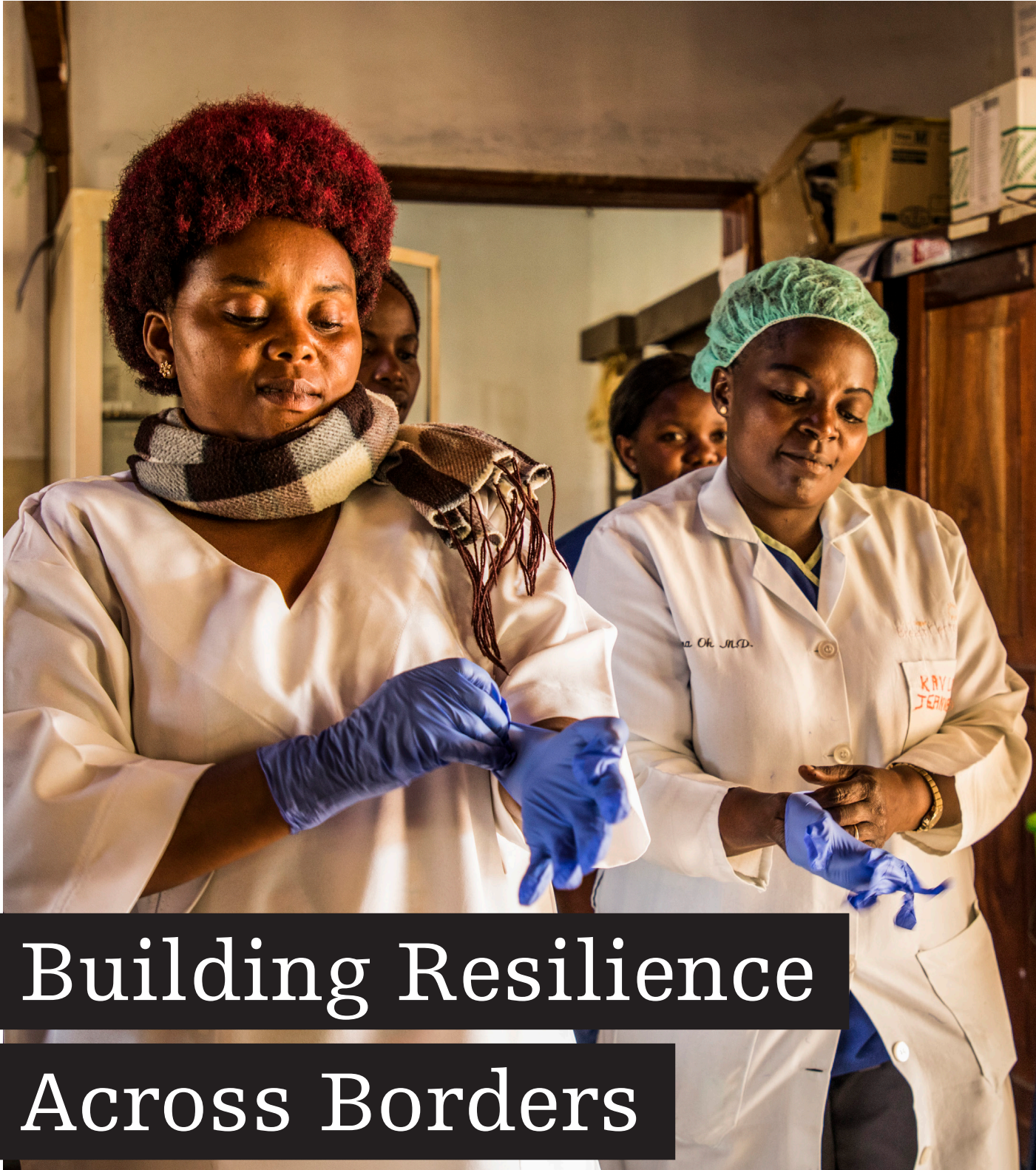**PUBLIC SERVICES**
INTERNATIONAL

The global union federation of workers in public services

FRIEDRICH EBERT STIFTUNG

Building Resilience Across Borders

A POLICY BRIEF ON HEALTH WORKER MIGRATION

By Jane Pillinger and Nicola Yeates

CONTENTS

By Jane Pillinger and Nicola Yeates

FOREWORD

The COVID-19 pandemic has shown the vital need for adequate numbers of health workers to provide universal health care services. It also highlighted the important role and contribution that migrant health workers have made to the COVID-19 crisis responses.

Migrant workers represent a highly significant proportion of the health workers at the frontlines. Sadly, many of them were among the estimated 7,000 health workers who have died from the infection, as documented by Amnesty International. The tragic and massive loss of health workers' lives is unacceptable and could have been avoided.

Yet, despite these deaths and them being sung as heroes, our health workers continue to work in dangerous and difficult conditions. They are undervalued, uncompensated and unprotected. Across the world, health workers are on strike demanding their rights and safety at work, for just compensation, for social protection, for their inclusion in decision-making and for funding of public health services.

The pandemic has shown evidence of the urgent need for better investments in public health care and in the health workforce in all countries. Strict lockdown measures were a direct response to the lack of capacity of health systems to deal with the large numbers of patients. The pandemic has also put a spotlight on the high number of migrant workers risking their lives on the frontlines. It has highlighted the need for international cooperation to address the global health workforce shortage. It has also underscored the imperative for effective governance of health labour migration and mobility, so that fragile health systems particularly in the developing countries are not stripped of their health workforce that is crucial in fighting the outbreak.

Public Services International (PSI), with the support of Friedrich Ebert Stiftung (FES), has prepared this policy brief to inform, raise awareness and stimulate discussion about migration in the light of recent global policy developments on health worker migration, set in the context of a current pandemic. It looks critically at some of the strategies being promoted in achieving the SDGs and recommends a Five-Point Plan for a continued and transformational policy, advocacy and social dialogue in this area.

Based on the evidence and recommendations provided in this brief, PSI puts forward the following key messages:

- In light of the projected global shortage, priority needs to be placed in strengthening public health care services as the foundation for the creation of at least 40 million new jobs in the health and social care sectors and reducing the shortfall of 18 million health workers, primarily in low- and lower-middle-income countries by 2030. This is an important recommendation from the UN High Level Commission on Health Employment and Economic Growth, where I served as one of the Commissioners.

- Ensuring adequate numbers of health workers to prepare for universal health coverage (UHC) and health emergencies, such as the COVID-19 pandemic, will require sustained public investment in staffing and equipment, planning and health systems restructuring that prioritizes people over profit.

- Building resilience to future health emergencies by investing in public services for both rich and poor countries alike. Rich countries must strive more to assist developing countries in the pandemic crisis response and recovery efforts, including debt cancellation for the poorest countries.

- Demanding the World Bank and the International Finance Corporation to stop privatisation and the flawed model of public-private partnerships, and for the International Monetary Fund to end its policy of directing governments to cut public spending and public sector wages that lead to more poverty and driving forced migration.

- The need for international cooperation and global governance strategies that prioritize investment in the local health workforce in all countries in order to reduce dependence on international migration to fill health staffing needs.

- The need for safeguards, including the better implementation and enforcement of the WHO Code on the International Recruitment of Health Personnel. We want to see the WHO Code becoming a binding instrument and for it to develop stronger lateral links to other international policies on equality and public health.

- With the increasing use of bilateral labour agreements in facilitating health worker migration and mobility, the WHO Code, along with human rights norms and labour standards, should serve as a pre-requisite in the negotiation and implementation of any bilateral or multilateral labour migration agreement. Only then can we ensure that international health and labour standards, as well as fair and ethical recruitment, are upheld and reciprocity is adhered to.

- Finally, the role of trade unions and civil society as partners of MEMBER STATES in the promotion and application of the WHO Code is crucial. Social dialogue on the governance of health labour migration can benefit from the guidance of the WHO Code, along with effective application of international human rights norms and labour standards.

Rosa Pavanelli
General Secretary
Public Services International
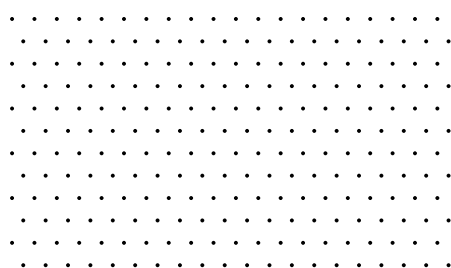
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1. Introduction

"If we do not send a strong message that each human being has a human right to dignity, to live in decent conditions, to have decent work, to access public services, we will not be able to defend the democracies of our nations, nor will we be able to address the fundamental root causes of injustice and inequality."

Rosa Pavanelli, PSI General Secretary (speaking at PSI roundtable Human Rights, Trade Unions and Quality Public Services for Refugees and Migrant Workers, Beirut, 15 February 2019)

This Policy Brief[1] aims to raise awareness and stimulate discussion about migration in the light of recent global policy developments on health worker migration, setting this in the context of impact of the COVID-19 pandemic. It documents efforts of public service trade unions to promote rights-based and sustainable approaches to migration, ethical recruitment and the role and contribution of public services to positive migration outcomes. Insights are also given into how the global union federation - Public Services International (PSI) – has added a critical voice to the emerging policy of global governance on international migration and the role that public services play in creating rights-based and sustainable global policy on international migration. Finally, the Policy Brief looks critically at some of the strategies being promoted in achieving global SDGs and sets out the urgent case (in a Five-Point Plan) for continued and transformational policy and advocacy work in this field.
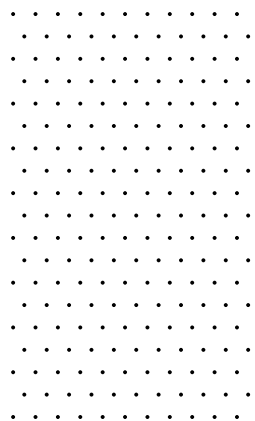
ABOUT PUBLIC SERVICES INTERNATIONAL

BOX 1

PSI is the global union federation for public service unions worldwide. PSI works to protect the rights of migrant workers and to advocate for quality of health and social care services, decent work, pay and working conditions, and to reduce the economic pressure faced by health workers to migrate.

