recruit healthcare personnel from the 57 countries on the WHO list with "critical shortages". These countries are also enlisted in the appendix of this law.
- Difficulties arise from the federal system due to a multitude of stakeholders and data sources, and the differences among the international curricula & diplomas. A

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<sup>56</sup> Presentations from the WHO Code Workshops in Bratislava and Lisbon.

thorough monitoring of the relevance of the legal basis will be necessary in the future.

#### *Recent pilot projects - recruitment of nurses from Asia*

As a solution to the current HWF crisis, different initiatives have been launched over the previous years. The legal basis for these initiatives was set in 2013, when the immigration of non-EU nurses was accepted by the German labour market authorities, provided that their qualifications are accredited in Germany. The following are major examples of the new forms of recruitment:

1. The German government now funds the six-month language training of 100 applicants in Hanoi, Vietnam and then their full training in elderly care in Germany.
2. The German Employers Association, similarly to other private and government initiatives, now implements such training-recruitment projects in China. There is, however, a lack of interest/engagement in Germany from institutions providing nursing care and hospitals that would employ these nurses after training.
3. A German hospital in cooperation with the Federal Foreign Office now trains 25 nurses from Tunisia.
4. Based on bilateral agreements with the Philippines, Serbia and Bosnia-Herzegovina, various training and recruitment schemes are currently run.
5. The German Association of International Collaboration now plans to recruit some 2,000 nurses, based on inter-governmental agreements.

#### *Lessons learnt from international recruitment schemes*

1. Governments and healthcare organisations of sending countries have a high willingness to cooperate. Similarly, the motivation of nurses in less-developed countries to move, live and become integrated in Germany is also high.
2. Both the language courses and the recognition procedure for foreign diplomas require significant time and financial resources. While Article 5.1. of the Code states that both source and destination countries should benefit from the international migration, it is still to be decided which organisations of the source and destination countries should pay for the recruitment process.
3. Circular and temporary migration should be incentivised, e.g. by creating jobs for those moving back home.
4. Sustainable financial mechanisms should be established for the running of the entire recruitment process.

5. It also has to be underlined that since the WHO Code prevents cooperation with countries facing critical shortages, they cannot benefit from the positive impact of organised migration on sending countries, however, there might be interest for cooperation from their side.

#### ***Experience of the Republic of Moldova with Bilateral Agreements***

(Based on the presentation by **Ms Eugenia Berzan**, Head of Department - International Relations and European Integration, Ministry of Health, Republic of Moldova<sup>57</sup>)

The Republic of Moldova is a Collaborating Partner of the EU Joint Action Health Workforce Planning and Forecasting. Moldova is represented by the Ministry of Health and its National Centre on Health Management that hosts the South-eastern Europe Regional Health Development Centre on Human Resources for Health.

In order to address the challenges in health workforce shortages, Moldova decided to start negotiations in order to conclude Bilateral Agreements based on the principles of the WHO Global Code. The 2013-2014 Action Plan of the Government determines: “to intensify bilateral dialogue with States where the largest Moldovan Diaspora populations exist, signing bilateral agreements in the field of social protection of migrants, as well as health, education, labour migration etc”.

Moldova seeks bilateral negotiation possibilities with Member States aiming neither to reduce or limit, nor to enhance or facilitate mobility, but to ensure the appropriate management of HWF whilst mitigating the adverse effects, ensuring circular migration, and maximising developmental benefits that result from mobility. Moldova intends to raise the issue of mobility at the international level, and point out the shared responsibility of countries.

One of the main challenges that the mobile HWF is facing is that their diplomas earned in Moldova may not be recognised in the destination countries. A workshop on the “Harmonization and Mutual Recognition of Health Professionals' Qualifications in Europe” was held in Chisinau in June 2013, where the key significance of the European Commission Directive 2005/36/EC on the recognition of professional qualifications was highlighted.

At the initiative of the Ministry of Health, based on nomination letters presented on behalf of all national key stakeholders, a Cross-Sectoral Working Group was established in July 2013, in order to cooperate in developing the draft bilateral framework agreement in the field of health personnel migration. During 2013-2014, several technical meetings and workshops were held on the Draft Bilateral Agreement.

The draft agreement was developed based on the innovative and comprehensive Model Bilateral Agreement I - as reflected in the publication “*Innovations in Cooperation: a*

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<sup>57</sup> Presented at the WHO workshop in Lisbon

*guidebook on bilateral agreements to address health worker migration*<sup>58</sup> - strongly building on the WHO Code of Practice provisions. This agreement was

- adjusted by the Cross-Sector Working Group, based on the Moldovan practice in concluding and implementing bilateral agreements in the field of labour migration and social protection of migrants, and
- approved by Government Decision No.936 dated 22 November 2013 as a basis for starting the dialogue on negotiations in the area of migration of health professionals, with Partners from the destination countries of Moldovan health workers.

Bilateral Agreements are in force on the Social Protection of Migrants with Bulgaria, Portugal, Romania, Luxembourg, Austria, Estonia, the Czech Republic and Belgium, and on Labor Migration with the Russian Federation, Ukraine, Belarus, Azerbaijan, Italy and Israel.

The Draft Intergovernmental Framework Agreement in the field of Health Personnel Migration consists of a Preamble, 1) Definitions 2) Objectives 3) Recruitment Standards 4) Employment Standards 5) Migration and Development 6) Implementation and Monitoring 7) Dispute Resolution, Entry into Force, Amendment and Denouncement. This is a comprehensive and innovative concept that takes into account the Extended Migration Profile of the Republic of Moldova, results from the most recent studies of priority destinations of health professionals migrating from the Republic of Moldova, and trends in international (especially European) migration flows.

19 countries were selected to launch the dialogue process for opening negotiations on the Draft Intergovernmental Framework Agreement in the field of Health Personnel Migration, including: Romania, Italy, Spain, Portugal, Germany, Israel, France, the United Kingdom, Turkey and Bulgaria.

Prioritisation of the countries to start negotiations on the draft agreement happened in 2014. Invitations to launch negotiations were addressed via diplomatic channels to partners from Italy, Spain, Portugal, Germany and Israel. Dialogue has recently begun with Germany on priorities for cooperation in the field of health personnel migration.

### **Implementing the WHO Code – the Finnish experience**

(Based on the presentation by **Reijo Ailasmaa**, National Agency for Health and Welfare, Ministry of Health<sup>59</sup>)

The WHO Code was translated into Finnish and published on the website of the Ministry. The National Development Programme for Social Welfare and Health Care (Kaste

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<sup>58</sup> Available at:

[http://www.aspeninstitute.org/sites/default/files/content/docs/pubs/Bilateral%20Report\\_final%20code.pdf](http://www.aspeninstitute.org/sites/default/files/content/docs/pubs/Bilateral%20Report_final%20code.pdf)

<sup>59</sup> Presented at the WHO workshop in Bratislava

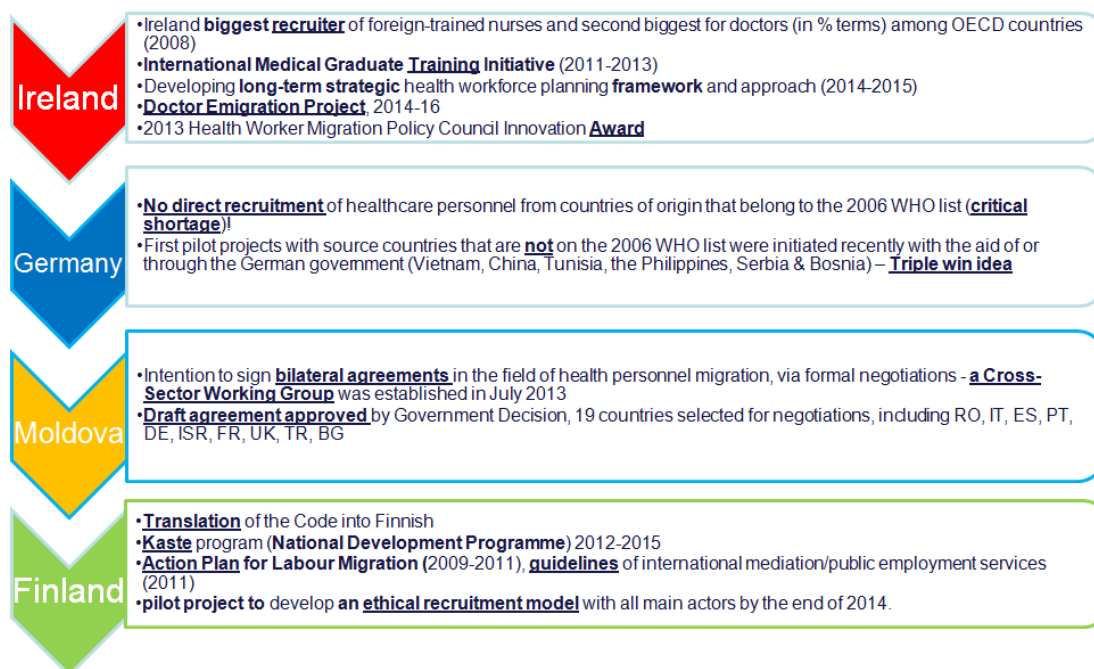
programme, 2012-2015) defines as a priority area the sustainability of the workforce in social and health care by means of clarifying practices on the international recruitment of personnel in social and health care. Finland also reported to WHO the following programmes:

- Government Resolution on Action Plan for Labour Migration in 2009-2011
- Guidelines of international mediation/public employment services (adopted in 2011 by the Ministry of Employment and Economy) – defining the role of public employment services in international recruitment from outside of the EU/EEA area
- A pilot project started by the Ministry of Employment and Economy in 2012 aimed to develop an ethical recruitment model for recruiting nurses and care assistants to Finland from outside of the EU/EEA area by the end of 2014.
- Multilateral and regional agreements regarding international recruitment

Monitoring of the WHO code and international mobility of healthcare personnel in Finland has also been introduced, together with data categories collected and institutions taking part.

