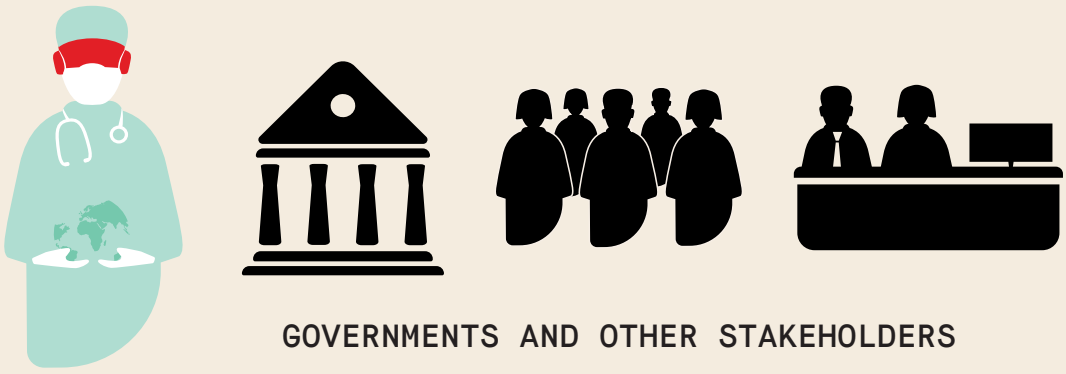
FACT SHEET 4: RISKS AND RESPONSES

MIGRANT HEALTH CARE WORKERS DURING THE COVID-19 PANDEMIC

WHAT RISKS DID MIGRANT HEALTH CARE WORKERS FACE DURING THE COVID-19 PANDEMIC?

WHAT WERE THE RESPONSES OF GOVERNMENTS AND OTHER STAKEHOLDERS?[1]

This Factsheet draws on OU and PSI research[2] carried out in 2022, which found that migrant health workers are regularly and disproportionately exposed to occupational health hazards, and are at a greater risk of contracting COVID-19 and experiencing severe harm and death. Policy responses have not addressed these additional risks and have not addressed health workforce shortages, putting health care workers and population health in harm's way.



GOVERNMENTS AND OTHER STAKEHOLDERS

"...a lack of available health workers is the largest constraint to ensuring the continuity of essential health services during the pandemic, including the delivery of COVID-19 tools." (WHO)

1 Citation: Jane Pillinger, Genevieve Gencianos and Nicola Yeates (2022) *Risks and Responses: What risks did migrant health care workers face during the COVID-19 pandemic? What were the responses of governments and other stakeholders?* Migrant health care workers during the pandemic, Factsheet 4. Milton Keynes/Ferney-Voltaire: The Open University/Public Services International.

2 Research papers and other Factsheets can be found at https://fass.open.ac.uk/research/projects/CRaR. The Factsheets are also available from People Over Profit's Care Campaign: https://peopleoverprof.it/resources/campaigns/care-manifesto-rebuilding-the-social-organization-of-care?id=11655&lang=en

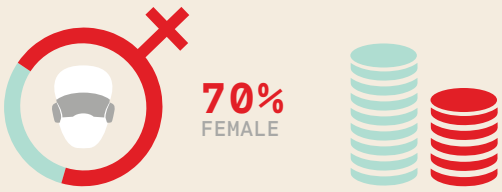
THE RISKS AND UNEQUAL IMPACTS OF COVID-19

Covid-19 amplified the existing global shortage of health workers. The most severe shortages are in developing countries, putting the achievement of universal health coverage by 2030 in greater jeopardy.

Repayment clauses attached to contracts require migrant health workers to pay a substantial sum of money before being allowed to resign. This, along with other vulnerabilities associated with visas and contracts, explains why some workers accepted more hazardous working conditions during the pandemic.

Decent work deficits. Migrant health workers often worked excessive hours, had insufficient rest periods, and faced discrimination and wage theft (not being paid overtime).

Migrant health workers are disproportionately affected by discrimination, violence and harassment. Systemic discrimination in health systems pushed migrant health workers to work in high-risk Covid-19 zones. Racialised narratives about the origins of Covid-19 generated unprecedented levels of stigmatisation and discrimination. As 70% of nurses are women, many face discrimination, sexual harassment, occupational segregation and gender pay gaps.



Lack of income protection, employment security and social protection left many migrant health workers without support and protection when they became ill, leaving many isolated and without financial support to return home.

Unethical recruitment practices continued during the pandemic, with greater competition for health workers resulting in the active recruitment of critical care nurses and other front-line health care roles in several of the countries on the WHO's 2020 Health Workforce Support and Safeguards List.[3]

"...they can't say no to being assigned to Covid wards...Filipino nurses can't [say no] because they are worried about their job security, because they are on visas with conditions and short-term contracts." (Interview, trade union representative, Asia)

3 https://www.who.int/publications/m/item/health-workforce-support-and-safeguards-list

HOW DID NATIONAL AND INTERNATIONAL RESPONSES PROTECT MIGRANT HEALTH WORKERS?