PSI's campaigns, advocacy and awareness raising aims to promote rights-based migration, decent work, fair and ethical recruitment, and to defend quality public services for all. This helps ensure that workers are able to make informed decisions about migration and that they can connect with unions in receiving countries. A further important objective is to ensure that the skills and experience gained when working overseas can be used to improve health care delivery when health workers return home. This work is closely linked to the PSI Right to Health campaign[2].

PSI's migration programme, with its origins dating back to 2003, has focused on the following pillars:

- **Participatory research, training, campaigns and advocacy with health workers in more than 15 countries**, including participatory research with health workers in six countries of migration origin (Kenya, Ghana, South Africa, the Philippines, Nigeria, Sri Lanka) and with migrant health workers in one destination country (Australia). The research gave insights into the perspectives and recommendations of health and social care workers to inform subsequent training, advocacy strategies, campaigns and social dialogue initiatives at the global and country level.

- **Informing and empowering health workers to make informed decisions** through information, awareness and Pre-Decision Kits, Return and Reintegration Kits, Passports to Workers' Rights and migrant desks in a number of countries[3], training and empowerment of public service union representatives in; and

participatory research on migration with health and social care workers (Kenya, Ghana, South Africa, Sri Lanka, Australia, Philippines and Nigeria).

- **Promoting fair and ethical recruitment** through lobbying national and global bodies about fair and ethical recruitment and ending the charging of recruitment fees and practices of unscrupulous recruitment agencies. PSI led the global campaign for fair and ethical recruitment, including the campaign to end recruitment fees #NoRecruitmentFees[4], and was a key stakeholder in the development of the ILO's Guidelines and Principles on Fair Recruitment (ILO 2016) and the complementary ILO Definition of Recruitment Fees and Related Costs (ILO 2018).

- **Advocacy and influence with global partners** to implement global standards relevant to health workers and the building of quality health care services, Sustainable Development Goals, UN Global Compacts on Migration and on Refugees, relevant ILO Conventions on workers' rights and social dialogue. For example, with WHO observer status, PSI participates in the multi-agency International Platform on Health Worker Mobility.

- PSI advocates for the **rights of migrants, refugees and internally displaced persons to access health and other public services** through projects it carries out in the MENA countries in and Nigeria involving its affiliates, a majority of which are in the health and social care sectors[5]. PSI advocates for quality public services for migrants, refugees and internationally displaced persons (IDPs) requiring protection, in a sector where service provision, contracting out and privatisation of services is common.

- PSI has been very active in responding to the **COVID-19 pandemic** in relation to the safety and conditions faced by health care workers, health worker shortages, advocating for rights-based migration policies and access to quality public health care services (PSI 2020).
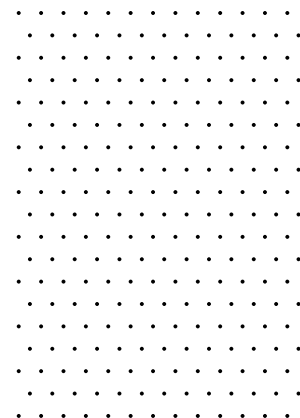
1. A separate Executive Summary of this report is published on
    https://publicservices.international

2. For further information on PSI's Right to Health campaign see:
    https://publicservices.international/campaigns/right-to-health-campaign?id=5736&lang=en&search=%7B%7D

3. Pre-decision kits on Labour Migration (Sri Lanka, Nigeria, Philippines, India, South Africa, Ghana, Kenya) and Return and Reintegration Kits (Sri Lanka, Nigeria, Philippines, India, South Africa, Ghana, Kenya); Passport to Worker and Union Rights (South Africa, Australia). These materials have been developed through project support provided by FNV Mondiaal, FNV PZ, IMPACT and ILO ACTRAV.

4. See PSI No Recruitment Fees Campaign: http://www.world-psi.org/es/node/9558

5. PSI Project on Human Rights, Trade Unions and Quality Public Services for Refugees and Migrant Workers, implemented PSI affiliates in the MENA (Lebanon, Tunisia and Algeria) in partnership with U2U and the Swedish affiliates: ASSR, Vardfordbundet, ST, Vision and Kommunal. For further information see:
    https://www.world-psi.org/en/psi-holds-roundtable-refugees-access-public-services

PSI U2U Project for Refugees and Migrants in the MENA, May 2018 © PSI

2. Background and context of international migration

International migration has become an issue of monumental importance. In 2019 around 272 million people were living outside their country of birth, of whom 164 million were migrant workers (UN DESA 2019). See **Box 2** for some facts and figures on recent migration trends. Projections of ever-increasing levels of migration arise because of poverty, political instability, climate change and conflict. Migration of health workers is continuing to increase because of chronic under-investment in public services in low-income countries and shortages of workers in high-income countries[1].

At the same time, the rise of populist parties and of anti-migrant, nationalist, racist and xenophobic attitudes is jeopardising progress made. The COVID-19 pandemic has put enormous pressure on underfunded public health systems, revealing a chronic lack of equipment and resources to enable governments to respond effectively to the health care needs. The pandemic has also revealed the depth and extent of social and economic inequalities within and between countries worldwide, and the deep vulnerabilities of different social groups that arise from these inequalities.
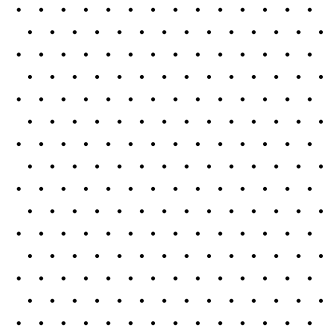
SOME FACTS AND FIGURES

BOX 2

International migration

- In 2019 the number of international migrants grew to 272 million globally an increase of 51 million since 2010 (making up 3.5% of world's total population, compared to 2.8% in 2000) (UN DESA 2019).

- Migrant workers represent 4.7 per cent of this global labour pool comprising 164 million workers, with nearly half being women. This is an increase of 14 million since 2013 (ILO 2017).

- Migrant workers sent record high remittances to low- and middle-income countries in 2018, amounting to USD 529 billion (9.6% above the previous record high of USD 483 billion in 2017). Global remittances, including to high-income countries, were USD 689 billion in 2018 (World Bank 2019).

Data on health worker migration

- High income countries have 12 times as many people employed in the health sector as low income countries (580 per 10,000 population, compared to 49 in low income countries) (ILO 2020).

- In Africa, there are only 57 health workers per 10,000 population and many countries fall below this (ILO 2020).

- With an estimated shortage of 18 million health workers by 2030, international migration will soar to fill the workforce gaps. The biggest shortages will be in Africa and South-East Asia (WHO 2016a).

- Health worker migration is highly feminized: women make up 72% of skilled health workers based on data from 100 countries (ILO 2020).

Data on refugee and asylum-seeking populations

- Between 2010 and 2017, the numbers of refugees and asylum seekers increased globally by about 13 million – making up around one-quarter of the increase in the number of all international migrants (UN DESA 2019).

- 41.3 million are internationally displaced persons (IDPs), the highest on record, triggered by conflicts and disasters, often with both factors overlapped, repeatedly displacing people in a number of countries, particularly in Africa (IDMC 2019).

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Alongside these significant global challenges are unprecedented and landmark developments in global governance, putting migration and ethical recruitment, global inequalities and access to universal health care, amongst other global challenges, in the spotlight. Much of this activity has been sparked by the 2030 Sustainable Development Agenda and the related 17 Sustainable Development Goals (SDGs), as solutions to significant global problems of sustainable economic and social development. While these are positive developments, they also pose some contradictions and worrying developments, not least in promoting commercialisation of public services and downplaying the role of quality public services.

Health workers from developing countries – doctors, nurses, social care workers and other health specialists - are being recruited in ever-increasing numbers by richer countries to fill ongoing and projected staffing shortages. This results from a mismatch between the supply of and demand for health workers and/or the chronic under-investment in quality public health services in many countries across the world, and particularly in low-income countries. In fact, in the last decade there has been a 60% rise in the number of migrant doctors and nurses working in OECD countries and there are predictions of even bigger increases in the international migration of health workers in future years (OECD 2020). The WHO's Expert Advisory Group's (EAG) (WHO 2020a) review of the effectiveness and implementation of the WHO

Code of Practice on the International Recruitment of Health Personnel (discussed below) notes additional predicted shortages that governments will seek to fill through migration, including an additional 1.8 million health workers needed in the EU by 2025. A shortfall of 500,000 health workers is also anticipated in nursing and elder care in Germany; a current shortage of 100,000 health workers exists in the UK's NHS, predicted to rise to 250,000 by 2030; and Japan's visa programme aims to attract 60,000 new health workers. The WHO EAG notes that health systems in many countries are simultaneously managing in-flows and out-flows of health workers (WHO 2020a).

On the one hand, rights-based and sustainable migration policies ensure that people can migrate in conditions that guarantee their human rights, including decent work and equality of opportunity. On the other hand, policies are needed to ensure that the conditions that compel people to migrate – as a result of poverty, lack of opportunities, conflict or climate change – are addressed in national and global policies.