### Summary positioning of the national cases within the framework of the WHO Code

The below chart provides a summary of the country-level examples presented in the previous section of this document.





In order to provide a quick summary of the country presentations, the columns in the below table represent the most important elements of Articles 4-8 of the WHO Code, and the rows summarise the relevant information provided by the countries in this activity. In other words, the table shows which concrete provisions of the WHO Code the four introduced countries have implemented. This is not a full overview of the Code's implementation.

#### Specific articles of the WHO Code covered by the country examples

Article	Number of the WHO Code Article and the focus point of the Article							
	4	4	5 & 10	5	5	6	7 & 9	8
	Employer & State recognition of the need for ethical recruitment	Implementation of fair treatment and encouraging education	Collaboration between countries with mutual benefits	Developing evidence-based HWF planning and taking measures for monitoring	Enhancing education and building on creative curricula	Improve data collection, evidence-based building and strengthening HWF research	Exchange information at Local & Global level	Promote the code and implement in local laws
<b>Ireland</b>	X	X	X	X	X	X	X	X
<b>Germany</b>	X	X	X		X		X	X
<b>Moldova</b>	X		X				X	X
<b>Finland</b>	X		X	X			X	X

**Note:** this table is set up for providing an overview of the areas of the WHO Code implementation that were presented by four countries - and does not intend to provide detailed scientific insight.

## Part 3. The applicability of the WHO Code's principles within the EU context

The issue of examining the effect of the WHO Code and its principles in the context of free movement within the EU was introduced into this discussion as one of the main focus points of this activity. Research has shown significant changes in mobility patterns as a consequence of recent enlargements, as the realisation of the free movement of persons principle offers better professional and financial possibilities for health professionals in other countries resulting in deepening inequalities in access to healthcare services.

### *Ideas from the first workshop*

The short introductory discussion at the first workshop<sup>60</sup> aimed to examine the contexts and different perspectives of participant countries. The discussion was opened by a short exchange of views about the mobility situation and ethical recruitment from the perspective of a (mainly) sending (Hungary) and a (mainly) receiving country (the United Kingdom).

The **Hungarian representative** highlighted that Hungary has an increased outflow since accession in 2004, with a stable number of around 2,000 health professionals leaving annually in the previous two years, while inflow is around 200 persons/year. The main target countries for doctors were Germany (1,200 Hungarians registered), and the United Kingdom (1,300 Hungarians registered) in 2011. Mainly younger doctors are leaving for Germany, while to the United Kingdom it is mainly specialist doctors with an average age of 35. Measures have been taken to retain health workforce, e.g. by increasing salaries or by introducing a scholarship programme for young practicing doctors. However, some measures are not an option, for example if Hungary increased the numerus clausus of university training, there is no guarantee that qualified doctors would stay in the country. It is important to note, however, that training capacities are already full, as 40% of them are dedicated to foreign students in English or German language courses. A concrete example of institutional level agreement has also been introduced providing for a circular mobility type solution.

The **United Kingdom representative** began by stating that in the United Kingdom a Code of Practice has existed for more than 10 years and that the United Kingdom is a signatory to the WHO Code of practice, which is robustly managed by the National Health System (NHS) Employers organisation. England has invested considerable resources in workforce planning and is moving towards a position of self-sustainability. However, the size and nature of the NHS means that there will always be some areas with shortages. Therefore, it is not surprising that the NHS recruits and will always need to recruit health professionals from around the world, while as a signatory to the WHO Code it aims to

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<sup>60</sup> Bratislava, January 2014

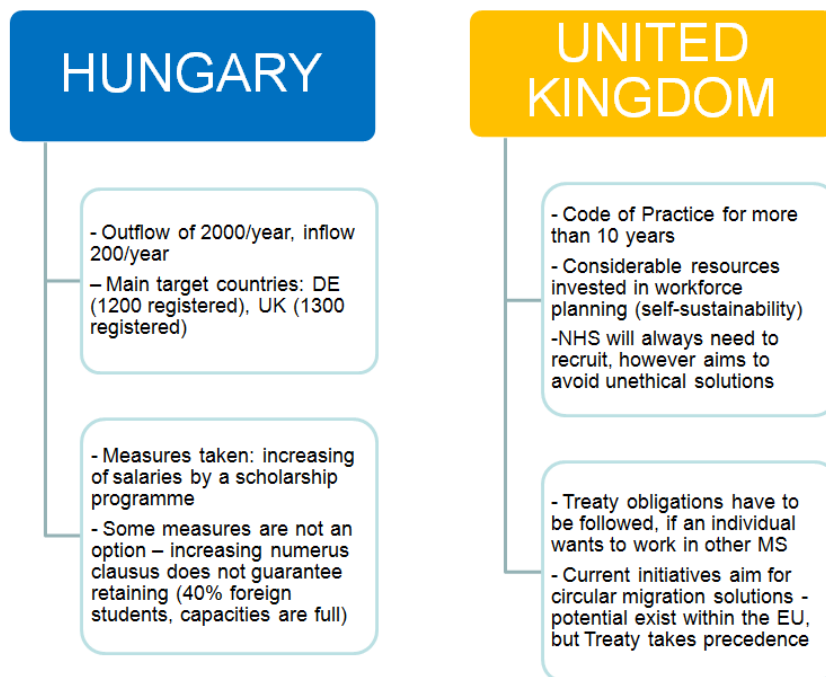
avoid recruitment in countries where it is not ethical. In the EU, Member States are obliged to honour the mutual recognition of professional qualifications and freedom of movement. This is a challenge to the health economies of Europe, for example the United Kingdom and Germany pay higher wages than other countries, and free movement and professional recognition mean that individual doctors are free to move between health systems at their choice. In terms of numbers coming to work in the United Kingdom overall, the Hungarian inflow is quite modest, however, the Hungarian perspective may be quite different, especially when considered in the context of overall outflows from Hungary. England honours its treaty obligations vis-à-vis individual health professionals looking to work in the United Kingdom. In circumstances where recruitment is on a larger than individual scale, countries approached are normally those with some evidence of oversupply.

Health Education England is responsible for education and training in the United Kingdom. Where shortages exist, the NHS may recruit from outside the EEA. Current initiatives seek to combine recruitment with a limited right to stay, providing for circular migration that could benefit the “donor” country. These individuals receive training in the United Kingdom, deliver services in the United Kingdom and return<sup>61</sup> with a qualification and experience, which is a benefit for the donor as well. The potential exists for similar schemes within the EEA and will generally respect a country’s wishes as requested. Nevertheless, Treaty obligations have to be respected if people decide to stay and work in the country. The outflow-situation of the United Kingdom is not perfectly known, and only approximate data is available. These suggest that the numbers of doctors with qualifications from outside the United Kingdom is proportionately lower now than it was in the past. The Department of Health would like to reduce reliance on migration in general, and is specifically looking for rectifying issues where there are shortages of skilled workforce.

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<sup>61</sup> Return means out of the United Kingdom - there is no control to verify that this workforce will return to their home country.

**Graph on the exchange of views about the mobility situation and ethical recruitment from the perspective of a (mainly) sending (Hungary) and a (mainly) receiving country (the United Kingdom)**

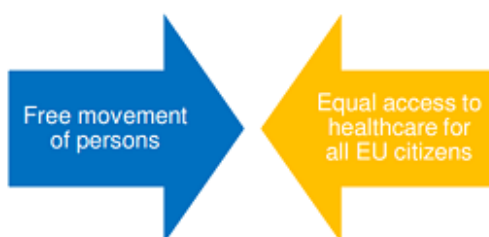


During the **group discussions** – the following questions were raised:

1. How relevant is it to build on the principle of ethical recruitment within the EU, where people have their right to free movement?
2. What kind of good practices could be implemented within the EU?
3. Which tools could support the availability of better and more data?
4. Which recommendations would be relevant at the EU level?