Many governments instituted measures to deliver the health services needed during pandemic, e.g. increased recruitment and redeployment of nursing staff to Covid care. But these measures often failed to recognise the adverse impacts on and discrimination faced by migrant health workers. Crisis responses were largely based on short-term solutions rather than building the much-needed sustainability of health care systems.

- **Recruitment:** In destination countries, budgets were temporarily increased to intensify national and international recruitment, while origin countries struggled to respond to their own pandemic challenges. Some countries resorted to measures to retain their migrant workforce: 17 countries implemented a temporary ban on international recruitment of health workers from their countries.

- **Short-term measures** included fast tracking of the integration of migrant nurses, reduced barriers to practice (80+ jurisdictions changed their regulatory frameworks and licensing procedures), changes in visa requirements, removal of immigration fees, postponing re-registration / revalidation for physicians, lifting of fee restrictions in order to facilitate access to health care/ social protection, and granting of immigrant and refugee health professionals' permission to work. But lack of recognition of skills and qualifications continued to lock qualified nurses and doctors into jobs below their education.

- **Cross-border mobility.** The pandemic increased the urgency of cross-border mobility and appeals for healthcare professionals to return home to countries with severe shortages of health workers during the pandemic. Travel bans made this very difficult in practice. In contrast, most OECD countries exempted health professionals with a job offer from travel bans.

- **Bilateral labour agreements (BLAs).** Governments entered numerous BLAs for healthcare personnel prior to and during the pandemic. Many of these BLAs contain limited monitoring mechanisms and guarantees for fair and ethical recruitment. The inclusion of trade unions and health authorities of both source and destination countries in the negotiation, implementation and monitoring of BLAs is crucial if these agreements are to adhere to international human rights norms and labour standards.

Examples of Responses by Trade Unions and Civil Society

- A coalition of 800+ NGOs and trade unions, including the PSI, drew up the "Nurse Manifesto – No going Back" to put pressure on governments to recognise, value and reward nurses for their critical roles during the pandemic.

- PSI and its affiliated unions have drawn up a set of demands for the WHO as it negotiates a new *Pandemic Treaty*, with measures to ensure protection and inclusion of migrant health workers and their families.

- The ITUC demanded a new global social contract between workers, government and business to provide a universal labour guarantee for all workers, including migrant (health) workers.

- New campaigns have been instituted by NGOs to reduce dependence on migrant health workers, such as recent launch in Europe of the *Pillars of Health Initiative*.

WHY IS RESEARCH DATA IMPORTANT?

The WHO's recommendation of standardised measurement and reporting of Covid-19 impacts on health workforces is a good start. However, our research findings lead us to recommend this be extended to include: disaggregated data by gender and ethnicity, along with workers' migrant status, country of origin, and whether they work in the public or private sector, and better systems for collecting and analysing disaggregated standardised data.

Such measures will help redress the near-invisibility of migrant health workers in Covid-19 impact studies, policy initiatives and responses, and improve their working conditions.

CONCLUSION

Our research shows few concrete national and international initiatives were designed to address the additional risks faced by migrant health workers during the pandemic. This is despite the fact that many international organisations, including the UN Network on Migration, regularly highlighted the critical role of migrant health workers during the pandemic and their exclusion from health, social and economic protections available to others.

Changes in regulatory frameworks and laws to address health emergencies have been short-term responses. Some have been progressive, others very regressive.

"The health sector should be, and must remain, a safe and attractive place to work." (WHO Europe)

STRATEGIES AND RESPONSES

Our research points to the need for international organisations, governments, employers, trade unions and other non-governmental organisations to learn from the pandemic and view it as an opportunity to address the rights of migrant health workers in developing strategies and policy responses:

1. Assess the impacts of policy responses, including the role of international recruitment, in preparing for future health crises, their remit on COVID 19-related vulnerabilities and the efficacy of safeguards against active international recruitment of health workers.

2. Implement, with much greater urgency, systematic and long-term measures to address understaffing and undervaluing of health care staff and the underfunding of public health services.

3. Promote fair and ethical recruitment, in line with the WHO Code and international human rights norms and labour standards, while providing guarantees for the protection of migrant health and care workers' rights and the right to health of the population.

4. Ensure workers' voice and social dialogue in all future policy developments, including in the negotiation and implementation of BLAs in the health sector.

5. Improve data systems to improve the visibility of, and responses to, the enhanced risks of infection and death faced by migrant health workers, and include workers' voice in future pandemic preparedness, and recovery.