THE COVID-19 PANDEMIC

The health and social care needs and challenges arising from the COVID-19 pandemic are unprecedented. The pandemic has shone a light on the significant under-investment in health equipment and personnel, brought about by many years of austerity and privatization. Coupled with this, high rates of infection amongst health workers, often

a result of a failure to provide adequate personal protective equipment (PPE)[2], has impacted on these shortages, putting added pressures on health workers providing care during the pandemic. In many countries health workers on the front line, many of who are women, have struggled to provide quality care, many risking their lives and well-being in doing so. As the PSI has stressed this is having catastrophic consequences for health systems and for health workers:

> Unpreparedness of health systems, including understaffing, grueling long working hours, and lack of personal protective equipment (PPE) are exposing health workers to fatal hazards that also undermine the capacity of the health systems to respond to the emergency.
> (PSI, COVID-19 Emergency – PSI priorities and perspectives, 15 April 2020)

With more than half of the world's population lacking access to essential health care, this unpreparedness means that access to life-saving care will be out of the reach of many. Investing in health care to achieve universal health coverage (UHC) in all countries and having adequate numbers of health workers could have saved lives.

This was one of the lessons learnt from the Ebola crisis that went unheeded. The outbreak of the Ebola virus in West Africa in 2014 showed the damaging costs on human lives of weak health systems and inadequate staffing levels. The devastating effects of the virus could have been reduced if there had been public health systems and adequate workforces (WHO 2015). PSI actively lobbied the ILO and WHO and has worked closely with health workers in affiliated unions to rebuild health services in the countries most affected by the Ebola crisis[3]. At the core of this, and most starkly relevant in the current COVID-19 pandemic, is the crucial role of UHC and the building of high quality comprehensive public health care services to prevent future outbreaks and manage health crises.

The COVID-19 pandemic has become an important issue of migration policy and global governance. This is important because migrant health workers are more likely to be employed on the frontline of COVID-19 responses in health and social care in both professional health care positions and also as 'low skilled' key workers providing social care to elderly and other vulnerable people in care homes. Many have been sick or have died as a result of the pandemic[4].

The impact of outward migration on countries of origin is already too high. Many countries of origin were already facing significant shortages of skilled health workers before the COVID-19 pandemic. Relying on further international recruitment of health workers in the light of the COVID-19 pandemic is unsustainable. As the OECD argues, migration is not an "efficient or equitable solution" as it does not take into account global imbalances of health workers and it deprives sending countries of essential health workers (OECD 2020).

Furthermore, during the pandemic the pressure to recruit migrant health workers has grown. Many destination countries affected by COVID-19 have relied on recruitment of migrant workers to fill these gaps, often finding new ways to increase the numbers of migrant health workers by simplifying and adapting the recognition and recruitment of migrant health workers (ILO 2020, OECD 2020). These initiatives show that it is possible to end speedily many of the delays, hurdles and financial burdens faced by migrant workers, including facilitating immediate renewal of visas and work authorization; fast-tracking of recruitment, visas, recognition of overseas qualifications or temporary licenses; recruiting medically qualified migrant workers working in other jobs to take up medical or support posts; and permitting employment in front line health care for refugees with medical or nursing qualifications.

For example, in recognition of the barriers many migrant health workers face in the UK doctors, nurses and paramedics and their families can automatically have their visas automatically renewed for one-year, and following a campaign in recognition of the risks faced by migrant health care workers the immigration health surcharge of £400 per annum payable by all migrant health workers and their family members was dropped. In some countries emergency measures have permitted the recruitment of foreign health workers without their qualifications being formally recognised, as is the case in Peru. Recruiting migrant doctors has been one strategy to fill gaps in Germany, including from refugee doctors who arrived in Germany in 2015. In Australia, international student nurses, who are restricted in the number of permitted hours of work, have been permitted to work longer hours in response to the pandemic. Short term licensing has also been an option, for example, a supervised 30-day medical license has been issued in Ontario, Canada for international medical graduates and Italy issued a decree for the temporary licensing of trained health professionals. In Peru and Argentina expedited procedures have been introduced for
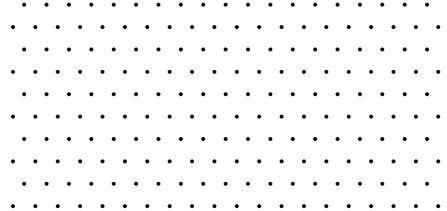
the recognition of the qualifications of Venezuelan migrants as a response to the COVID-19 pandemic.

SOCIALLY-JUST APPROACHES TO MIGRATION DURING COVID-19

There has been a chorus of organisations seeking better solutions and possibilities for international migration that are socially-just and based on principles of ethical recruitment. In particular, the COVID-19 pandemic has revealed the even more urgent need for strengthened global governance measures. The OECD (2020), amongst others, highlights the need for urgent global responses to the COVID-19 pandemic, including the full implementation of the WHO Code, better international cooperation to address global shortages and assistance in building health systems for less advanced countries, increased training capacity to address domestic shortages, equal working conditions for migrant health workers and recognition of their contribution during the COVID-19 pandemic, providing streamlined procedures for recognition of foreign qualifications and bridging courses.

The ILO (2020) has also argued that migrant workers' inclusion in national COVID-19 policy responses is crucial to equality and social justice. This recognises the need to reverse negative attitudes towards migrant workers seen in rising levels of discrimination and xenophobia against migrants during the COVID-19 pandemic, stigmatization of migrant workers as carriers of the virus, and growing levels of violence and harassment against migrant workers, including those working at the frontline of health and social care (ILO 2020). Some migrant workers have faced poverty and food insecurity, layoffs, worsening working conditions, reduction or non-payment of wages. To avoid the situation escalating further, the ILO recommends that in the future gender-sensitive, rights-based policies and measures are needed to prevent abuses of human rights and labour rights.

Achieving migrant workers' inclusion will only be possible if the voices of women and men migrant workers, including migrant health and social care workers, are effectively included in national COVID-19 responses and recovery. Similarly, there needs to be much better integration of human and labour rights into bilateral cooperation between countries of origin and destination; social dialogue with the full involvement of employers and workers organisations in the development of COVID-19 responses; and better systems of skills recognition to take up jobs in healthcare.

PSI (2020) has been at the forefront of responses to the needs of all migrants, including health workers and has called for urgent responses from the trade union movement with recommendations for immediate targeted emergency actions and an economic response to "build a radical new economy and develop policies that put people and the planet over profit." (p.2) In addition, in relation to protection for vulnerable migrants during COVID-19, PSI (2020) has recommended that the international community provides an urgent, inclusive and rights-based solution to migrants in detention, those trapped at the borders and the refugees, asylum seekers, migrants and displaced persons living in camps.

The COVID-19 pandemic has led to global mobilization for universal health coverage (UHC) and the importance of investment in quality public health services. PSI's **No Going Back Manifesto** is an example of this (See **Box 3**). The manifesto argues that adequate public funding is vital:

> Health systems would not have been so unprepared for the pandemic if they had been adequately funded, if governments had legislated for adequate nurse to patient ratios and if countries ensured they had the productive capacity for lifesaving PPE, medical equipment, medical research and the production of vaccines and treatments[5.]

BOX 3

PSI's Manifesto 'No Going Back' signed by nearly 800 trade unions and civil society organisations across the world calls on unions and civil society organisations to mobilise for universal public health care, once and for all. In recovering from the crisis, PSI has made a plea for governments to implement a **transformative approach to how societies are organised**. This should be **centred on their capacity to care**, on the basis that if we cannot provide care our societal cohesion will be at risk: "When care and wellbeing of all people is the central organising principle of a society, rather than the capacity to extract and grow profits and consumption, all society will prosper."

Critical to this is that governments have the capacity to provide public health care, with systems of trade that enhance the capacity of nations to provide quality public health care, rather than restrict it. As the manifesto states: "The COVID-19 crisis has been made worse by years of under-funding of public health systems and the ideological virus of neoliberalism."

It calls on governments to:

· draw up public health reconstruction plans with nurses and their unions;
· remove all obstacles to ensure timely and affordable access to medical supplies and vaccines;
· support a global COVID-19 commons for all research, data, technology, treatments and vaccines as a non-proprietary shared global resource.

In addition, it calls on the World Bank and International Finance Corporation to end health privatisation and the flawed model of public-private partnerships, and for the IMF to end its policy directing governments to cut public spending and public sector wages.

1. The World Bank (2018) predicts that climate change will result in more than 140 million people in three regions of the developing world will migrate within their native countries and particularly to cities between now and 2050.
2. In a PSI survey of health care unions, 56.5% of respondents indicated that workers have not been given adequate PPE during the COVID-19 pandemic. This has become an important issue in the PSI's 'Safe Workers Save Lives' campaign: https://publicservices. international/campaigns/safe-workers-save-lives?id=10633&lang=en%29
3. For further information about PSI's campaigns and work: https://www.world-psi.org/en/issue/Ebola
4. See reports on migrant health workers in the UK: https://www.nytimes.com/2020/04/08/ world/europe/coronavirus-doctors-immigrants.html; and https://www.theguardian.com/ uk-news/2020/apr/07/foreign-nationals-nhs-indefinite-leave-remain-coronavirus-cov- id-19; and of Filipino migrant health care workers: https://www.broadbentinstitute.ca/filipi- no_healthcare_workers_during_covid19_and_the_importance_of_race_based_analysis
5. No Going Back: https://publicservices.international/campaigns/ sign-on-to-the-nurses-manifesto---no-going-back?id=10773&lang=en

3.

Global policy on migration, ethical recruitment and sustainable development

Migration is a human rights issue reflected in global policies and initiatives on the rights of migrants, ethical recruitment and labour rights (see **Box 4**).

In particular, the last decade has seen an unprecedented emergence of landmark initiatives that are having a direct impact on the globalization of health labour market and health worker-migration (Yeates and Pillinger 2019). **Box 5** lists these important global policy initiatives (2010-2018). Many of the most recent initiatives are spurred by the 2030 Sustainable Development Agenda and the linked Sustainable Development Goals. They recognise the need to address health worker shortages, alongside global commitments to UHC and safe and fair migration.