Based on these questions, the following standpoints were expressed:

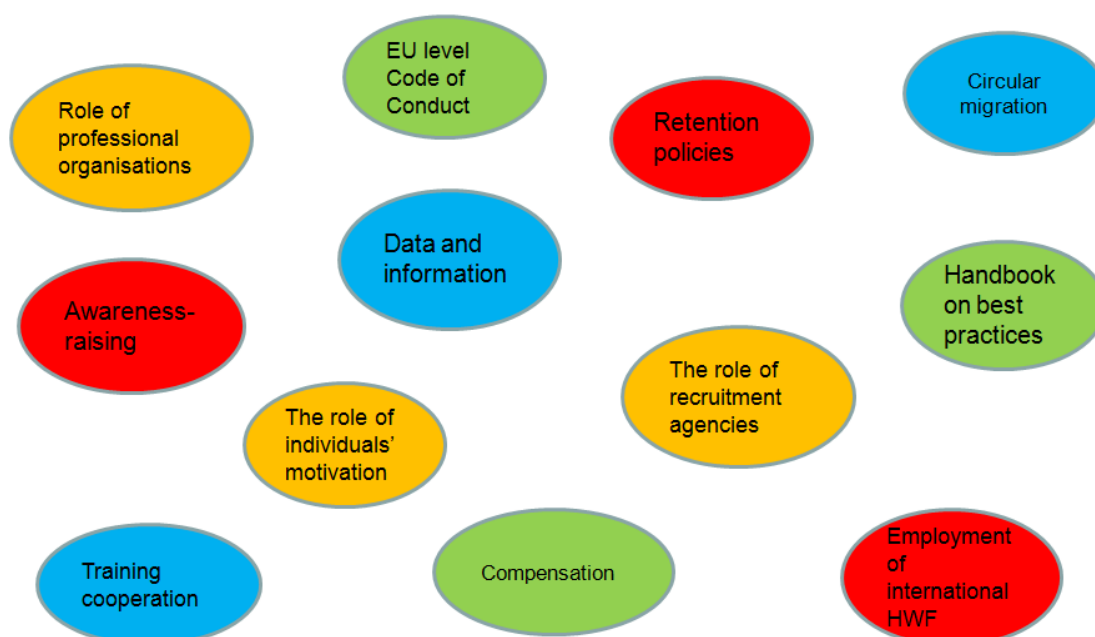
- Consistency is needed to address the issues. When the enhancement of free movement is promoted, equal access to health care for all EU citizens must be given equal weight. The two basic principles may come into conflict when the realisation of free movement results in considerable imbalances in the healthcare systems of some regions or countries within the EU.



- A lack of clarity persists within EU countries about what the WHO Code refers to, and what the countries could or should do. More transparency could help Member States understand how concrete principles can be applied in practice.
- The implementation of the WHO Code at the EU level should reflect the aims of sustainability in the health workforce.
- The WHO Code is much broader in scope than retention. In the EU labour market (which is uneasy to influence) foreign health professionals often work below their skills and competencies.
- The WHO Code should be used as some kind of “catalyst” to draw attention to (raise awareness) and/or implement initiatives to strengthen human resources for health. It should not focus only on ethical recruitment.
- The principles of the Code must be translated to the individual level as “real life” people, e.g. hospital directors, may not take into account (if they are aware of) EU-level political issues.
- To better control recruitment agencies, a new (legal) framework should be developed within which they should operate, and they have to be quality-assured. This legal framework should be consistent with host countries’ legislation and also supported at the EU level to make implementation feasible.
- Feedback from receiving countries – in an automatic way - to source countries could ensure the drawing up of flow maps in the EU.
- Enhanced quality measures are needed on temporary mobility, use of job portals should be considered, and closer contact with DG MARKT should be established.
- Bilateral agreements are remarkable initiations and should be widely accessible to other health professionals; shared responsibility of capacities in training by bilateral agreements should be encouraged, since the know-how is transferable.
- Important measures are to be taken to establish partnerships with professional organisations to enhance transparency, knowledge sharing and awareness raising. A bottom-up structure should be created within the legal framework.

## *From initial discussion to concrete statements - preparation for the second workshop*

The JA Work Package 4 team decided to build the discussion on pre-sent statements distributed with some background information. The statements have been chosen by the WP4 team based on the topics and ideas from the first workshop discussion, while the explanations were based to a great extent on the results and the findings of the Prometheus book II, and aimed to provoke discussion. The following items have been identified (with short explanations extracted from the pre-reading material).



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**Note:** This choice is discretionary and does not pretend to cover all the matters raised by the WHO Code.

### **1. Role of professional organisations**

Professional organisations represent the interests of the professionals themselves. Professional bodies have an important role in integrating migrant professionals, they can also provide support for individuals who would like to find a job in another Member State, or can play a role in attracting and retaining professionals in their jobs. In order to have success in implementing the WHO Code, professional bodies such as trade unions and employers' organisations - who have their own guidelines on recruitment and retention practices - should continue their efforts to promote adherence to ethical recruitment principles not only in relation to third countries, but also within the European Union.

## 2. Possibility of an EU level Code of Conduct

The WHO Code on ethical recruitment does not intend to deal with region-specific situations, especially not with those arising from the challenges of a free movement zone. An EU-Code could be considered if Member States found added value in codifying common principles and possible solutions. Growing inequalities within the EU after the latest enlargements have to be dealt with before it is too late. Examples exist for similar codes, such as the 2008 agreement for the hospital sector between the European Federation of Public Service Unions (EPSU) and the European Hospital and Health Care Employers' Association (HOSPEEM), and also the 2008 European Commission Green Paper on the European Workforce for Health, which raised the possibility of a more broad-reaching EU-level code.

## 3. Retention policies

Retention policies are being examined and discussed at different levels and forums, an inventory commissioned by the European Commission is under preparation and the newly published Prometheus book II also deals with successful retention policies in some of its chapters. Elaborating programmes to facilitate the return of emigrated health professionals can also be examined from the ethical point of view. If no ethical concerns arise, the questions remains of how to follow migration, how to get in touch with migrant health workers, how to inform them about improved conditions, or how to offer them concrete job opportunities. It is also important to take a closer look at how these tools can relate to other retention measures.

## 4. Circular migration

Circular migration is defined as when a health worker moves to another country to obtain training or gain experience and then returns to his/her home country with improved knowledge and skills. The benefits of circular migration continue to be debated in the literature, however. Within the EU, where people can take up jobs freely in other Member States, bilateral agreements promoting circular migration might also have added value. According to Prometheus, the largest labour movement between countries takes place outside the channel of bilateral agreements (through recruitment agencies, family links and social networks). So the question is, how can these instruments better serve the aim of manageable migration?

## 5. Awareness-raising

The Global Code of Practice was adopted by the WHO Assembly in May 2010. It applies to all health personnel and to all WHO Member States. The key argument is that there is a need for capable Member States to take more responsibility for planning and meeting their staffing requirements from their own resources. WHO Member States are invited to periodically report on the implementation of the Code and the first round of national self-assessment reports were to be completed by June 2012. The experiences of the first reporting round show, however, that commitment is lacking in many countries to adhere

to the Code, so further awareness-raising and sharing of best practices have a real added value.

#### **6. Possibility of compensation**

Training health professionals is a very costly investment. The WHO Code calls for countries to provide technical assistance, support and training of health professionals in countries they recruit from, although there is no explicit mention of financial compensation. Mechanisms for possible compensation are considered in some countries, however, we do not have many examples of real investment, for these projects are mainly under development. Within the EU some countries are considering, or have even introduced systems, where the reimbursement of state-financed training costs are imposed on professionals if they do not spend a certain period of time working in the home health system. The implementation of these types of solutions, however, provides many challenges.

#### **7. Employment of international health personnel**

The need to better integrate foreign health workforce and to ensure their equal treatment is an important principle of the WHO Code. However, there is evidence that migrant health professionals are at greater risk of being required to work below their skill level, which can then lead to disappointment for the individuals and wasteful situations in health systems. Discrimination and unfavourable working conditions also appear to disproportionately affect the foreign workforce. Within the EU, Directive 2005/36/EC (amended by 2013/55/EU) on the mutual recognition of professional qualifications ensures the right for workers to pursue a profession in other Member States. However, the analysis contained in the Prometheus study indicates that professionals from new EU Member States might perform tasks below skill level also within the EU.

#### **8. Possibility of a handbook on best practices**

It is important to initiate a discussion about the feasibility and usefulness of certain EU tools concerning the implementation of the Code. Some countries in Europe have invested energy into the implementation of the Code, and some of the good practices have also been introduced at WHO Code workshops. It is worth considering how these experiences could be of help for other countries, and also considering the strength and weaknesses of different EU-level tools that could include and promote them. An EU-level document focusing on the implementation of the Code could also reflect on the intra-European context of mobility. Of course, the method for European-level actions is something that needs to be discussed, but a handbook of best practices and “stronger” tools can all be evaluated along the lines of feasibility and usefulness.

#### **9. The role of individuals’ motivation**

Among the factors influencing mobility, individual motivations, experiences and expectations play a crucial role. The patterns of mobility have recently changed. For



some individuals, the negative impact of the crisis was the motivation to move. According to the Prometheus study, behind the statistics and aggregated data, health professional mobility is a phenomenon composed of different types of mobile health professionals, with each having a particular set of motivations and behaviours. Identifying and distinguishing the types is of relevance to policy-makers as it allows targeted health workforce measures to retain and recruit health professionals more effectively.

#### **10. Data and information**

In the world of rapidly changing mobility patterns, the need for accurate health workforce data is growing, as discussed in many studies and workshops. International data collection has its limits, especially when addressing comparability. As outflow data are the most difficult to collect, source countries often underline the need for cooperation with destination countries about data provision on mobility. It is also important to take into account that data collected at the international level can only be as good as the data provided by national bodies, which means that countries have to invest in better health workforce data collection systems at the national level. However, it is worth considering the possible and feasible solutions for better data exchanges on mobility at the EU level.

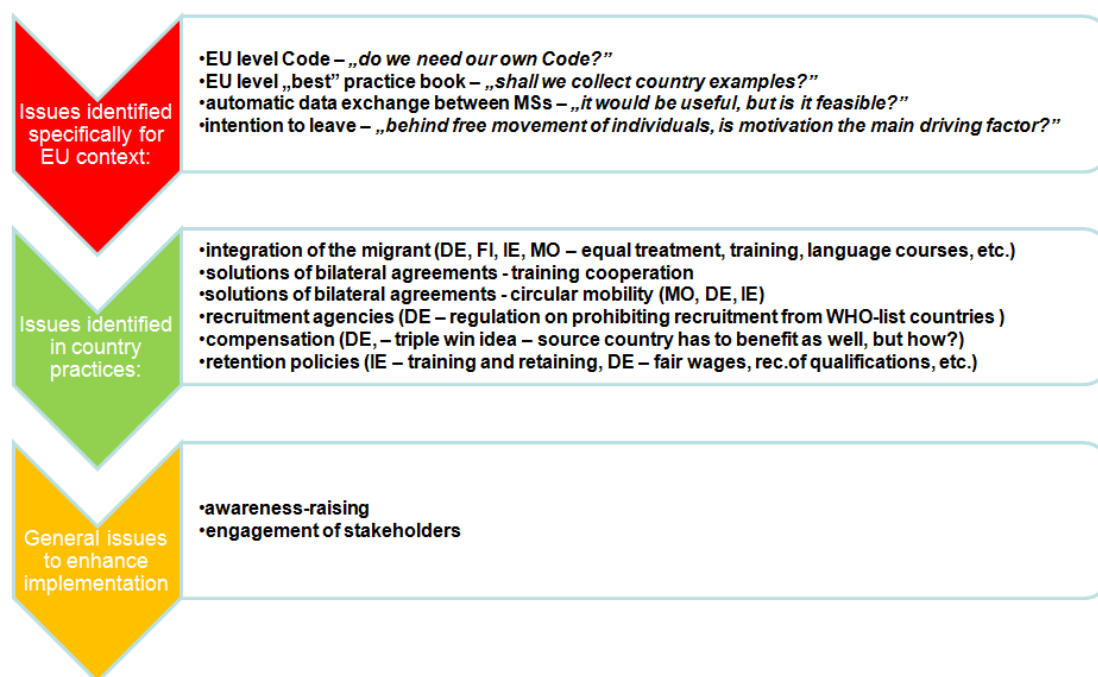
#### **11. Cooperation in the field of graduate and postgraduate training**

The use of bilateral agreements as a tool to support cooperation in the field of graduate and postgraduate training should be thoroughly examined, as they could have a real added value in ensuring a sustainable health workforce for Europe. There are well-developed exchange programmes in the field of higher education at the EU level supported by the Commission, however other forms of cooperation can also be established. Some Member States can experience difficulties if a considerable part of their capacity is filled by foreign students who do not stay in the country upon completing their training, while others might have capacity that could be offered. It is reasonable to find a transparent solution for this cooperation, as capacities have to be planned and investment from a Member State should not be disregarded.

#### **12. The role of recruitment agencies**

In many countries, active recruitment of health professionals takes place via the services of recruitment agencies. They act as intermediaries in the recruitment process, making the connection between the employer and potential recruits. Those companies often also arrange travel, accommodation and administrative requirements (such as residence permits, diploma recognition/equivalence) or even provide language courses for their recruits. If we consider the role of recruitment agencies in influencing the mobility situation as decisive, we have to discuss how these actors could be integrated into our endeavour to decrease reliance on internationally recruited health personnel. We already have examples of national level Codes of Practice or legislation, but the effects of these new solutions have to be assessed.

## Grouping of selected issues - including links to country experiences



## Exchange of views at the second workshop

The discussion was organised in small groups that included participants from different backgrounds (professional organisations, national ministries, etc.), as well as from source and destination countries. A template was developed as a tool to manage the discussion (summaries are not formulated according to the template’s logic), and participants discussed the statements after deciding on the order of priority for them. At the end of the discussion, a plenary reporting of the reformulated statements containing proposed actions took place. In the end, participants voted on the statements to indicate<sup>62</sup> the ones that are the most and the least relevant/important/feasible for them. Participants could express their preferences by using three “+” and one “0” mark per person. **31 participants voted with “+” marks (93 “+” votes together) and only 18 of them were willing to use “0”, showing how difficult it was to give lower importance to any of the identified areas.**

Results of the discussion are reported as follows: *Top importance* is given to statements where the summation evaluation (“+” mark minus “0” mark) is above 10, *High*

<sup>62</sup> The goal of this consolidation is to provide indicative information for potential future work on this subject. It is not to be considered a scientific consultation.

*importance* is given above 5, *Medium* above 0, and *Low* under 0. The WP4 Team acknowledges that this categorisation is somewhat arbitrary when giving high and medium importance for issues having only a couple of votes, however, according to our opinion, it is justified by the fact that all issues originate out of a selection in an earlier phase and were considered relevant. Some individuals did not even use the “0” mark to demonstrate the importance of all questions raised.

The WP4 Team also knows that the exercise can only count as an indication of people’s impressions after a day of discussion and common reflection, as they had to rank statements according to their importance in a short period of time. However, the result very clearly shows the differences of the EU context by placing the emphasis on different questions, as did the implementation discussion on useful practices.

#### Summary table of the final, revised statements with indicative scores:

Grouping	Revised statement	# of vote of importance	# of vote of lower-importance
TOP	Retention is an essential part of health workforce planning. Retention is a voluntary choice to stay, and it can be fostered by creating fair, equitable working conditions. Circular mobility can be beneficial to source and destination countries. <b>(retention policies)</b>	23	-
TOP	Mobility within the EU is also related to the question of solidarity and equal access. To support ethical solutions, cohesion policies and other funds have to be used to strengthen training and retention strategies in source countries. <b>(compensation)</b>	18	-
TOP	Circular migration has to be fostered within the EU in a way that benefits source countries, destination countries, and individual health professionals themselves. Bilateral cooperation tailored to different types/profiles of health professionals could be developed. <b>(circular migration)</b>	14	-
HIGH	Patient safety comes first. Each health system needs the right people (qualifications, skills, competencies, etc.) in the right places (jobs), without discrimination of any kind in the health workforce. Training and information in a proper way for migrant health professionals is needed in advance. <b>(employment of international HWF)</b>	9	-

HIGH	Countries within the free movement zone have poor control over the flow of HPs, therefore a possible automatic information exchange based on existing processes is requested for HWFP. (data and information)	7	-
MEDIUM	WHO Code is not widely known or is narrowly interpreted among the stakeholders involved in health workforce migration. Reasons for this may include the lack of translation of the WHO Code into national languages. As international recruitment cannot be banned, commitment to training and retaining has to be reinforced at all levels. (awareness-raising)	5	-
MEDIUM	A handbook of best practices derived from the experiences and knowledge of Member States is the best tool to support the practical implementation of the WHO Code and could also support the development of intra-EU solutions. <sup>63</sup> (handbook on best practices)	4	-
MEDIUM	Individuals' motivation patterns play a very important role in EU health workforce mobility that are influenced by the regulatory and social environment, as well as the free market. Analysis is needed. (role of individuals' motivation)	4	1
MEDIUM	Cooperation in the field of graduate and postgraduate training in health within Member States and within the EU should be a process that is transparent, planned in due time and regulated on multilateral and multi-stakeholder bases, otherwise countries might get into a situation where imbalance exists in their own healthcare system. (training cooperation)	5	3
MEDIUM	In order to help Member States prevent imbalances of healthcare personnel – from sending and receiving countries – activities between employers and recruitment agencies should be undertaken within a framework of transparency, and ethical and quality cooperation. (role of recruitment agencies)	2	1
LOW	Professional organisations have a role in determining standards for the quality of professional practice. The	2	3

<sup>63</sup> This has not changed as the group did not discuss it due to lack of time.

	extent of their involvement in questions of mobility, ethical recruitment and overall workforce policies depends on the Member States. (role of professional organisations)		
LOW	The feasibility, applicability and necessity of an EU-level Code of Conduct should be examined by the Commission. (EU level Code of Conduct)	-	10

As seen from the grouping above, attendees chose retention policies, better use of financial support from cohesion funds and circular mobility as the most important/relevant/feasible items to start with, while the creation of an EU level Code of Conduct is evaluated as the least important/relevant/feasible topic within the context of the Treaty on the Functioning of the European Union, which establishes free movement and with regard to legislation, regulations on fair and equal treatment and protection of workers' rights in the EU.

Proper integration of foreign health personnel and the need for better data exchange followed on the priority list, while further awareness-raising, dealing with recruitment agencies, involving professional organisations, creating a handbook, examining individual motivation and supporting cooperation among training institutions seemed to be of medium relevance, or in some cases less feasible, from the point of view of participants mainly representing ministries.

### Detailed discussions

#### Role of professional organisations

*Initial statement:* The attitudes of professional organisations at the national and EU level towards the questions of mobility and ethical recruitment is a key factor in the retention and recruitment of health professionals, so without their involvement sustainable workforce policies do not work.

*Final statement:* Professional organisations have a role in determining standards of quality in professional practice. The extent of their involvement in questions of mobility, ethical recruitment and overall workforce policies depends on the Member States.

*Result of plenary evaluation of the final statement:* The statement received two votes of importance and three votes of lower-importance from the participants.

#### Summary of the discussion:

Participants stated that the role of professional organisations in retention and recruitment may be questioned, as they neither directly implement retention practices nor recruit health professionals. Nevertheless, professional organisations have a variety of profiles: some have regulatory functions, others act as trade unions, while some have a scientific

profile, relating e.g. to a certain specialty, so their level of involvement in retention and recruitment also varies. Their attitude towards the sustainability of health systems and health workforce mobility issues, however, is influential, especially in cases where they are representing their members' interests or have a regulatory role.