INTERNATIONAL HUMAN RIGHTS NORMS AND STANDARDS

RELEVANT TO HEALTH WORKER MIGRATION

BOX 4

- UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 1990
- ILO Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143)
- ILO Migration for Employment Recommendation (Revised), 1949 (No. 86)
- ILO Migrant Workers Recommendation, 1975 (No. 151)
- ILO Multilateral Framework on Labour Migration: ILO Multilateral Framework on Labour Migration, 2006

Nurse in a Kenyan hospital © PSI

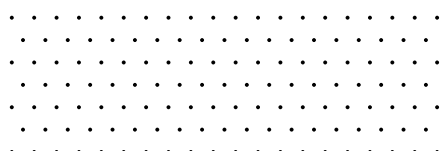**PRINCIPAL INTERNATIONAL GOVERNANCE INITIATIVES IMPACTING ON HEALTH WORKER MIGRATION AND RECRUITMENT, 2010-2018**

BOX 5

1977	ILO Nursing Personnel Recommendation (R157).
2010	WHO Global Code of Practice on the Ethical Recruitment of Health Personnel
2012	UNGA gives the mandate for universal health coverage (UHC)
2012	ILO Social Protection Floors Recommendation (R.202)
2014	ILO Fair Migration Agenda
2015	2030 Sustainable Development Agenda and SDGs
2016	UN High-Level Commission on Health Employment and Growth
2016	ILO General Principles and Operational Guidelines for Fair Recruitment
2018	International Platform on Health Worker Mobility
2018	UN Global Compact for Safe, Orderly and Regular Migration (UN Global Compact)

THE SUSTAINABLE DEVELOPMENT GOALS AND HEALTH WORKER MIGRATION

The 2030 Sustainable Development Agenda marks the renewal of global governance for sustainable development with a commitment to **leave no one behind**. SDG priorities aim to address a comprehensive range of challenges affecting people and the planet. They add a new impetus to the debate about international health worker migration, alongside goals for UHC and building sustainable health care systems, new strategies on skills in the context of migration, inclusive growth and decent work, gender equality and greater multi-stakeholder participation. SDG Goal 3 on health (see **Box 6** below) has given a renewed focus and recognition to the fact that UHC can only be achieved through strengthened health care systems and workforces that are capable of delivering UHC and ending global health emergencies (such as HIV, SARS, Ebola and COVID-19).

BUILDING RESILIENCE ACROSS BORDERS

15

Alongside this is that the SDGs recognise health as a human right and the importance of quality health care services in meeting global health targets, including UHC. This reflects shifting perceptions and growing consensus in international organisations about the critical role quality health care services as a public good. It has resulted in calls for funding of quality pubic health care services, an example of which is the joint OECD/WHO/World Bank (2018) report which argues that "high-quality, safe and people-centred health care is a public good that should be secured for all citizens." (p.58)

In relation to health, on-going investment in the training and recruitment of a sustainable health workforce is urgently needed if **all** countries are to achieve the SDGs by 2030. Health workforce availability and international migration of health workers are interconnected issues, affecting the quality and accessibility of health care and health outcomes for the population. The need for robust, effective and comprehensive global governance responses based on international cooperation involving governments and civil society, including workers' organisation, is critical if the following UN objectives for inclusive growth and sustainable development in relation to migration are to be achieved:

> We recognize the positive contribution of migrants for inclusive growth and sustainable development. We also recognize that international migration is a multi-dimensional reality of major relevance for the development of countries of origin, transit and destination, which requires coherent and comprehensive responses. We will cooperate internationally to ensure safe, orderly and regular migration involving full respect for human rights and the humane treatment of migrants regardless of migration status, of refugees and of displaced persons. (Sustainable Development Agenda, United Nations, 2015, para. 29)

The question remains as to whether wealthy industrialised countries can meet their increasing demand for health care workers, while avoiding negative development outcomes. With a growth in health care needs across the world and a corresponding growth in demand for health services plus a predicted growth of the global health labour market, higher levels of international recruitment of health workers puts further pressures on health services in lower income countries. Some high-income countries continue to recruit health workers from countries where there are critical shortages of health workers, even though this is discouraged in global policy on ethical recruitment. There has been some explicit promotion of health worker recruitment from certain African countries within the WHO list of 57 countries with critical health worker shortages (Gencianos 2019). For example, the Ghanaian President recently agreed to send 375 Ghanaian nurses to Barbados to work in the health sector there. Although Ghana remains a country with critical shortages of health workers (Pillinger/PSI 2011), the President stated that "We have a surplus of nurses in Ghana"[2]. In Nigeria, where there continues to be critical shortages of health workers (Pillinger/PSI 2014), an estimated 600 physicians migrate annually

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to Europe, North America and Africa. It is reported that the government has supported the 'export of doctors' in return for foreign exchange earnings[3].

SDG Goal 3, including UHC, will only be achieved if there is a commitment to strengthened health systems and health workforces. Aside from the costs associated with COVID-19, achieving UHC should be well within the reaches of the global economy. WHO estimates published in the Lancet Global Health (Stenberg et al. 2017) are that, in an ambitious scenario, it will cost USD 371 billion (or USD 58 per person) annually to meet the SDGs health goal by 2030. This would provide sufficient investment for 67 low- and middle-income countries that represent 75% of the world's population. In addition, 75% of the costs are for health systems (workforce, infrastructure and medical equipment). However, the authors anticipate that there will be a financing gap of USD 20–54 billion per year.

MEETING THE GROWING DEMANDS FOR HEALTH AND SOCIAL CARE SERVICES

Globally, growing demands for health and social care arise because of rising expectations, an ageing population, an increase in chronic health conditions and noncommunicable diseases (such as cancer, heart disease, diabetes) and rising health care costs associated with new technologies. In addition, internal and international migration of health workers affect the capacity of low-income countries to adequately staff existing health services (WHO 2013 & 2020, PSI 2020).

A warning sign comes from the UHC SCI (Index of Service Coverage) which has been drawn up to measure progress towards UHC. It is based on an indicative minimum number of 4.45 physicians, nurses and midwives per 1000 population needed to meet the SDG health goal, including UHC (Scheffle et al. 2016). However, many low-income countries continue to face critical health care shortages and are a long way from meeting this minimum. Ensuring there are adequate numbers of health workers, sits alongside the other principles of accessibility, acceptability and quality of health services, as the basis for meeting health goals.

As stated earlier, despite standards on fair and ethical recruitment in the WHO Code (see below), high-income countries have continued to recruit from countries that have critical shortages of health workers. Dating back to 2006, the WHO's World Health Report Working Together for Health set out the challenges related to the global health workforce shortages. At the time it was estimated that there was a **shortage of more than 4.3 million health personnel across the world, and 57 countries faced a critical shortage** (i.e. less than 2.28 doctors, nurses, and midwives per 1,000 in the population), of which 36 were in sub-Saharan Africa.

BOX 7

40 million new health sector jobs by 2030, but not where they are needed the most

WHO (2016) has estimated that **40 million new health sector jobs will be created by 2030**. This is a doubling of the current global workforce. Most of these new jobs are being created in upper middle- and high-income countries and not in the regions and countries where they are needed the most. **The creation of 40 million new health care jobs is likely to put greater pressure on health worker migration from poorer countries to meet the demands of richest countries.**

There is an estimated shortage of 18 million health workers by 2030. These shortages will mainly be in low and lower middle-income countries as they seek to meet the needs of the population and achieve UHC.

These shortages will particularly affect the countries that fall below the SDG threshold of **4.45 physicians, nurses and midwives per 1,000 population. In these countries, which continue to face critical shortages, there will** be needs-based shortages of over 14 million health workers. The remaining shortfall of 4 million health workers will be in high-income OECD countries. These needs-based shortages arise because of under-investment in education and training of health workers and a mismatch between education strategies, health systems and population needs.

The biggest shortages will be in Africa and South-East Asia

The largest estimated needs-based shortages of health workers will be in South-East Asia (a shortage of 6.9 million health workers) and Africa (a shortage of 4.2 million health workers). Although in absolute terms these shortages are highest in South-East Asia due to the large populations of countries in the region. However, in relative terms taking account of population size the **most severe shortages will be in Africa, which faces the largest burden of diseases in the world, and where 36 out of the 57 countries listed by the WHO are facing a human resources for health crisis** are found (Liu et al. 2017).

Updated estimates (WHO 2016a) suggest that 40 million new health jobs will be created by 2030, but there will be a shortage of around 18 million health workers mainly in low and lower middle-income countries. See **Box 7**.

With the slowing of progress towards UHC since 2010 and the fact that based on current trends only 39% and 63% of the global population will be covered by essential health services by 2030, the WHO argues that: "Progress requires considerable strengthening of health systems to provide UHC, particularly in lower income settings... progress must markedly accelerate – and coverage needs to double – to reach the SDG target of UHC for all by 2030." (WHO 2019a, p.2)

CHALLENGES FOR GLOBAL GOVERNANCE IN ACHIEVING SDG GOAL 3

The WHO and the UN High-Level Commission on Health Employment and Economic Growth both argue that achieving SDG Goal 3, including UHC, depends on the availability, accessibility, and capacity of health workers to deliver quality people-centred care. In response to these challenges, some important strategies and reports have been issued on the health workforce. They include:

● The **WHO Global Strategy on Human Resources for Health: Workforce 2030** (WHO 2016b) has put health workforce planning centre stage. Driven by SDG Goal 3, the strategy emphasises the importance of the health workforce to realising health and development goals.