The role of national professional organisations in health workforce planning depends to a great extent on national health policies and also on the activity focuses of the organisation. In cases where a professional organisation owns a registry, contribution to health workforce planning is necessary. As working conditions are influenced by the supply of health professionals, it is of great importance for professional organisations to ensure that health workers are present in sufficient numbers in healthcare provision. The major role of these organisations is to define professional standards and monitor the quality of professional training. They also have the power to lobby both at the national and European level, consequently they can influence health policies towards mobility this way. The extent of their involvement in discussion and policy making on the question of mobility, ethical recruitment and workforce policies shows great variations across countries.

International professional organisations, especially "umbrella" organisations, can represent the voice of health professionals at the European level. They can follow mobility trends among their members, monitor the fulfilment of mutual recognition in practice, check if migrants work at their qualification level in the receiving country, and they can raise their voice for the ethical treatment of immigrants. International professional organisations can also be channels towards the European Commission; they have the ability to report good and bad practices.

### An EU level Code of Conduct

*Initial statement:* An EU level Code of Conduct – taking into account provisions from the WHO Code and the EPSU/Hospitem Code – is feasible and necessary for providing guidelines on ethical solutions within the EU.

*Final statement:* The feasibility, applicability and necessity of an EU-level Code of Conduct should be examined by the Commission.

*Result of plenary evaluation of the final statement:* The statement received ten votes of lower-importance from participants, meaning that this was the statement that participants found the least relevant/important/feasible.

#### *Summary of the discussion:*

There is an obvious necessity for following the spirit of the WHO Code of Conduct at the European level. The question, however, arises about its feasibility. Treaty obligations on free movement, recognition of professional qualifications, legislation on equal treatment and other priorities all suggest against having a European Code of Conduct. The legal regulations are obligatory for all the Member States and they are based on the basic

principles of the European Union. Access to job opportunities have to be provided equally to European citizens, since employers cannot discriminate among job applicants on the basis of their nationality. Hence, the relevance of improving retention practices is growing in the context of ensuring a sufficient number of health professionals for healthcare services.

Taking into account the existence of the WHO Code of Conduct, which is applicable on a voluntary basis, the relevance of an additional Code is questionable. As EU Member States are members of WHO, they are free to implement the WHO Code of Conduct, and recommendations formulated at the European level could also be channelled into the WHO Code.

Good practices can be collected at the European level, but this cannot serve as a basis of a European level Code. Joint Action on Health Workforce Planning and Forecasting is also a possible forum for collecting good practices and identifying challenges hindering the implementation of the Code, but all the recommendations made in the framework of the Joint Action have to take into account the basic legal principles of the European Union. Only the European Commission can - within the legal framework provided by the Treaty - examine and if justified initiate more flexibility in the legislation to tackle the problem of health professional mobility in agreement with the Member States.

### Retention policies

*Initial statement:* EU Member States have to put much more emphasis on retention practices not only in source, but also in destination countries. However, measures aiming at retention – better and more flexible working conditions, higher monetary recognition, etc. - might not be sufficient. They have to be complemented with the tracking of health professionals who left the country and then attracting them back home, which is feasible in the 21st century.

*Final statement:* Retention is an essential part of health workforce planning. Retention is a voluntary choice to stay, and it can be fostered by creating fair, equitable working conditions. Circular mobility can be beneficial to source and destination countries.

*Result of plenary evaluation of the final statement:* The statement received 23 votes of importance; this was considered the most relevant/important/feasible issue among all topics.

#### *Summary of the discussion:*

Retention issues are equally important for source and destination countries. Retention practices elaborated at the national level are not enough to tackle the health workforce crisis, it should also be an issue at the cross-country and European level. Destination countries should act responsibly, taking into account the shortages in source countries. Retention policies should also be treated in the context of health workforce planning. An adequate knowledge of health workforce availability - if there is a shortage or surplus in

a given area - is equally essential for health workforce planning and retention purposes. However, the principle of free movement is superior to retention aims; retention at the individual level cannot be considered anything other than an individual's choice to stay. Retention policies have to focus on creating working conditions that increase the individual's willingness and provide an incentive to stay. The beneficial effect of mobility should also be kept in mind. Mobility cannot be considered only negatively, but it is better if it is circular. Individuals and both source and destination countries can benefit from circular mobility, for example for training purposes offering solutions for short-term shortages. The availability of adequate mobility data could enhance cooperation at the international level. The health workforce can be followed at the country level, however, it would have added value if MSs could offer solutions to stay in contact with migrating health professionals, thus possessing more information on individual movements.

Facilitating retention is possible at various levels. At the institutional and national level improvement in working conditions and adequate remuneration for health professionals can serve as effective tools for retention. Institutions can provide training for skills development, which can increase the individual's proficiency and ensure the competencies needed most by the institution. Several Member States have to face the problem of geographical maldistribution, which can be tackled by regional incentives (e.g. higher salaries in rural areas). Paying more bonuses for certain specialties is a short-term solution; it is better to focus on adequate recruitment strategies for the long term. The possibility of career development also impacts the willingness to stay; spending more years in the same institution can also provide progress in a career. Health workforce planning and human resource management should take into account career development (not only for newly graduated professionals), which has to be adjusted to the needs of the healthcare system. Offering an educational loan with the condition to remit the loan after a pre-determined amount of years spent working can also be a possible tool for retention. The public sector is also competing with the private sector for human resources for health; "buying back" health professionals from the private sector is much more expensive than keeping them from the beginning of their careers.

Directive 2005/36/EC reduces the barriers of moving to another EU country, and it also eases circular mobility, making it possible to spend time in another country and return. Circular mobility can have a beneficial role in individual career development; it could also be planned into career pathways in a systematic way. Bilateral agreements for fixed periods between organisations and countries can facilitate circularity. Retention focus can be enhanced at the European level by disseminating good practices on retention and sharing case studies. The Joint Action on Health Workforce Planning and Forecasting can also have a role in this process.

### Circular migration

*Initial statement:* Circular migration has to be fostered within the EU, as triple win solutions are also feasible within the context of free movement. In order to facilitate mutual benefits, short-term employment – no longer than a year – based on bilateral



agreements could be the proposed solution.

*Final statement:* Circular migration has to be fostered within the EU in a way that benefits source countries, destination countries, and individual health professionals themselves. Bilateral cooperation tailored to different types/profiles of health professionals could be developed.

*Result of plenary evaluation of the final statement:* The statement received 14 votes of importance, being one of the most relevant/important/feasible issues among all topics.

*Summary of the discussion:*

With short term contracts, temporary mobility can be encouraged and is feasible, however, it is difficult to ensure that professionals return to their countries of origin. Professional bodies may also need to be involved to facilitate return. The ideal length of such periods spent abroad remains a question. Taking into account that migration has costs, integration takes time and language is a barrier, the period should be more than a year. However, if the period is too long and the professional becomes integrated, it is difficult to encourage him/her to return. There is also the question of whether the source country can offer better possibilities compared to when the migrants left (income, work standards, etc.).

To meet the short-term needs of the health system, circular mobility can also be a good solution in certain cases. In Hungary, for example, an institution has an agreement for the short-term exchange of pathologists. Concerning the timeframe, the level of seniority is also a factor. Within the EU the recognition of diplomas and similarities in health systems makes the situation different from the solutions EU Member States developed for third countries. The most important aspect of this type of migration is the development of all parties involved, and not the specific time period. The definition by the International Organisation for Migration talks about temporary and long-term circular migration.

The aim of migration management at the EU level is an important question. At the individual level, free movement is now a right and a viable option, but it affects health systems in the source country. Intra-EU migration requires less tools to be utilised, as it does not require immigration policy tools such as in the case of third countries. First of all, EU immigration policies need to have an aim. A decision is to be made on how actively the EU needs to be involved in its management, and steps are to be taken so that source countries could also benefit from migration. Secondly, the length of stay in a host country is also an important issue, but this is difficult to manage at the EU level, as orientation, cultural and linguistic circumstances, etc. are considerable. Different circumstances call for different solutions, and health professionals are ready to invest only if they can work abroad for a longer period. Thirdly, we have to close the circle: the source country has to create jobs and improve conditions, as people cannot be forced to return, and attractive possibilities have to be offered to them. Different solutions are needed for different age-groups and situations (e.g. at the age of 50, well-experienced

professionals may consider returning to look after old parents), however if young people leave, it has to be taken into account that they will not always have strong ties to go back. A long-term contract in the source country could allow or facilitate a short-term contract to travel for work to other European countries.

The institutional level is the most suitable and feasible within the EU to manage circular mobility. The aims and mutual benefits for all parties involved have to be assessed in advance. Losses within the EU resulting from the use of other countries' training capacities are difficult to compensate, however, exchange programmes by teachers for medical schools and knowledge-transfer could be useful. Easier conditions for opening up training facilities can be considered. At the national level, not much experience exists with cooperation agreements within the EU. EU-level action could be taken on the agreement of Member States to emphasise the shared responsibility principle (to find solutions beneficial for all) e.g. by Council Conclusions. Destination countries have to offer proper training for migrants and enough training posts in order to retain them. The idea of an EU certificate for institutions for fair treatment with migrants (accreditation) popped up. Most measures in this area are long term. The introduction of retention measures in source countries is perhaps the most urgent item.

### Awareness-raising

*Initial statement:* The WHO Code is not widely known and accepted among the EU stakeholders involved in health workforce migration as a result of unsuccessful awareness-raising activities, including the lack of translation of the WHO Code into national languages. As international recruitment cannot be banned, commitment has to be reinforced at all levels.

*Final statement:* The WHO Code is not widely known or is narrowly interpreted among the stakeholders involved in health workforce migration. Reasons for this may include the lack of translation of the WHO Code into national languages. As international recruitment cannot be banned, commitment to training and retaining has to be reinforced at all levels.

*Result of plenary evaluation of the final statement:* The statement received five votes of importance from the participants.

#### *Summary of the discussion:*

According to the experts, we cannot explicitly say that different actors do not know and accept the Code, but they often do not understand what is behind it, and which measures can be taken to implement it. There is legislation for banning recruitment from countries on the WHO list of countries with fragile health systems, however what has to be developed is how to collaborate with those countries that are not on the list and how to fill this collaboration with content that provides mutual benefits. At the same time in some countries, not many stakeholders or policy makers are aware of the Code. In countries where international recruitment is at a low level, awareness about the

implementation of the Code is low. People think that the Code is only about recruitment, however it is also about training and retention. Inadequate training capacities and the lack of efficient retention policies force countries to recruit from abroad - but solving training and retention questions eases this pressure. An important question is how to reach the level of institutions with the message of the Code, as many recruit on their own. Frequently recruitment agencies are also unaware of the Code.

The causes for the lack of understanding cannot be determined, so the part of the original statement "as a result of unsuccessful awareness-raising activities" was proposed to be deleted. Hopefully the Health Workers for All project can reveal the causes. The translation might help, as in the project the Code has been translated into the languages of the participating countries.

Different types of stakeholders need different solutions to reach them (organisational/institutional levels can be distinguished). Ministries (especially health ministries) possess the main responsibility in dissemination and awareness-raising. If stakeholders are not aware, it is the fault of the governments, the signatories of the Code. We have to improve coordination and communication between government departments. The national reporting process has to be made more transparent. Professional bodies have to be engaged in dissemination, which is a step that can be done in a reasonable amount of time to improve awareness-raising. The action plan for MSs could be a good step forward to make the implementation process more efficient. The EU Action Plan also includes that Member States will be supported by the Commission in implementation of the Code, however not that much has been done yet. The EU could advise Member States to make Action Plans to implement and communicate the Code. Extra funding would be difficult at the EU level, as Health Workers for All is the running programme financed by the EU. The EU countries which are big recruiters have to be committed to following good practices. EU recommendations in this direction could help Member States in stimulating discussion at the national level and enhance their endeavours.

### Compensation

*Initial statement:* Mobility within the EU is also related to the question of solidarity and equal access, but within the internal market no ethical solutions can be forced. However, an EU-level system of compensation or at least the reimbursement of the state's investment into the training of professionals can be established.

*Final statement:* Mobility within the EU is also related to the question of solidarity and equal access. To support ethical solutions, cohesion policies and other funds have to be used to strengthen training and retention strategies in source countries.

*Result of plenary evaluation of the final statement:* The statement received 18 votes of importance; being considered one of the most relevant/important/feasible issues among all the topics.

#### *Summary of the discussion:*

The first part of the statement was easily acceptable, however, we cannot say that within the internal market no ethical principles exist, so this part had to be reformulated. Discussions have already been carried out about financial compensation measures when preparing the Code, however, the agreement was that it cannot be enforced. The question is how we interpret compensation/reimbursement. We can say that if a country benefits from a significant number of health professionals arriving from another country, there is some responsibility to strengthen training and retention in that country. However, EU Member States would never agree on a financial compensation system to reimburse training costs. It is difficult to find the basis for reimbursement. The United Kingdom example where fees were introduced and students took out a loan to finance their training can be feasible, but it might cause difficulties in countries where training was traditionally free. However, other solutions within the EU are hardly imaginable, for only individual countries can find their own solutions, without EU-level action. Some countries are experimenting, for example, by requiring the repayment of training costs if the professional does not stay for a pre-determined period in the country where they trained. Some bilateral agreements with third countries try to be of benefit to the source country, therefore it has to be examined how similar solutions can be implemented within the EU. Cohesion policies must be better implemented by source countries to support retention. Mentioning cohesion policies is important, and at the national level more focus and commitment has to be given to these areas when deciding on operational programmes.

#### **Employment of international health personnel**

*Initial statement:* All aspects of the employment of international health personnel – also including professionals from other EU Member States – should be without discrimination of any kind. It is not acceptable from the ethical point of view to employ migrants in jobs requiring much lower level qualifications.

*Final statement:* Patient safety comes first, each health system needs the right people (qualifications, skills, competencies, etc.) in the right places (jobs), without discrimination of any kind in the health workforce. Training and information in a proper way for migrant health professionals is needed in advance.

*Result of plenary evaluation of the final statement:* The statement received nine votes of importance from the participants.

#### *Summary of the discussion:*

Participants affirmed that individual brain waste, when a foreign health professional performs a job in the target country that needs lower qualifications and skills that she/he has should be avoided. On the other hand, outflow can also be identified as brain waste for the country of origin. If a foreign health professional works below their qualification/skill level, it is important to take into account whether he/she was informed

about this beforehand. Accepting a lower-level job on a voluntary basis after having been informed about it properly can be an acceptable solution in certain cases, if e.g. at home there are no employment possibilities. The group stressed the crucial importance of patient safety in this regard, and proposed it as the starting point for the final statement.

It is also important to consider what our approach is to qualifications and/or skills and competences when talking about waste. This leads us to job content, which was according to the group the most important for being informed about before taking up a job. Job content might have big variations in different countries, even with the same qualifications and requirements. Job satisfaction can only be accomplished when job content is clear and accepted. Directive 2005/36/EC defines the level of qualifications needed for health professions, thus determining job content to a certain extent based on mutual trust. In reality, differences remain, but the Directive itself is a positive tool in this context. For health professionals from outside the EU, however, it means a barrier.

Since a language test has been introduced in the Directive without further guidance, language can be used for discrimination, as without proper language skills, professionals can easily find themselves in lower level jobs. There are no set rules for deciding on the level of language knowledge for a job, and it is not always possible to return to the original skills level when the language improves. Language training beforehand should be made available. Proper language skills are of great importance from the point of view of patient safety, as professionals have to be able to communicate with the patient, which cannot be questioned.

When talking about possible actions and their feasibility, participants saw the need to seek an agreement on the professional side on a language certificate/evaluation in order to *enhance patient safety*. More information has to be provided on the job content supported by a legal framework ensuring transparency, while information exchange, better access to the information and enhanced communication in general are also of crucial importance. At the professional level, more importance should be given to better job classification together with salary and benefit packages. The use of databases and mapping of information on the whole health workforce is useful for tracking the work situation of migrants. The legal framework at the national level - National Code of Employment, special regulations on HWF employment - could be more transparent. The EPSU-HOSPEEM Code of Conduct could have even more significance when talking about the employment of foreign workforce. Mapping Continuous Professional Development, its monitoring at the European level, continuous updating at the organisational and national level, as well as its recognition are all important tools to help the integration of foreign workforce.

### Handbook of best practices

*Initial statement:* A handbook of best practices deriving from the experiences and knowledge of Member States is the best tool to support the practical implementation of the WHO Code and could also support the development of intra-EU solutions.

*Final statement:* No change, the group has not discussed the issue.

*Result of plenary evaluation of the original statement:* The statement received four votes of importance from the participants.

#### Individuals' motivation

*Initial statement:* Individuals' motivation patterns play the most important role in EU health workforce mobility, which cannot be influenced by regulation.

*Final statement:* Individuals' motivation patterns play a very important role in EU health workforce mobility that are influenced by the regulatory and social environment and the free market. Analysis is needed.

*Result of plenary evaluation of the final statement:* The statement received four votes of importance and one vote of lower-importance from the participants.

#### *Summary of the discussion:*

The extent of the reliance on information - which can be significantly different among groups of health professionals - is an important factor in influencing individuals' motivation. Financial and career issues are present simultaneously in individual motivation. Job opportunities, or on the contrary, unemployment as a pushing factor, questions of licensing and qualifications are the important aspects from the career side, while uncertainty (concerning employment, career pathways, etc.), austerity measures, globalisation (economic crises as pulling, or possibly as pushing factors) can have an influence from the financial side. Language and culture also influence motivation, since moving to another country, learning another language and culture can be "trendy" for some. It would be important to have a better understanding not only of the movements of the health workforce, but also of the reasons behind them.

In order to facilitate return migration, countries should learn the lessons and understand motivations behind the decisions to leave. Local regulations can also be a pushing factor for if everyday work is too burdensome and/or over-regulated, health professionals may decide to escape from unnecessary administration.

When thinking on possible actions at the institutional/organisational level, it is worth conducting some research on the motivations of the health workforce for moving and for staying. All types of movements could be interesting for examination: between organisations, between countries, from/and to Europe and also between professions (within healthcare or from healthcare to other professions). Access to data/information at this level is also important, while the question is how to make information available. At the national level, registries can help follow the mobility of the health workforce to a certain extent, while at the EU level IMI and other mechanisms for automatic information provision could be examined. The possible harmonisation of CPD is also to be mentioned. Information exchange, analysis and common understanding come first when setting up

an action plan. A thinking process on influencing motivation may start only after obtaining a better understanding of the mobility of health professionals.

#### Data and information

*Initial statement:* Countries within the free movement zone have no control over flows of health professionals, therefore an automatic information exchange based on existing structures is needed for effective health workforce planning to have at least data and information on the extent and trends of the phenomenon.