- The report of the UN High-Level Commission on Health Employment and Economic Growth **Working for health and growth: Investing in the health workforce** (UN HEEG 2016), made 10 recommendations and five immediate actions to transform the health and social care workforce in order to achieve the SDGs. It recognizes that investment in the health workforce, amongst other key policy actions, will result in economic and social gains. Fair recruitment practices and the need to safeguard migrants rights are viewed as being central to this. It made a suggestion for new "transnational standards" and an "updated broader international agreement on the health workforce, including provisions to maximise mutuality of benefit from socially responsible health worker migration." (2016, p.49-50)

- Tasked with implementing these recommendations the ILO/OECD/WHO **Five-year action plan for health employment and inclusive economic growth (2017–2021)** sets out unprecedented actions, including renewed impetus to implementing the WHO's **Global Strategy on Human Resources for Health 2030**. However, the action plan lacks binding measures and concentrates on policy dialogue, including establishing the **International Platform of Health Worker Mobility**.

- The **2020 State of the World's Nursing** report noted that 1 in 8 of all nurses worldwide are migrant nurses and that the proportion of migrant nurses will accelerate significantly in the next decade in response to demographic factors (WHO 2020b). The report recommends greater investment in the nursing workforce and building on the *Global strategic directions for strengthened nursing and midwifery 2016-2020* (WHO 2016b).

UN GLOBAL COMPACT FOR SAFE, ORDERLY AND REGULAR MIGRATION

The UN Global Compact (UN 2018) followed the 2016 New York Declaration for Refugees and Migrants, where 193 UN Member States recognised the need for a comprehensive approach to human mobility and enhanced cooperation at the global level. It is relevant to SDG Target 10.7 which aims to improve coordination and cooperation on global migration governance.

The UN Global Compact has 23 objectives that have relevance to health worker migration covering fair and ethical recruitment, decent work, labour rights, social protection and portability of social security, access to services, skills recognition and skills partnerships, and vulnerabilities related to migration. The role of civil society and trade unions are recognized.

WHO GLOBAL CODE OF PRACTICE ON THE ETHICAL RECRUITMENT OF HEALTH PERSONNEL

One of the most important themes running through recent global policy, including in the UN Global Compact, is fair and ethical recruitment. The most important global agreement on this issue is the 2010 WHO Global Code of Practice on the Ethical Recruitment of Health Personnel. The WHO Code sets out voluntary standards for the international recruitment of skilled health workers. Included in its 10 articles is the principle that destination countries seeking to recruit overseas health workers have a responsibility to sustain health workforces and protect migrant health workers' rights. This endorses the principle that any country can recruit overseas health workers so long as this is not from countries with critical health worker shortages:

> 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. (WHO Global Code, 2010, para 3.3.)

Although there are signs that some WHO Member States have made efforts to implement some aspects of the WHO Global Code, it is still woefully short of being fully implemented by all MEMBER STATES. Reporting remains low with only 80 out of 194 WHO Member States submitted reports for the third round of reporting and only a very small number of independent stakeholders reported on the Code's implementation (rising from 1 in 2015 to 14 in 2019) (WHO 2019b). Around 70% of Member States submitting reports had taken steps to implement the Code – with only 27 Member States highlighting laws and policies consistent with the Code and 23 showed good practices consistent with the Code. Of the 29 Member States that reported that they had been a party to bilateral, regional or multilateral arrangements on the international recruitment and

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migration of health personnel, 23 of these Member States noted that some or all of the Code's principles and recommendations were incorporated into them.

In addition, 50 of the 64 countries reporting to the WHO had requested technical support from the WHO in implementing the Code. However, the WHO's current support is largely focused on the 'Brain Drain to Brain Gain' project which is limited to providing on-going support to five countries.

The WHO's response has been to establish the International Platform on Health Worker Mobility to promote international policy dialogue, although there is still a strong case for further specific country-level support in implementing the Code.

In 2019 the **WHO Expert Advisory Group's Second Review of the WHO Code's relevance and effectiveness** was carried out (WHO 2020a). Their findings and recommendations (summarized in Box 8 below) are important in pointing to the future direction of the WHO Code and particularly its crucial connection to UHC. Some of this engagement comes from the visible and effective lobbying by PSI and other civil society organisations, but also reflects recognition of PSI's status as an observer in the WHO. PSI and EPSU both contributed to the discussions, providing expert advice and recommendations from a trade union perspective.

The report of the Expert Advisory Group was presented to the 2020 World Health Assembly with a call to address health worker shortages through strengthened international cooperation between Member States. It highlights both the WHO Code's increasing relevance and the acute problems associated with creating a sustainable health workforce in the future capable of meeting health needs and UHC, at a time when there is a shortfall of 18 million health workers globally and a predicted increasing demand for health workers globally. Furthermore, the Expert Advisory Group encourages leading countries and development partners to invest in the implementation of the Code as a commitment to global public good.

According to the Expert Advisory Group: "Migrant health workers – moving permanently or temporarily for employment – are taking an increasing role in delivering UHC. However, for several Member States escalating international health worker migration threatens achievement of UHC." (WHO 2020a, para. 4, p.7) The WHO Code's relevance is also noted in the Political Declaration of the High-Level Meeting on Universal Health Coverage 2019, which called for the strengthened implementation of the Code to ensure UHC (UN 2019).

BOX 8

Key points from the EAG review about the Code's **relevance:**

- The Code's relevance is high and growing, particularly in the context of the SDGs and the global policy priority of UHC, growing health security challenges and the increasing international mobility of health personnel; its full implementation is needed to achieve the global vision of "building a healthier world together".

- It represents the universal ethical framework linking international recruitment of health workers and the strengthening of health systems.

- The Code remains relevant to donor nations, destination countries and international organisations and financial institutions in providing technical and financial assistance for health personnel – this is particularly relevant for developing nations and nations in transition, who may face challenges in educating, employing, managing and retaining health workers, and where there is limited financial capacity in low-income countries.

- There is a growth in bilateral agreements between governments on international health worker recruitment, as well as provisions on international recruitment in trade agreements. However, there is limited involvement from health ministries and health stakeholders (including unions) in the negotiation and implementation of agreements.

- Based on the 43 countries that fall in the lowest quartile of the UHC SCI with less than the median density of doctors, nurses and midwives, it is recommended that these countries should be prioritized for health personnel development and health systems related support and additional active recruitment related safeguards, for example, in bilateral agreements, as provided for in the Code, and which is currently being piloted by the WHO and Germany.

- Improvements in data are needed to capture the full dynamics of the health labour market related to the workforce, employment and migration.

Key points from the EAG review about the Code's **effectiveness:**

- In relation to legal effectiveness there is better awareness and engagement of Member States, improved quality of reporting and data and information on bilateral agreements etc.

- There is some evidence of behavioural effectiveness, through implementation mechanisms, e.g. stakeholder engagement and record of recruiters, and integration of the Code's principles in regional instruments such as the EPSU/HOSPEEM Code of Practice drawn up by the social partners in the health sector in Europe.

- However, critical gaps exist in the implementation of the Code, especially in countries and regions most severely affected by health workforce shortages

- Gaps also exist in engagement with non-State actors that could assist with implementation and hold governments accountable.

Recommendations suggested by the EAG:

- Strengthened WHO Technical cooperation with Member States, WHO Secretariat and non-State actors to accelerate the implementation of the Code.

- Mobilization of WHO Member States to invest in the education, recruitment and retention of health workers to effectively deliver UHC.

- Leverage of resources from leading destination countries and development partners to implement the Code as a global public good.

- Deployment of WHO resources to support the Secretariat's health workforce activities on health workforce education and employment; and a further review for reporting in 2023-2024.

- Improve resources for data to enable the WHO and other actors to provide better support for ethical recruitment.

GLOBAL POLICY ON MIGRATION, ETHICAL RECRUITMENT AND SUSTAINABLE DEVELOPMENT

PSI and other advocacy organisations are strongly of the view that the WHO Global Code is an important mechanism that can underpin all global migration policy developments that impact on health worker migration. However, its implementation needs to be significantly strengthened and effectively incorporated into all future national, regional and global policy developments. On this basis, international standards on ethical recruitment, human rights norms and international labour standards should be firmly embedded in all future bilateral, regional or multilateral agreements, including trade agreements. There is also a need for a more effective regulation of private recruitment agencies and other developments on skills and training that impact on health worker migration.

THE ROLE OF BILATERALISM

A further important development is the increasing use of bilateral labour agreements (BLAs) between countries of origin and destination, reflecting the role that governments can play in governing and regulating migration. BLAs have the potential to address social and development outcomes and promote ethical recruitment and rights-based approaches to health worker migration. At best, they set out labour standards and guarantee ethical recruitment, including rights relating to settlement, integration and work, mutual recognition of qualifications and equality of treatment (Yeates and Pillinger 2019).

However, BLAs often set quotas for short term health worker migration without these minimum conditions, and most do not contain provisions relating to equal treatment, compensation or ethical standards (Yeates and Pillinger 2019). A further problem is that BLAs reflect and extend a global shift in policy towards temporary and circular migration. Too many of them do not embrace reciprocal measures that help build capacity of health systems in developing countries and countries with economies in transition (Yeates and Pillinger 2018, 2019). Good practices that have included social dialogue in the development and monitoring of migration are hard to come by, but one widely cited good practice is the bilateral agreement between the Philippines and the Federal Republic of Germany, known as 'The Triple Win Programme' (PSI 2017, UN HEEG 2016). See **Box 9.**

GERMANY-PHILIPPINES BILATERAL LABOUR AGREEMENT (BLA) ON THE DEPLOYMENT OF FILIPINO HEALTH PROFESSIONALS TO GERMANY (2013) (THE TRIPLE WIN PROGRAMME)

BOX 9

The agreement refers to key human rights norms, fair recruitment, non-discrimination, trade union rights, social protection and career development. A Joint Monitoring Committee made up of ministries of labour and health and PSI affiliated trade unions from Germany (Ver.di) and the Philippines (PSLINK), has been established to monitor the implementation of the agreement.

It is the first agreement of its kind giving trade unions affiliated to the PSI direct oversight of the work of a BLA (PSI 2017b). According to PSI and its affiliates, experience shows that the participation of trade unions and employers is essential to concluding effective BLAs. The presence of trade unions can help ensure that reference is made to international labour standards and relevant international human rights norms.

The WHO Global Code states that BLAs "should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate [compensation] measures" (WHO 2010). BLAs can and should provide source countries a means of recouping the cost of educational investment, as exists under the 'Triple Win Programme', but this is also rare to find in existing BLAs.

GLOBAL SKILLS PARTNERSHIPS IN THE HEALTH SECTOR

As noted above, the UN Global Compact is a major breakthrough in global governance on migration. Here we look at one particular provision relating to Global Skills Partnerships (GSPs), which are promoted as a mechanism to strengthen capacity on training of national authorities and relevant stakeholders (such as the private sector). GSPs

are bilateral public-private partnerships established to train and source skilled workers from low- and middle-income countries in their home countries providing workers with the relevant skills and visas to migrate to work for an agreed duration to the country of destination that funded their training, while a second track provides training for the country's home market. The rationale is that it costs 5–8 times as much to train a nurse in Western Europe as it costs in North Africa, and that the costs of training could be recouped from the worker who migrates through a student loan type repayment system (Clemens 2015).

Commentators argue that GSPs would overcome staffing shortages by ensuring that migrant workers have the relevant and appropriate skills (Clemens 2015), and that in line with the WHO Code there will be no adverse consequences in terms of brain drain in low income countries (Dempster and Smith 2020). In this context migration is encouraged as a solution to address serious health worker shortages in order to combat the future pandemics and population ageing. But should health worker migration be the solution to addressing future shortages? How could guarantees be put in place to ensure adherence to ethical recruitment and international labour standards, when the evidence suggests that this has not been achieved in most countries? It is moreover absurd to assume, as suggested by Dempster and Smith (2020), that the problem of future staffing shortages during a pandemic could be solved by a mobile cadre of health workers who move from one country to another filling gaps in stretched health care systems as pandemics hit countries at different times. Given the evidence noted above that migrant health care workers are frequently on the front-line of COVID-19 care and that many are at risk and have died as a consequence, such a proposal further relegates migrant health workers to temporary migration and highly unsafe and dangerous working conditions. Again, the assumption is that migrant health workers will fill the gaps in care that cannot be filled by a country's own health workers, often in situations that undervalue their skills and contribution.

In contrast, strategies are needed to invest in and build the health workforce in all countries, and to reduce reliance on international migration to fill essential health care staffing needs. International cooperation on health labour migration governance should be aimed at building resilience to pandemics and other emergencies for rich and poor countries alike.

Furthermore, GSPs set worrying precedents that are designed solely to benefit destination-countries and to enable private finance to be levered through public-private partnerships and private financing of training (PSI 2018). It is not clear how a twin-track (international and country of origin) training programme would work in practice, how and if at all this would benefit a country of origin, and whether there would be willingness on the part of the private sector to engage in such a programme beyond investing in training for international migration. Furthermore, GSPs have been criticized for not providing a human rights-based approach to health development, and for failing to recognise the role of health care services as a global public good that can contribute to meeting the goals of UHC and sustainable health systems (van de Pas & Mans 2018, PSI 2018, Yeates & Pillinger 2019).

For GSPs to be sustainable it is essential that they are bound by a regulatory and investment framework that is based on health as a public good, encompassing relevant international human rights, equality, international labour standards and ethical recruitment as set out in a strengthened WHO Code. It would be essential for there to be a robust and effective global governance framework for this that regulates and monitors the implementation of agreements in the public interest, with the capacity to address abuses.

In addition, these developments need to benefit from social dialogue with effective trade union involvement to ensure that the rights of migrant health care workers are fully protected. In the absence of a regulatory framework, along with legally enforceable guarantees for trainees, it is unlikely that GSPs will be an effective or workable solution to health worker shortages in the future.

1. For further information see: https://sustainabledevelopment.un.org/sdg3
2. President Nana Addo Dankwa Akufo-Addo, quoted at : https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Barbados-requests-375-Ghanaian-nurses-President-accepts-in-principle-755623
3. Minister of Labour and Employment, Dr. Chris Ngige, quoted in: https://punchng.com/doctors-free-to-leave-nigeria-we-have-enough-ngige/, Published April 24, 2019

4.

PSI action and future challenges on international migration

For more than 10 years the PSI's research and advocacy on health worker migration has stressed that migration should be a choice for any health worker, but this choice should not be constrained by low pay, poor conditions of employment and limited opportunities in career development.

So what does the PSI's work tell us about international migration of public service workers? The views and perspectives of public service workers, captured during the PSI migration programme and particularly the role of decent work and quality of public services in countries of migration origin, tell us a lot about the needs and hopes of public service workers and how public services play a vitally important role in sustainable development[1].

> At Public Services International, an international trade union federation dedicated to promoting quality public services all over the world, we are convinced that in a democratic society, access to work, education, health care, dignified retirement, quality infrastructure, mobility services, equal opportunities for men and women, culture – all of this under environmentally-friendly conditions – are not just services, but rights for all…Public services are the bedrock of solidarity. Public services are human rights.

Geneviève Gencianos, Migration Programme Coordinator, Public Services International.

PSI'S PARTICIPATORY RESEARCH AND ADVOCACY

PSI's participatory research and advocacy with health workers in more than 15 low-income countries shows, that when migration takes place out of choice, rather than economic necessity, it can have benefits for individuals migrating and the economies of their home countries. However, the reality is that many low-income countries suffer negative consequences from outward migration, often stripping health services of important skilled health workers, while the depletion of staff and the costs of training in the country of origin are never recouped.

The reasons why health and social care workers choose to migrate overseas has been documented in PSI's research, with poor quality health care, chronic under-investment in health care, low staffing levels, inadequate pay and conditions of employment, limited career opportunities, being cited as the main reasons that health and social care workers opt to work overseas. The research[2] also found that some health workers experienced discrimination, deskilling and problems in gaining visas for long-stay, and in the worst cases exploitation by unregulated unethical recruitment agents. PSI's research also show that most health and social care workers want to contribute to the health and care systems in their home countries but have little alternative but to migrate in order to earn a decent income and gain opportunities to develop their skills and careers. Their departure has a negative

IDPs camp in Northeast Nigeria 2020 © PSI

impact on the health and social care services in their home countries, making it harder to achieve health goals and UHC.

PSI's research and advocacy work on health worker migration in low income countries has shown the critical importance of:

- Quality public services in retaining health workers, ensuring that health workers can provide the best quality health care to their populations with decent working conditions, pay, staffing levels, social protection and opportunities for skills development.

- Investment in quality public services and a redistributive tax system so that resources are provided for pro-poor growth, along with investment in health and education infrastructure, adequate staffing levels in the public services, social protection, and decent work and pay.

- Information about migration (source and destination) to support migrant health workers in making informed decisions and to prevent exploitation, discrimination and deskilling when they migrate to work overseas.

- Building the capacity and effectiveness of tri-partite and bi-partite social dialogue to promote the rights of migrant workers, and fair and ethical recruitment.

- Lobbying to enhance the capacity of government authorities and other actors to monitor private recruitment agencies, detect fraudulent agencies, and implement no recruitment fees.

- Extend and implement rights-based and gender-responsive policies to guarantee decent work for all, including effective implementation of international labour standards (covering social dialogue, non-discrimination, equal pay, working time, and gender-based violence and harassment).

- Support through PSI's network of affiliated unions to assist migrant workers in making informed decisions about migration, to assist them when they migrate and to ensure that they have decent working conditions in the country of destination and representation by trade unions.

BUILDING RESILIENCE ACROSS BORDERS
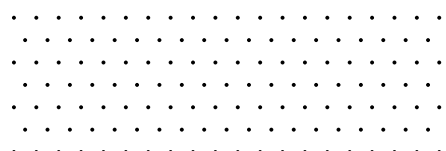
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QUALITY PUBLIC HEALTH CARE SERVICES ARE PUBLIC GOODS

Quality public services are critical for sustainable development, to promoting solidarity, inclusion and eradicating inequalities, including rising economic inequalities within and among countries. They are crucial in providing services for and solidarity towards people who are vulnerable. Their role has never been so important at a time of unprecedented humanitarian crises and forced displacement because of violence, humanitarian crises and climate change, and most recently the health crisis caused by the COVID-19 pandemic. Quality public services make it possible for health and other public service workers to contribute to the economic and social development of their own countries. In addition, sustainable solutions are needed in the light of these global challenges, and PSI has advocated for access to quality public services, access to justice and non-discrimination to be available to all migrants irrespective of their legal status.

As recommended by the UN High-Level Commission (UN HEEG 2018), WHO (2016, 2018) and Lancet Commission on Investing in Health (Jamison et al. 2013), amongst others, increasing public health spending and giving attention to hiring and training health workers are urgently needed in order to realise UHC.

PSI's approach is to work with affiliates by addressing inter-linking global and national health challenges. For example, PSI's Africa Regional Plan makes commitments to tackle the chronic under-funding of health services and to ensure decent work and fair and ethical recruitment (PSI 2019). Similarly, PSI's Human Right to Health Global Campaign and manifesto (PSI 2016), promotes quality health care services and the right of everyone to access health care regardless of their background, status or income. It has advocated for the public provision of healthcare, on the basis that the state is responsible for the provision of quality health services. Its campaign slogan 'My health is not for sale' is a response to the growing commercialisation and privatisation of health and the influence of multinational cor¬porations on the private health care and insurance markets.

Furthermore, PSI is clear that it will be impossible for the SDGs to be achieved unless a radical new approach is taken to improving the provision of quality public services across the world. Privatisation, neo-liberalism, austerity and reductions in funding for public services are a threat to the accountability and inclusion that quality public services can bring. Widening inequalities and an increase in anti-migrant, racist and xenophobic attitudes have become more prevalent in destination countries. In contrast, the most dynamic and prosperous societies across the world have benefitted from inward migration, contributing talent, innovation and prosperity – this

is why closing borders and restricting immigration threatens economic and social development there and risks turning the clock back, reversing decades of prosperity and growth.

MIGRATION IS MORE THAN ECONOMIC DEVELOPMENT – IT IS ABOUT THE RIGHTS OF MIGRANTS!

Migration is increasingly viewed as a source of economic development for poorer countries, as reflected in the UN's 2030 Sustainable Development Agenda. The 'migration for development' argument is that there are positive effects from migration that can help poorer countries achieve sustainable development, for example, when migrant health workers send remittances home to support their families and alleviate poverty, or reaping the benefits of the 'brain gain' and 'brain circulation' when migrants return to their home countries with new skills and knowledge. Important as these development benefits are, 'migration for development' as a strategy is insufficient for ending the under-investment in public services and inequalities that lead to migration.

PSI's advocacy and campaigning have promoted an alternative vision based on shared global solidarity. Investing in public services can have economic spin-off effects across an economy. Building sustainable public health care systems with adequate resources to ensure quality health care services, decent work, pay and career progression for health workers, is critical in ensuring that if health workers migrate, they do so out of choice rather than out of economic necessity.

INVESTING IN PUBLIC HEALTH CARE SERVICES: COUNTERING THE NEO-LIBERAL AGENDA

The chronic under-funding of health services in many low- and middle-income countries means that an estimated eight million deaths per year result from conditions that are treatable. This results in USD 6 trillion in economic losses (Kruk et al. 2018). However, if adequate funds are made available and used as planned, as recommended in Lancet Global Health (Stenberg et al. 2017), 97 million lives would be saved, and life expectancy would increase. According to WHO, scaling up primary health care alone in low and middle-income countries could save 60 million lives and increase average life expectancy by 3.7 years by 2030, while investing in broader health systems would save close to 100 million lives (WHO 2019a).

Progress has been slow in achieving UHC.

Commitments made at the 2001 **Abuja Declaration** by African Union (AU) Heads of State and Governments, to spend at least 15 per cent of their annual budgets on the health sector, have not yet been achieved. Although 26 countries have increased government health expenditure, only Tanzania had achieved the target by 2011, while 11 countries had actually reduced government health expenditure. By 2009, only five international donor countries had made strategic health workforce planning priorities in their development cooperation programmes with low-income countries (WHO 2011). Without greater investment in health care, the UN's **High-Level Commission on Health Employment and Economic Growth** argued that "inequalities will rise, and social cohesion will be adversely, even catastrophically, affected" (UN HEEG 2016). As well as meeting health needs, the High-Level Commission also argued that investing in health stimulates growth and the economic empowerment of women and youth.

Since the onset of the COVID-19 pandemic, the case for investment in public services has never been stronger. However, there are worrying signs about the increasing role of private sector investment in health and the move towards the much greater use of blended finance using both public and private finance to lever a much greater use of private capital in order to achieve development outcomes. Already in the health sector, privatisation and the greater use of public-private partnerships is undermining the right to health. However, there is extensive evidence to show that private sector finance and provision results in socially inequitable access to health care (Lethbridge 2014; PSI 2018) and that private sector employment often has lower staffing ratios, worse working conditions and a lower priority for social dialogue that can lead to successful health work¬force sustainability initiatives (PSI 2018). These developments undermine the critical role of the public sector in providing for quality health care services in the future and in achieving the right to health for all, as well as the potential for social dialogue to be the basis for sustainable migration policies.

THE INCREASINGLY IMPORTANT ROLE OF BIG BUSINESS OVER GOVERNMENT POLICY AND PUBLIC FUNDING FOR QUALITY PUBLIC SERVICES

The emphasis on multi-stakeholder partnerships in the SDGs reflects the growing influence of the corporate sector and of non-UN bodies in global health developments. These frequently promote public-private partnerships, and the enhanced role of the private sector and corporate philanthropy in

achieving health goals. This has the effect of diverting resources away from the public sector for sustaining public health care systems, which require long-term investments in health and social care. Of concern is that this development is outside of the systems of democratic governance, UN multilateral standard-setting, and the principle of health as a public good provided by health care services in the public sector (Martens and Seitz 2015). The prominent role played by private foundations and philanthropy amounts to some USD 7.8 billion a year in the OECD countries alone, the largest of which is the Bill & Melinda Gates Foundation.

This is resulting in a shift in global policy on health away from the public sector based on the idea of health as a public good towards the neoliberal agenda and philanthrocapitalism (Dentico & Seitz 2018). On the one hand, private corporate players, including venture philanthropists, are involved in implementing the SDGs. On the other hand, they are playing an increasingly important role in determining global health programmes. The danger is that the prominence given to corporate and philanthropic actors in global health may set back progress in achieving the global goals on health worker-migration and UHC, particularly if priority is given to selective health care initiatives and away from health systems sustainability and the provision of UHC. It is a worrying development that the private sector is being given greater prominence for its contribution to UHC and a solution to health care funding for training and infrastructure, including in response to the Covid-19 pandemic. This discourse works against the global social justice approach to public health, through redistribution or resources and the building of sustainable health care systems.

Furthermore, global and regional trade agreements, along with trade and economic partnerships and regional integration processes, are playing an increasingly important role in the regulation health worker migration, while also impacting on the sustainability of quality public services (Yeates & Pillinger 2019). For example, trade agreements increasingly refer to the supply of services through the migration of workers without according corresponding rights to them. It is imperative that such agreements incorporate ILO labour standards and UN human rights.

HEALTH WORKER MIGRATION – OPPORTUNITIES AND SOLUTIONS

This Policy Brief has shown that international health worker migration is very much on global policy agendas. This is not surprising given that in the next

decade it is anticipated that health worker migration will continue to grow in order to address the predicted growth in health needs. However, global shortages of health workers will continue to rise, and this will affect low-income countries and their poorest populations the most. However, health worker migration is a global issue in which everyone has a stake.

The unprecedented recent global debate and action to address international migration, recognises that health systems sustainability and good quality health care are the very bedrock for improved health outcomes and the principle of 'leave no-one behind'. One of the positive outcomes of this global dialogue is the recognition of health as a public good and the potential for much better coordination of global policy around the WHO Global Code, UN and ILO instruments and standards on decent work, gender equality, fair recruitment and migration. Particularly crucial is that there are opportunities for training and decent work and pay in the countries with critical shortages of health workers so that they can achieve UHC and other health-related goals.

Priority needs to be given to strengthening public health care services as the foundation for the creation of at least 40 million new jobs in the health and social care sectors and reducing the projected shortfall of 18 million health workers, primarily in low- and lower-middle-income countries by 2030. Without this investment it will be impossible for the SDG health goal, including UHC, to be achieved in many low-income countries. As a result, the PSI has argued that it is not acceptable that shortages of health care workers in richer countries should be filled by health workers from poorer countries, without mechanisms to compensate those countries most affected. Investing in quality health care services, including sufficient health workers, to meet global health goals, not only helps to reduce health inequalities and to improve access to health care for all, it has a positive impact on the economic and social development on all countries. Moreover, health workers can work in and contribute to the health care in their own countries.

The COVID-19 pandemic has shown the vital role played by migrant health workers in front-line health and social care services. In most high-income countries, migrants make up a large share of health workers and are more likely to be on the frontline of the COVID-19 response. In the likelihood that pandemics will become increasingly common health worker shortages will grow even further, putting further pressures on public health systems to respond. Ensuring adequate numbers of health workers to prepare for UHC and future health

emergencies will require sustained investment in staffing and equipment, planning and health systems restructuring.

This Policy Brief has also pointed to some policy contradictions and where emphasis is put on the growing importance of the private sector and public-private partnerships and a corresponding reduction in financing for the public sector, alongside an increasing emphasis on the role of the private health sector in trade-led initiatives. It has pointed to the need for international cooperation and global governance strategies that give priority to investing in the local health workforce in **all** countries in order to reduce the dependence on international migration to fill essential health care staffing needs and to ensure adequate resources and staffing to ensure resilience to future health emergencies for rich and poor countries alike.

Solving the problem of staffing shortages through migration should not be the only solution. As we have argued in this paper, recruitment of overseas health workers may (and often does) strip poorer countries of important health resources (investment in training without a return) and personnel (doctors, nurses, social care workers etc.). Indeed, proposals for initiatives like Global Skills Partnerships start from the presumption that future staffing shortages will be solved through migration, albeit supported through a twin-track process of training of health workers taking place in the country of origin. This is not to argue against migration of health workers, in fact migration can have enormous benefits for knowledge development, building experience and exchange of ideas, research and innovation. However, it is essential that migration and mobility are freely chosen and fully adhere to the principles of the WHO Code, which have stood the test of time in the ten years since it was agreed by the World Health Assembly. A major issue is that the WHO Code remains voluntary, despite it being mandated by the World Health Assembly and agreed by all WHO members. As the issue of staffing shortages becomes more serious across the world the need for safeguards, including the better implementation and enforcement of WHO Code is essential. It is for this reason that momentum is building for the WHO Code to become a binding instrument and for it to develop stronger lateral links to other international policies on equality and public health. If embedded in the negotiation and implementation of bilateral agreements this would help ensure that international health and labour standards are upheld and reciprocity is adhered to. This also applies to the need for binding international standards applicable to private recruitment companies that

promote human rights due-diligence and international labour standards (Yeates and Pillinger 2020).

A further issue faced by migrant workers is that long delays in processing certification and visas create hardship and delays in recruitment. The COVID-19 pandemic has shown the need for more efficient systems for recognition and vetting of skills certifications and for issuing of visas. Now is the time for effective, more efficient and rights-based systems for the global governance of labour migration. Furthermore, the WHO Code, the SDGs and UHC, are important global bilateral and multilateral governance mechanisms which promote global solidarity and responsibility for health. In the future, access to good quality public health services, staffed by adequate numbers of health workers **in all countries**, will make it easier for health worker mobility to take place out of choice rather than dire need.

The COVID-19 pandemic has shown the urgent need for better investments in public health care and in the health workforce in all countries, particularly countries most affected by the pandemic. Strict lockdown measures introduced in some low- and lower middle-income countries were a direct response to the lack of capacity in the health system (of equipment and personnel) to deal with large numbers of sick patients. The COVID-19 pandemic has also brought to public and media attention to the large numbers of migrant workers risking their lives on the front-line response to COVID-19. It has also put a spotlight on the need for better global responses to the global health worker shortage. As the global health care workforce faces significant challenges in the future, stronger implementation of a strengthened WHO Code is more urgent than ever.

1. http://www.world-psi.org/en/migration-here-stay-funding-public-services-vital-address-it; See also PSI Ten Key Messages to the UN GCM http://world-psi.org/sites/default/files/attachment/news/psi_ten_key_messages_at_un_gcm.pdf
2. Participatory research studies were carried out in countries of origin with health workers (in Kenya, Ghana, South Africa, the Philippines, and Nigeria) and one country of destination with migrant health workers (Australia). The reports of these studies can be found on the PSI's web site.

BUILDING RESILIENCE ACROSS BORDERS

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5.

A five-point plan

This final section sets out a five-point plan for a sustained PSI advocacy and campaigning on health worker migration.

1. GLOBAL SOCIAL RESPONSIBILITY WITH FUNDING FOR THE LONG-TERM SUSTAINABILITY OF HEALTH CARE SYSTEMS, QUALITY PUBLIC SERVICES AND THE RIGHT TO HEALTH.

● PSI affiliates and partners have a key role to play in advocating at national and global levels for global social responsibility and a social justice approach designed to promote a new partnership for global health. This needs to embody the universality of health and social care, equality and social justice, and planning for health systems post-COVID-19 so that they are capable of providing the resources and personnel to meet health care needs during and recovering from the pandemic.

● Implement the recommendations of the PSI's 'No Going Back' Manifesto calling for governments to draw up public health reconstruction plans with nurses and their unions; to remove all obstacles to ensure timely and universal access to medical supplies and vaccines; to support a global COVID-19 commons for all research, data, technology, treatments and vaccines as a non-proprietary shared global resource; to end the policy of neoliberalism and public-private partnerships of the World Bank and International Finance Corporation, and end IMF's policy directing governments to cut public spending and public sector wages.

● Promote a long-term approach to health systems investment, workforce development and capacity, thereby avoiding the problems inherent in short-term development aid and charitable funding programmes, and for-profit privatisation schemes.

● Ensure greater public investment in health care, in line with the PSI's campaign 'Health Care for All[1].

● Include in the remit of the new partnership for global health the development of rights-based multilateral and bilateral agreements, investment in quality public services, and to challenge the view that universal health coverage (UHC) can only be achieved through investment from commercial health care providers and public-private partnerships.

- Critique the migration-led recruitment strategy being used by high-income countries of destination as a means of solving their health workforce shortages.

- Promote the use of public-public partnerships, sending a strong message of support for shared global social responsibility in achieving UHC so that health systems have the capacity to respond to future pandemics post-COVID-19, and thereby reducing the need for health workers to migrate.

2. A STRENGTHENED WHO CODE TO ENSURE THE FULL IMPLEMENTATION AND MONITORING OF THE PRINCIPLES ON ETHICAL RECRUITMENT.

- The COVID-19 pandemic has made the need for a strengthened WHO Code on the International Recruitment of Health Personnel all the more urgent. It is imperative that all WHO Member States fully implement the standards set, and fully and regularly report on its implementation.

- Building on the existing strengths of the WHO Global Code, new measures are needed to further strengthen the Code and its implementation in meeting the health and health-related Sustainable Development Goals (SDGs), and in ensuring its effective implementation post-COVID-19.

- Binding measures are needed to mandate governments to take action to ensure ethical recruitment and implement legislation to regulate private recruitment companies and eradicate unethical recruitment practices.

- From a trade union perspective, social dialogue and partnerships with workers' organisations are critical to the implementation and monitoring of the Code. Ensuring that workers' voices are heard will help to give focus to fair recruitment and the protection of health workers rights.

- Greater awareness and visibility is needed to promote the principles contained in the WHO Code and to encourage stakeholder participation in its implementation and monitoring.

- Countries of origin should be supported with adequate resources to implement the WHO Code and ensure that its provisions are included in bilateral labour agreements with the purpose to promote the retention of health workers through investments in the health workforce and in quality public health services in countries with critical and ongoing shortages.

- Continue to lobby for better regulation of and enforcement of international standards in the activities of recruitment companies, including ending the practice of charging health workers recruitment fees.

3. FUNDAMENTAL LABOUR RIGHTS OF MIGRANT WORKERS AND THE FULL IMPLEMENTATION OF GLOBAL GOVERNANCE INSTRUMENTS ON MIGRATION.

- Trade unions, along with civil society organisations, have a key role to play in building on the momentum for UHC, strengthening their global campaigns as a matter of priority, and encouraging the engagement of leading public figures and global influencers in this.

- Improvements in ratification and implementation of key ILO and UN instruments on migration and international labour standards will help to strengthen the rights of migrant health workers, and to include the principles contained in these instruments in bi-lateral agreements (BLAs) and social dialogue.

- Investments in health care systems – through national programmes of taxation and global social responsibility – are essential in guaranteeing migrant workers' their fundamental rights at work, protection from exploitation, and proper reintegration support when they return to their home countries.

- In line with the recommendations of the UN Migration Network[2], include migrant health workers and their unions in COVID-19 responses, and ensure that migrant health workers are included in professional indemnity schemes for COVID-19 for health workers; that migrant workers are included in policies and protocols on health worker infection, disability, or death and in return-to-work protocols, and are given adequate support with on-the-job training.

- An important opportunity exists through the full implementation of the SDGs and the UN Global Compact on Migration – this must recognise the importance of quality public services in the context of migration.

- Trade unions have an important role to play, with civil society and advocacy organisations, in challenging commercial and private solutions to meeting the SDGs, including the implementation of the UN Global Compact on Migration and the UN Global Compact on Refugees.

4. BILATERAL LABOUR AGREEMENTS (BLAS) THAT PROMOTE ECONOMIC AND SOCIAL DEVELOPMENT, FAIR AND ETHICAL RECRUITMENT AND INTERNATIONAL LABOUR STANDARDS

- BLAs should be designed and grounded on the main principles and standards set out in ILO and UN instruments, and serve as a tool to promote fair and ethical recruitment that ensure migrant workers' rights.

- Ensure that training and other reciprocal arrangements are designed to mitigate the effects of outward migration in the source country, and that initiatives are grounded in social dialogue.

- A comprehensive database of BLAs should be established and their content should be monitored to ensure they meet the broad objectives to promote economic and social development, ethical recruitment and international labour standards.

- Critique the inclusion of labour mobility and labour migration in trade agreements, on the basis that 'Labour is not a commodity'. Any agreements involving labour mobility and migration must be governed by bilateral and multilateral labour migration agreements grounded on the principles of fair and ethical recruitment, human rights norms and international labour standards.

5. SOCIAL DIALOGUE IN NATIONAL AND GLOBAL MIGRATION GOVERNANCE.

- Tri-partite and bi-partite social dialogue should be promoted in all global governance initiatives that impact on migration and the role of public services in meeting human rights needs in the context of migration (for migrant workers, refugees and asylum seekers).

- Social dialogue would also add significant value to the implementation and monitoring of the WHO Code, including the specific inclusion of social dialogue in a future strengthened WHO Code.

- Effective social dialogue should be built into all negotiations for and implementation of BLAs, and all monitoring of BLAs should measure progress in and outcomes of social dialogue, including collective agreements.

- Global migration developments relating to health workforces, such as global skills partnerships (GSPs), should be agreed and implemented through social dialogue. In particular, the full engagement of trade unions will ensure protection of human and labour rights and mutual benefits for both countries of origin and destination.

- Post-COVID-19 policy responses on migration policy and recruitment in the health sector should involve migrant health workers, including in social dialogue initiatives and negotiation, implementation and monitoring of collective agreements. It is important to emphasise that COVID-19 is far from over and may become endemic if not fully vaccinable. Therefore, this will need constant public health efforts and investment in quality public services, which can be reinforced through social dialogue.

- Support worker organising and promote social dialogue in ensuring safe and healthy working conditions. In the context of the pandemic, support the call for the classification of COVID-19 as an occupational disease thereby requiring stronger workplace protections and access to compensation and medical care when workers fall ill. Migrant health workers have the right to remove themselves from unsafe working conditions and must have access to grievance mechanism and redress as well as to labour inspections.

1. See: https://publicservices.in-ternational/resources/page/health--social-care-services?lang=en&id=9507
2. UN (2020) Working Better Together. UN Migration Network Working Group on Access to Services. Policy Brief : https://migrationnet-work.un.org/sites/default/files/docs/final_net-work_wg_policy_brief_covid-19_and_access_to_services_1.pdf

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The global union federation of workers in public services

45 AVENUE VOLTAIRE, BP 9
01211 FERNEY-VOLTAIRE CEDEX
FRANCE

TEL: +33 4 50 40 64 64
E-MAIL: PSI@WORLD-PSI.ORG
WWW.PUBLICSERVICES.INTERNATIONAL

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