*Final statement:* Countries within the free movement zone have poor control over flows of health professionals, therefore an as automatic as possible information exchange based on existing processes is requested for HWFP.

*Result of plenary evaluation of the final statement:* The statement received seven votes of importance from the participants.

#### *Summary of the discussion:*

It is not possible to track the movement of people within the EU, and there is no necessary reason for health professionals to be tracked. Tracking of mobility is not common practice for other professions either. Political views and reasons do count a lot in this issue. Courageous political action should be needed to track HWF mobility.

Language exams could provide some information on mobility flows. However, there are professions which do not require direct professional-patient contact, thus there is no need for speaking the local language.

Countries receiving health professionals do have some data, so the possibility exists for a simple exchange of data. For the purposes of health workforce planning, it could be beneficial, but people may not want to be tracked.

Individual and aggregated data issues are also to be mentioned, highlighting that tracking double registrations and commuters is difficult. Health professionals could only be tracked for statistical reasons; the level of influence on domestic stock can justify this (decent flow - 1/5 of production). Automatic information exchange depends on the type of data, which for some data might be possible. When discussing the creation of new structures or developing existing ones for this information exchange, it would be important to have information on the EU level systems that could already be used.

#### Cooperation in the field of graduate and postgraduate training

*Initial statement:* Cooperation in the field of graduate and postgraduate training in health within the EU should be a process that is transparent, planned in due time and regulated on a bilateral basis, otherwise countries might find themselves in a situation where they are unable to train for their own healthcare system.

*Final statement:* Cooperation in the field of graduate and postgraduate training in health within and between Member States should be a process that is transparent, planned in due time and regulated on multilateral and multi-stakeholder basis otherwise countries might find themselves in an imbalanced situation within their own healthcare system.

*Result of plenary evaluation of the final statement:* The statement received five votes of importance and three votes of lower-importance from the participants.

#### *Summary of the discussion:*

The first element to consider in this process is whether countries have set quotas for training and/or for the legal enforcement of the number of students. Countries may train foreign students (e.g. training of French students in Belgium), who will possibly never contribute to the domestic health workforce. In order to take them into account when setting quotas, it is also important to consider the feasibility of “reasonable minimal health workforce planning” if there is a set or recommended capacity in EU Member States for inland health workforce. Relevant rulings by the European Court of Justice must be taken into account.

Right now barriers characterise cooperation in this regard: a Member State may have different agreements with different countries. Cooperation is also needed within countries and regions, as policy recommendations may not cover the entire inland training and differences in cooperation may occur within the country itself. While recognition of diplomas is set by EU law, licensing requirements can differ significantly in Member States. For example, while graduated medical students from the Czech Republic who start practising in Portugal can prescribe independently, for Portuguese medical graduates with the same diploma it takes two more years to obtain prescription rights due to different national regulations for prescribing.

Some countries require a license from doctors to enter postgraduate training. More clarity is needed for professionals who want to work in a different country about the meaning of being licensed, about application rules, extra requirements for practicing, or about what happens between application and delivery of the licence in order to close the gaps and make cooperation feasible. Directive 2005/36/EC established national information points which could be better used to support this process.

Difficulties might occur when the number of students’ admissions in a country is increased, but at the same time the number of places in postgraduate training is constant. Professionals may end up in a situation where they cannot practice and have no access to postgraduate training either. In such a case they are more likely to go work in the private sector or abroad.

Lots of different types of bi- and multilateral mobility agreements exist in Europe, for example for Belgian dentists studying for one year in Switzerland. It is also important to be aware of the in-country differences regarding curricula and the protection of domestic training capacities. At the same time, some countries already rely on foreign students



trained domestically.

The offering of trainings should be synchronised. A cartography of training capacities and the limitations of planning should be drawn up in order to see the situation clearly. Having more Erasmus, shared training and internships in the EU would be appreciated, thus the mobility of students could be enhanced. It would be also important to fine-tune postgraduate trainings.

Participants took the view that actions at the EU level could encompass the updating of Annex V of Directive 2005/36/EC with respect to clarification, synchronisation and harmonisation. At the institutional and organisational level, increased involvement by stakeholders (chambers, education institutions) is needed, while at the national level, governments (health and education ministries) and competent authorities have an important role. Awareness-raising on the Annex V and better implementation of the mutual recognition directive 2005/36/EC is also needed. When discussing steps that could have priority if an action plan were drawn up, participants felt that the first step could be the clarification of the terms independent practice, certification and exams. Mapping of issues, such as capacity and flows in training would also be desirable in parallel with the updating of Annex V and the fine-tuning of postgraduate trainings. Involvement of all related actors and stakeholders is needed for this exercise.

### The role of recruitment agencies

*Initial statement:* The activities of private recruitment agencies should be restricted and controlled by national-level legislation, for ensuring adequate numbers of health professionals in the publicly financed healthcare sector is of the public interest.

*Final statement:* In order to help Member States prevent imbalances of healthcare personnel – from sending and receiving countries – the activities between the employer and recruitment agencies should be provided within a framework of transparency and ethical and quality cooperation.

*Result of plenary evaluation of the final statement:* The statement received five votes of importance and two votes of lower-importance from participants.

*Summary of the discussion:*

Recruitment agencies exist because of market needs, although with the latest technology, various types of information necessary for a job search can be directly accessed by employees. There are information and service providers (for example in the area of language training, CV writing), messengers and facilitators setting up, for example, interviews. These are important actors on the market for employees looking for a job and for employers looking for an employee, therefore their activity should not be restricted.

Ensuring health professionals in adequate numbers for the publicly financed healthcare sector is not the goal/task of recruitment agencies. Their significance in recruitment is low, since recruitment is mostly done by training institutes or employers. Governments should collaborate with end recruiters, especially employers, as the key responsibility is with them. They can establish guidelines, set priorities, coordinate activities in this sector, ensure the exchange of information and strive for establishing a partnership between the private and public sectors. Recruitment agencies should also contribute to the mitigation of the negative effects of shortages.

To manage the activity of recruitment agencies, a system providing quality certification for excellent agencies could be better than regulations. The market itself should label the company, based on user feedback of its services. Job market realities should be considered and an ethical and quality framework is needed. Adequate and accurate information from the companies is necessary in order to provide for full transparency. The possibility of regulatory enforcement depends on the attitudes/traditions of a concrete country, and in countries with a strong private sector, mandatory regulation is less feasible. Listing existing recruitment companies, the number of their contracts, mapping and monitoring their operations is important to ensure trust, while gathering some in-depth information on their activities helps to identify the problem areas of healthcare personnel.

Concerning moral aspects, it is to be underlined that many agencies recruit from areas of high unemployment, i.e. not only from countries with shortages.<sup>64</sup> The question of ethics comes into the picture when high unemployment goes together with imbalances in the domestic health workforce. Another morally sensitive issue is the loss of investment by the countries that lose workforce trained through their expenses. Another challenging issue is that recruitment agencies may start recruitment already at medical schools, significantly influencing health workforce planning perspectives. However, because of the free movement principle, the individual choice to leave a country cannot be questioned.

Actions could be undertaken at the EU level to map recruitment agencies, label the quality of their operations, and to promote platforms where social dialogue at the international level could take place. Institutional/organisational level cooperation could provide information and data, while at the national level enhancing intrasectoral collaboration involving education, finance and labour sectors could be of added value. The first step of the mapping exercise should be to ensure transparent data and information from the institutional/national level, followed by the identification of actors and their roles, and finally the timeline and legislation might be considered.

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<sup>64</sup> Areas where there are no vacant posts or new posts such as Spain, Portugal and Greece.

## Conclusions

This Report on the WHO Code activity is part of the Mobility Activity of Work Package 4 of the Joint Action on Health Workforce Planning and Forecasting that addresses the phenomenon of the mobility of health professionals in terms of data collection and monitoring. The report is therefore closely connected to the Report on mobility data (D042), but has, however, a different focus. When examining the implementation of the WHO Code and the applicability of its principles within the EU, this analysis focuses on the possible directions of policy actions to better manage mobility, whereas Report D042 will concentrate on data and monitoring.

As a result of the WHO Code activity, conclusions could be drawn on one hand from the experiences of the Member States regarding the implementation of certain provisions of the Code, and on the other hand from the discussions on the applicability of its principles within the EU. Concerning the EU-context discussion, however, the 12 statements resulting from the workshop's activities are held as independent conclusions. These 12 statements - introduced in Part 3 of this Report - have been formulated in connection with those aspects that participants found the most relevant for examination in the EU-context, and they have been refined and to a certain extent evaluated during the second workshop. WP4 submits these conclusions as input for further deliberations to the sustainability work package (WP7), and obviously builds on and refers to them in its Report on mobility data (D042).

The concluding remarks below present the general impressions resulting from the sharing of implementation practices, and also the ideas held as most relevant by the WP4 team and the participants of the WHO Code activity from the statements of the EU context discussion.

The main value of this activity is its contribution to knowledge sharing and offering an opportunity for discussion of the WHO Code between HWF experts from across the EU. The number and the dedication of the participants at the discussions, the feedback on the usefulness of the workshops and the demand for follow-up all call for a continuation of this structured and focused dialogue. The agenda of the applicability of the WHO Code for the EU context is still not complete, which also undoubtedly calls for further discussion of its principles.

*The most relevant conclusions concerning the **implementation of the Code** in the European Region*

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| 1. There are considerable efforts in some Member States that are considered big recruiters to avoid recruiting from countries on the WHO list with critical shortages. |
| 2. Solutions to benefit all actors affected by international recruitment (source country, receiving country and the migrant professional) have to be elaborated,       |

with a special focus on also benefiting the source country.
3. Useful practices in European countries are available in growing numbers, and introducing them as part of the Joint Action activities had a real added value for several countries. The sharing of knowledge should be continued.
4. The WHO Code is much broader in scope than ethical recruitment practices. More attention has to be given to the integration and fair treatment of foreign health personnel.
5. Engaging professional organisations, and especially the level of employers with the messages of the WHO Code is inevitable for proper implementation. Governments have the responsibility for implementation, thereby engaging stakeholders.
6. Further awareness-raising is needed – the Code is not widely known or is narrowly interpreted.
7. EU Member States should invest the necessary resources for the operation of the national designated authority for the WHO Code, and communicate and share information on health worker recruitment and migration issues.
8. Initiatives aiming to better monitor migration flows could support decision-makers in finding the necessary points of intervention, where the implementation of the Code has to be strengthened.

#### *Applicability of the Code's principles within the EU*

Discussions led to the conclusion that - although the WHO Code itself cannot address inequalities and deepening HWF imbalances within the EU - **the principles of the Code are also relevant within the free movement zone of the EU**. Some tools developed and used when implementing the WHO Code in relation to third countries cannot be applied because of the special legal framework of the European Union. However, **by improving workforce planning and by looking for solutions from a wider range of health workforce measures, the application of the Code's principles can be supported and thus inequalities within the EU could be mitigated**.

Within the context of free movement of the labour force, **retention measures seem to be the most feasible and effective way** of keeping health workforce in the source countries, as migrating is a voluntary choice. It can be fostered by creating fair and equitable working conditions. Retention focus can be enhanced at the European level by disseminating good practices and sharing case studies.

Fostering **circular migration has been identified as a tool which can also be effective** within the EU context. **Institutional level bilateral cooperation** seems to be the most feasible solution, **tailored to the needs of different types/profiles of health professionals**. The aims of such cooperation have to be clearly set, the proper time-frame adjusted, and the circle has to be closed by offering in the source country relevant posts with a salary level that reflects the value of the experience gained abroad (which also has to be recognised at the professional level).

**The principle of free movement does not make it possible to set up EU systems for financial compensation of source countries for the emigrating workforce** (this solution does not exist in other professional areas either). Solutions have to be sought first at the national level (introduction of tuition fees together with loans to finance studies, or in the case of free training, reimbursement of training costs to the state when migrating, etc. could be examples). **Ethical recruitment practices** have to be sought also at the EU level. **Better use of EU cohesion policies and the European Social Fund** could support compensating source countries for investments made in training of health workforce. This aspect has to be taken into account when EU Member States decide on the priorities of the operational programmes providing the framework for setting the national spending priorities of EU funding.

**Employment of foreign health workforce from other EU countries has to be based on ethical principles**, avoiding discrimination on the basis of nationality and/or the country of first qualification when offering jobs. Directive 2005/36/EC (amended by 2013/55/EU) should be properly implemented and no extra barriers introduced (e.g. high fees for recognition).

**Data exchange on mobility should be as automatic as possible**, especially data from receiving countries on the registration of foreign workforce in their system, which is already required, while fully respecting data protection legislation. Use of existing channels for data provision should be investigated.

This report, a **milestone** of the activities of Work Package 4 of the Joint Action on Health Workforce Planning and Forecasting, summarises expert opinions discussed at workshops on the topic of **EU context specificities of the WHO Global Code** of Practice on the International Recruitment of Health Personnel, which have not been discussed to such an extent before, and also **introduces good practices of the Code's implementation**. We hope that it contributes to the update of the **EU Action Plan**, to the accomplishment of The **Global Health Workforce Alliance Strategy<sup>65</sup> 2013 – 2016** "Advancing the health workforce agenda within universal health coverage", and finally to the **Global Strategy on Human Resources for Health** that will be considered by WHO Member States at the 69th World Health Assembly in May 2016.

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<sup>65</sup> Available at: [http://www.who.int/workforcealliance/knowledge/resources/ghwa\\_strategy\\_long\\_web.pdf?ua=1](http://www.who.int/workforcealliance/knowledge/resources/ghwa_strategy_long_web.pdf?ua=1)

## Appendix - WHO Global Code of Practice on the International Recruitment of Health Personnel

Source: [http://www.who.int/hrh/migration/code/full\\_text/en/](http://www.who.int/hrh/migration/code/full_text/en/)

### Preamble

The Member States of the World Health Organization,

Recalling resolution WHA57.19 in which the World Health Assembly requested the Director-General to develop a voluntary code of practice on the international recruitment of health personnel in consultation with all relevant partners;

Responding to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) and the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a code of practice;

Conscious of the global shortage of health personnel and recognizing that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

Deeply concerned that the severe shortage of health personnel, including highly educated and trained health personnel, in many Member States, constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;

Stressing that the WHO Global Code of Practice on the International Recruitment of Health Personnel be a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening,

### THEREFORE

The Member States hereby agree on the following articles which are recommended as a basis for action.

### Article 1 – Objectives

The objectives of this Code are:

(1) 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;

- (2) to serve as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of 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;
- (4) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.

#### Article 2 – Nature and scope

2.1 The Code is voluntary. Member States and other stakeholders are strongly encouraged to use the Code.

2.2 The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.

2.3 The Code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states.

#### Article 3 – Guiding principles

3.1 The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member States should take the Code into account when developing their national health policies and cooperating with each other, as appropriate.

3.2 Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

3.3 The specific needs and special circumstances of countries, especially those

developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.

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. However, nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them.

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries. Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind.

3.6 Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programmes.

3.7 Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code.

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.

#### Article 4 – Responsibilities, rights and recruitment practices

4.1 Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

4.2 Recruiters and employers should, to the extent possible, be aware of and consider the outstanding legal responsibility of health personnel to the health system



of their own country such as a fair and reasonable contract of service and not seek to recruit them. Health personnel should be open and transparent about any contractual obligations they may have.

4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions.

4.4 Member States should, to the extent possible under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered.

4.5 Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

4.6 Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.

4.7 Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

#### Article 5 – Health workforce development and health systems sustainability

5.1 In accordance with the guiding principle as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.

5.2 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. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent.

5.3 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country.

5.4 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.

5.5 Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors.

5.6 Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies.

5.7 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, social and professional support.

#### Article 6 – Data gathering and research

6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base.

6.2 Taking into account characteristics of national health systems, Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning.

6.3 Member States are encouraged to establish or strengthen research programmes in the field of health personnel migration and coordinate such research programmes through partnerships at the national, subnational, regional and international levels.

6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated and collected pursuant to paragraphs 6.2 and 6.3 for ongoing monitoring, analysis and policy formulation.

#### Article 7 – Information exchange

7.1 Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or nongovernmental.

7.2 In order to promote and facilitate the exchange of information that is relevant to this Code, each Member State should, to the extent possible:

- progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;
- progressively establish and maintain updated data from health personnel information systems in accordance with Article 6.2; and
- provide data collected pursuant to subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the Code by the Health Assembly.

7.3 For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. Member States so designating such an authority, should inform WHO. The designated national authority should be authorized to communicate directly or, as provided by national law or regulations, with designated national authorities of other Member States and with the WHO Secretariat and other regional and international

organizations concerned, and to submit reports and other information to the WHO Secretariat pursuant to subparagraph 7.2(c) and Article 9.1.

7.4 A register of designated national authorities pursuant to paragraph 7.3 above shall be established, maintained and published by WHO.

#### Article 8 – Implementation of the Code

8.1 Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders as stipulated in Article 2.2, in accordance with national and subnational responsibilities.

8.2 Member States are encouraged to incorporate the Code into applicable laws and policies.

8.3 Member States are encouraged to consult, as appropriate, with all stakeholders as stipulated in Article 2.2 in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

8.4 All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code. Recruiters and employers should cooperate fully in the observance of the Code and promote the guiding principles expressed by the Code, irrespective of a Member State's ability to implement the Code.

8.5 Member States should, to the extent possible, and according to legal responsibilities, working with relevant stakeholders, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

8.6 Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code.

8.7 Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration.

#### Article 9 – Monitoring and institutional arrangements

9.1 Member States should periodically report the measures taken, results achieved, difficulties encountered and lessons learnt into a single report in conjunction with the provisions of Article 7.2(c).

9.2 The Director-General shall keep under review the implementation of this Code, on the basis of periodic reports received from designated national authorities pursuant

to Articles 7.3 and 9.1 and other competent sources, and periodically report to the World Health Assembly on the effectiveness of the Code in achieving its stated objectives and suggestions for its improvement. This report would be submitted in conjunction with Article 7.2(c).

9.3 The Director-General shall:

- support the information exchange system and the network of designated national authorities specified in Article 7;
- develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the Code; and
- maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned nongovernmental organizations to support implementation of the Code.

9.4 WHO Secretariat may consider reports from stakeholders as stipulated in Article 2.2 on activities related to the implementation of the Code.

9.5 The World Health Assembly should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text that should be brought up to date as required.

#### Article 10 – Partnerships, technical collaboration and financial support

10.1 Member States and other stakeholders should collaborate directly or through competent international bodies to strengthen their capacity to implement the objectives of the Code.

10.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development.

10.3 Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries.