Policy responses to address risks of harm to migrant health care workers in times of COVID-19

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COVID-19 sample collection at a migrant workers' campsite in Bang Sue,Bangkok
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ABSTRACT

This paper presents a 'state of the art' comprehensive review and discussion of global and national policy responses to address the risks faced by migrant health care workers during the COVID-19 pandemic (2020-2022). It shows that remarkably few of the policy responses directed at the health workforce have addressed the specific circumstances, risks and needs of migrant members of this workforce, and not all such workers benefited from the measures. Beneficial measures, notably recognition of COVID-19 as an occupational safety and health issue and as an ILO fundamental right, are accompanied by measures infringing health workers' earlier acquired rights. Accelerated international recruitment of health workers has been facilitated by rapidly-adjusted domestic regulations on qualifications and skills recognition, licenses and visas, exacerbating extant staffing shortages in countries of origin and collective rights to health of populations in those countries. Global policy responses have been largely declaratory, focussed on mobility, skills and training capacities, ethical recruitment and government-to-government programmes to manage health worker migration. Long-term policy responses in relation to rights-based approaches to health worker migration and building sustainable health care systems have been very limited. Further research is required to assess the efficacy of the measures adopted and whether those introduced on a temporary basis have been revoked, retained and/or extended.

Key words: Covid-19, global policy; health workforce; health services; working conditions; international recruitment; international migration; bilateral labour agreements.

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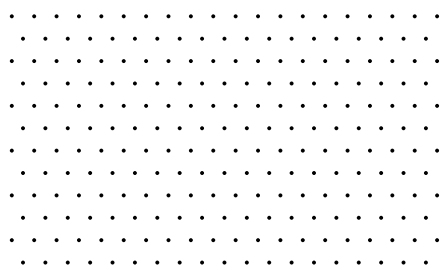
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LIST OF ABBREVIATIONS AND ACRONYMS

BLA	Bilateral agreement
CARICOM	Caribbean Community
CGFNS	Commission on Graduates of Foreign Nursing Schools
CBA	Collective bargaining agreement
CGIL	Confederazione Generale Italiana del Lavoro [General Confederation of Labour, Italy]
CISL	Confederazione Italiana Sindacati Lavoratori [Italian Confederation of Workers' Trade Unions]
CITUB	Confederation of Independent Trade Unions of Bulgaria
CUPE	Canadian Union of Public Employees
EC	European Commission
ECOWAS	Economic Community of West African States
EMO	European Medical Organisations
EP	European Parliament
EPSU	European Public Services Union
EU	European Union
FiSPU	Finnish Public Services Unions
GBP	Great British Pounds (Sterling)
HOSPEEM	European Hospital and Healthcare Employers' Association
ICN	International Council of Nurses
IHF	International Hospital Federation
IHR	International Health Regulations
ILC	International Labour Conference
ILO	International Labour Organization
IOM	International Organization for Migration
INMA	Irish Nurses and Midwives Association
ITUC	International Trade Union Confederation
NGO	Non-governmental organisation
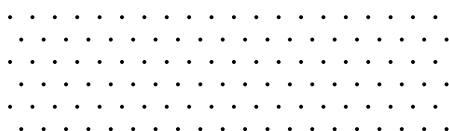
NHS	National Health Service
NNU	National Nurses United
OECD	Organization for Economic Cooperation and Development
OSH	Occupational safety and health
OU	The Open University
PAHO	Pan-American Health Organization
PPE	Personal protective equipment
PSI	Public Services International
PTSD	Post-traumatic stress disorder
TEG	Technical Expert Group
TPVH	Third party violence and harassment
TUAC	Trade Union Advisory Committee
UAE	United Arab Emirates
UHC	Universal health coverage/care
UIL	Unione Italiana del Lavoro [Italian Labour Union]
UNI	UNI Global Union
UNISON	UK public service union
UK	United Kingdom of Great Britain and Northern Ireland
UNECA	United Nations Economic Commission for Africa
UNNM	United Nations Network on Migration
USA	United States of America
USD	US dollars
WAHO	West African Health Organization
WHA	World Health Assembly
WHO	World Health Organization
WHO Code	WHO Global Code of Practice on the International Recruitment of Health Personnel
WMA	World Medical Association
WMC	World Medical Council
WTO	World Trade Organization
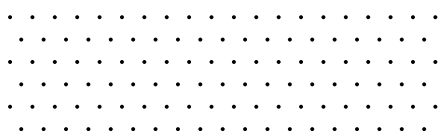
Section 1 Introduction

This paper reviews and discusses global and national policy responses to address the risks faced by migrant health care workers during the COVID-19 pandemic. It complements and extends other papers in this series addressing risks faced and impacts experienced by migrant health workers during the pandemic (Tipping, Murphy and Yeates et al., 2022; Vaillancourt-Laflamme, Pillinger and Yeates et al., 2022). During the COVID-19 pandemic, governments adopted a range of measures to ensure the ability of healthcare services to withstand the anticipated and actual surges in demand for medical intervention. Some of these measures were specifically directed at *migrant* health workers, others impacted on them indirectly. It presents a 'state of the art' review of these policy initiatives instituted by governmental and non-governmental actors, nationally and globally, during the pandemic. These responses are situated in relation to global issues and initiatives at the intersection of health services provision, the health workforce and international migration.

During the COVID-19 pandemic, governments adopted a range of measures to ensure the ability This paper is structured around four main sections, followed by a conclusion. Section 2 reviews in detail responses specifically aimed at increasing workforce capacity through international recruitment, as well as those pertaining to international mobility. This discussion includes consideration of bilateral agreements and measures aimed at retaining health workers, including how far they benefit migrant health workers. Section 3 considers measures adopted by multilateral organisations, global unions, international employers' organisations, international professional organisations and international NGOs. The paper ends with an overall conclusion and recommendations (Section 4).

Section 2 Country-level responses

2.1 HEALTH WORKFORCE CAPACITY

A main concern of employers of health workers throughout the pandemic has been to ensure sufficient staffing numbers to deliver the services required. This has been complicated by the pre-existing shortage of health workers as well as by the fact that health workers were among those infected by the virus. Measures geared toward the rapid expansion of workforce capacity to meet the surge in demand for many occupations deemed essential, primarily jobs in the healthcare sector, have been a principal type of response. Measures regarding the health workforce in general include requiring longer working hours and/or different shift patterns, moving from part-time to full-time work, allowing extra overtime; cancelling holiday leave; redeploying staff from other clinical areas or institutions; bringing non-practising clinical staff back into the workforce as temporary/voluntary 'returners'; deploying medical and nursing student nurses to frontline work, and using temporary/ agency staff (ICN, CGFNS and Buchan 2022:10; Williams et al., 2020a). In the European Union (EU), many countries suspended the otherwise-comprehensive regulations pertaining to recruiting health workers (HOSPEEM, 2020). Other measures imposed derogations related to working time arrangements, reducing barriers to entry into healthcare practice for national and international health workers, and limiting health workers' right to strike. Many of these measures required passing special emergency legislation or the suspension or cancellation of existing legislation (Williams et al., 2020a), and were instituted on an emergency basis and at speed, without, it seems, due attention to their consequences. These measures were continuously revised during the different waves of the pandemic (European Parliament, 2022: 88).

Below we discuss those measures pertaining to international recruitment of foreign-trained and -born health workers and their incorporation into the health workforce. As will become apparent, there has been a plethora of responses—some in tension with each other, and heading in opposite directions— as countries have made different policy choices.

2.1(A) INTERNATIONAL RECRUITMENT

Prior to the pandemic, many Organization for Economic Cooperation and Development (OECD) countries already had a high dependence on internationally-recruited health workers (OECD, 2021:14) and a substantial number of unoccupied vacancies in their health workforces (Yeates and Pillinger, 2019). COVID-19 increased the demand for healthcare services, particularly in critical care, and was confronted with what was already a chronic shortage of health workers. A shortage of more than one million health workers was estimated in the EU (McGrath, 2020); in Australia there were 12,200 vacant nursing positions (Le Grand, 2021), and in England the NHS entered the pandemic with one in ten registered nursing posts vacant (OECD, 2021:15).

Many OECD countries responded to this situation by intensifying their international recruitment effort as an immediate solution to their staffing shortages (OECD, 2020a; see also Section 2.2). For example, in Québec (Canada), the authorities undertook recruitment missions to France, Belgium, Lebanon, Brazil, Algeria, Libya, Mauritania, Morocco and Tunisia, with the aim of filling 4,000 nurse

vacancies (Ross, 2021). In England, for the six-month period of April- September 2021, almost 11,000 international nurses were registered — more than for the whole previous 12-month period — including more than 4,500 nurses from India, 3,000 from the Philippines and 1,300 from Nigeria (ICN, CGFNS and Buchan, 2022:39). Scotland followed suit, announcing in October 2021 that it would allocate £4.5 million to actively recruit overseas nurses as part of the overall plan for pandemic recovery and renewal (Government of Scotland, 2022). Spanish authorities recruited 400 foreign health workers as of end April 2020 (OECD, 2020a:4). Western Australian health authorities offered to cover the cost of flights, relocation fees and the mandatory 14-day COVID-19 hotel quarantine period in a bid to recruit 2,800 nurses by 2023. With this offer, Australia is attempting to also attract back some of its nurses working abroad. Despite Australia having fortressed itself during the pandemic, Australian Nursing and Midwifery Federation data show that skilled migrants make up 21% of all newly-registered nurses. In Victoria, overseas-trained doctors make up 23% of total doctors and 30% of doctors in regional areas (Le Grand, 2021). In the Caribbean, the government of Barbados recruited nurses from Ghana and sought the assistance of Cuban nurses during the worst of the pandemic (Loop News, 2022).

Ethical recruitment

The May 2022 World Health Assembly (WHA) discussed the fourth report on the implementation of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel (WHO Code), where the WHO noted:

> …the rising demand for health personnel [in times of COVID-19] has prompted contrasting government measures. While some countries have introduced a moratorium on the outward migration of health personnel during the COVID-19 pandemic, a far greater number has simplified the process for inward migration and professional licensure to facilitate rapid recruitment of international personnel. (WHO, 2022a:1)

The OECD drew a similar conclusion, noting that despite increased investment in training domestic nurses, reliance on international health workers has not only continued to grow but countries have adopted measures to speed up the recruitment of healthcare professionals during the pandemic (OECD, 2021:5).

The supporting narrative for this reliance on migrant health workers emerging from many countries revolves around the 'essential nature' of international recruitment in meeting the high demand for healthcare. National Health Service for England (NHS England), for example, stressed that, "international recruitment will be a vital component of support for ongoing management of COVID-19 in areas across England, for other service pressures, and for recovery for the NHS from the pandemic", adding that "[s]ome new potential supply nations are also emerging" (NHS England, n.d.). This example illustrates the ethical issues arising from this resurgence of international recruitment drives by some high-income countries. Notably, such recruitment is targeting countries with health workforce shortages, including several countries in Africa on the WHO's Health Workforce Support and Safeguards List (WHO, 2020a). This heightened recruitment is undermining the ability of some 'source' countries to respond effectively to pandemic challenges (ICN, CGFNS and Buchan, 2022:30; Africa News, 2022). Indicative of the extent of depletion of these countries' health workforces, in August 2022 the government of South Africa added six categories of specialist nurses to its latest critical skills list (Magubane, 2022).

The advent of the pandemic, and the rapidity with which some countries have reverted to international recruitment to increase surge capacity, has seen countries adopt or revise national recruitment guidelines. Updated Codes of Practice on international recruitment aligned with the WHO Code have been drawn up in England (Department of Health & Social Care, 2022). and Scotland (Government of Scotland, 2022). The efforts of the United Kingdom (UK) in that regard were

highlighted by the WHO's most recent review of the implementation of the WHO Code, which praised the country's recent survey of recruitment agencies as well as the publication of an updated Code of Practice for the international recruitment of health and social care personnel in England "aligned with the WHO Global Code of Practice" (WHO, 2022a:5). Although the UK's new Code supports lowering the repayment charge for nurses leaving their employment before completion of the contract from GBP 14,000 to GBP 2,000, it remains to be seen how it can fully ensure compliance with fair and ethical principles in recruitment and employment of migrant health care workers (Interview, trade union, Europe; see also Vaillancourt-Laflamme, Pillinger and Yeates, et al., 2022; Moriarty et al., 2022).

However good these Codes of Practice may be, they remain aspirational and voluntary, and their robustness in effectively supporting ethical international recruitment of health workers remains in doubt. As one review reaffirmed,

> Codes need to operate within a transparent and fair immigration policy and to be underpinned by good recruitment practices which give potential international recruits all the information necessary to make informed decisions about whether to move to another country or remain in their country of birth. (Moriarty et al., 2022: 38)

If the adoption of such Codes of Practice by countries heavily relying on international health workers is to be applauded, especially if they are the outcome of genuine social dialogue involving employers and representatives of the healthcare workforce at country level, it is also critical that the international mobility of health workers be governed effectively at global level. As two of the authors of this paper have previously argued, this entails:

> 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. (Pillinger & Yeates, 2020:4)

In this regard, the intensification of international recruitment and revisions to national Codes of Practice need to be contextualised in relation to the sustained permissiveness over many decades towards international recruitment and migration to address health workforce shortages (Yeates and Pillinger, 2019; Yeates, 2009). The expansion of the private sector medical and nurse training schools has been an integral part of this so-called 'export industry' and the subject of critical scrutiny. In Asia, the Philippines and India adopted an explicit policy of 'training for export', serving lucrative international markets in the West, while Bangladesh, Indonesia and Vietnam emulated these as 'new' market entrants serving less lucrative regional markets (Yeates, 2009). In India, for example, the rapid growth in the nursing education sector translates into a high number of nurse graduates with a Bachelor of Science (BSc), which is the qualification most in demand by high-income countries but not necessarily the most needed in India. There were only 30 colleges offering the internationally desired BSc in nursing in 2000, but by 2010, this had grown to 1,326. More than 90% of these establishments are in the private sector (ICN, CGFNS and Buchan, 2022:41). In Kenya, South Africa and Thailand, we also see the growth of unregulated private sector institutions in medical and nursing education. As the cost of education in these private facilities is high, graduates are rarely attracted into the national public health sector, diminishing the probability they will remain in their own country and undermining national efforts to achieve universal health coverage (UHC) (WHO, ILO and OECD, 2016:25).

Universal health care is dependent on a sufficient number of equitably distributed, qualified and experienced health workers. COVID-19 has severely challenged progress in this area. A World Medical Council (WMC) Resolution regarding the Medical Profession and COVID-19 (WMA, 2020) highlighted the importance of new commitments on the financing of health care systems to ensure accessible

and quality health care. For the EU, the pandemic provided it with an opportunity to take further steps. Its *EU4Health 2021-2027* initiative is a direct response to the COVID-19 pandemic; it takes up the criticism that the EU (particularly its enforcement capacity) has not proved very effective in supporting critical workers, (European Parliament, 2022:14). The initiative proposes to go beyond crisis response and pave the way for "a stronger, healthier, and more resilient Health Union" (EC, 2021:1) by developing the EU health workforce and building the skills of current health workers. It particularly anticipates that the use of digital health technologies to provide health care will increase in the years to come.

Bilateral labour agreements

Contrary to unilateral recruitment drives, bilateral labour agreements (BLAs) adhering to the WHO Code (WHO, 2010) have long been hailed as auspicious policy tools to address the needs of source and destination countries, as well as those of the migrating workers (Yeates and Pillinger, 2019; Pillinger and Yeates, 2020; Makulec, 2014; Moriarty et al., 2022; WHO, ILO and OECD, 2016; Aspen Institute, 2010). Indeed, those concerning health personnel have increasingly become a policy tool of choice for governments seeking to bolster their health workforce capacity. Prior to COVID-19, a number of such agreements were already in place, such as between the Philippines with Bahrain, UK and Germany; Bangladesh with Italy; Tunisia with Germany; Bosnia-Herzegovina with Germany; Sudan with Saudi Arabia and with Ireland (Interview, employer, Europe; Interview, trade union representative, Asia; ILO, 2022a; Carzaniga et al., 2019; Moriarty et al., 2022; Yeates and Pillinger, 2019). At the height of the pandemic, few countries initiated discussions to recruit additional staff through government-to-government agreements, but, in the European context at least, several new agreements have since emerged. An agreement between Romania and Austria was designed to allow Romanian temporary workers in the social and long-term care field to work in Austria. Given the existing acute shortages of health workers in Romania, this agreement seems to have failed to address the immediate service provision needs arising from the country's own health workforce crisis (Rohova, 2011; European Parliament, 2022:62). The UK entered new bilateral agreements with Kenya (July 2021) and India (July 2022)[1], while the United Arab Emirates (UAE) reported having entered into a bilateral agreement with the view to facilitating

> …the recognition of academic qualifications acquired outside the country, whereby registered nurses and licensed midwives from Australia, Canada, Ireland, New Zealand, UK and USA are exempt from all stages of the assessment required by health authorities, on condition that the certificate of registration is valid and a good standing certificate (GSC) status from the home country is provided at the time of application. (ILO, 2022a:380)

Though often presented as an ethical response, BLAs are not without ethical concerns. As a case in point, the UK signed a BLA with Nepal in 2022 at time when Nepal appears on the most recent WHO Health Workforce Support and Safeguards List (Gulland et al., 2022; WHO, 2020a) and where there are ongoing concerns about unethical and exploitative recruitment practices (Das, 2022a, 2022b). Although the UK-Nepal BLA complies with the WHO Code of Practice in that it conforms with the principle that recruitment from countries facing "the most pressing health workforce challenges related to [Universal Health Coverage]" goes through government-to-government arrangements, this BLA falls short of respecting the recommendation of the 2020 WHO Health Workforce Support and Safeguards List that "Government-to-Government health worker mobility-related agreements are not prescribed for *listed* countries" (our emphasis), namely Nepal in this case (WHO, 2020a:1).

The 2022 ILO discussion on the application of ILO standards to nursing personnel revealed how several governments have entered into a BLA for healthcare personnel prior to or as a result of the pandemic. These include agreements between Ghana and Barbados; Portugal with Cuba, Colombia,

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1 The UK-Kenya BLA on healthcare workforce collaboration, with specific reference to nurses, was signed on 29 July 2021, in the thick of COVID-19. A UK-India Framework agreement on health workforce collaboration was signed on 21 July 2022.

Costa Rica and Uruguay. Mali indicated it has negotiated agreements with partners "under the framework of the Conférence Interafricaine de la Prevoyance Social (C.I.PRE.S) to ensure reciprocity for migrant workers, including nurses, in matters of employment, work and social security" (ILO, 2022a: 382). Argentina, Brazil, Canada, Chile, Colombia, Ecuador, Indonesia, Japan, Mali, Mauritius, Peru, Philippines, Poland, Qatar, Slovenia, Tunisia, Uruguay, Viet Nam and Zimbabwe have also developed BLAs on the mobility of healthcare personnel (ibid.).

There remains the important task of assessing the *quality* of the agreements and whether the agreements are implemented in full (Makulec, 2014; Yeates and Pillinger, 2019; Pillinger and Yeates, 2020). Too often, BLAs are entered into by foreign or trade ministries leaving aside health ministries and organisations representing health workers in source and destination countries. The inclusion of all stakeholders, including trade unions and health authorities of both source and destination countries, in the negotiation, implementation, monitoring and evaluation processes of such agreements, is often a good predictor of the quality of an agreement, including its incorporation of international labour standards (WHO, 2010; Pillinger and Yeates, 2020). The extreme difficulty in accessing the text of these agreements in order to scrutinise them is behind the global trade union movement calls to increase access to the negotiation of BLAs and render transparent what is agreed (Pillinger and Yeates, 2020:21).

Shift from international recruitment to self-sufficiency

The intensification of international recruitment and 'training for export' strategies (Yeates, 2009; Yeates and Pillinger, 2019) is not the only policy option to address health workforce shortages, nor has it been the only response during the pandemic. Increasing the numbers of home-trained health workers has been one option, with several countries making a concerted effort to shift towards self-sufficiency. For example, in Switzerland, a referendum was organised on 28 November 2021 on nursing shortages.[2] With leadership from the Swiss Professional Association of Nurses, it achieved a voting majority which aims to improve training, quality assurance through more staff, fair employment conditions and improved recognition of the profession (ICN, CGFNS and Buchan, 2022: 36). The initiative focused on the duty of national and cantonal governments to address a long-standing shortage of nursing staff by increasing the number of Swiss trainees in an attempt to reduce reliance on foreign-trained nurses. It also sought to increase retention by improving working conditions and salary rates, easing workload and raising professional status (Geiser, 2021; Romy, 2021). A similar strategy has been adopted in Oman, whose government consolidated its pre-COVID-19 policy to 'Omanise' its nursing workforce by replacing expatriate nurses with similarly qualified Omani nurses (ICN, CGFNS and Buchan, 2022:44; Ennis and Walton Roberts, 2018). In similar vein, the UAE announced in July 2021 that it intends "to develop national cadres in the nursing sector, targeting 10,000 Emiratis within 5 years" (ICN, CGFNS and Buchan, 2022:44).

2.1(B) ENTRY AND INTEGRATION INTO THE HEALTH WORKFORCE

Entry requirements into the health professions have also been a focus of government efforts to address health workforce shortages. Over 80 jurisdictions have changed their regulatory frameworks and licencing practices and procedures so as to loosen requirements for retirees, students and migrants to enter the healthcare workforce (Interview, International Organisation, Europe). Furthermore, the WHO's fourth review of the implementation of the WHO Code noted that 20 member states reported measures to ease the entry or integration of foreign-born or -trained health personnel (WHO, 2022a). Countries adopted various measures to reduce language requirements, waive fees for conversion exams, and automatically extend work visas and licenses to practice for trained healthcare professionals (Williams et al., 2020a; Gulland et al., 2022). In the UK, foreign-trained doctors, nurses

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2 Approval of a people's initiative – a key element of Switzerland's system of direct democracy - is exceptional. Only 24 proposals - out of more than 220 - have ever won majorities over the past 130 years (Geiser, 2021; Romy, 2021).

and paramedics with visas due to expire before 1 October 2020 had them automatically extended for one year (OECD, 2020a:4; ICN, CGFNS and Buchan, 2020:4). Austria, Germany, Hungary and The Netherlands also suspended the need for doctors to re-register or re-validate their licenses (Williams et al., 2020a: 53-54). In the UK, in October 2021, the government announced it would lift the Immigration Health Surcharge (an annual fee for health care levied on UK visa applications) for health workers coming to the country (UK Government, 2021). Ireland adopted similar fee-waiver measures (OECD, 2020a: 4; Williams et al., 2020a:55).

Recognition of foreign qualifications is a major issue in facilitating international migration. OECD countries expedited pending applications for the recognition of the foreign qualifications of health professionals (OECD, 2020a). At one extreme, the Chilean national health service authorised recruitment of foreign health professionals even if their qualifications were not formally recognised by that country (ibid.:4). In the United States of America (USA), health authorities in eight states have been experimenting with new pathways for international health professionals already resident there to be licensed to practice, so they could join the fight against COVID-19 (Batalova and Fix, 2020). Federal states with very defined jurisdiction regulating the practice of healthcare professionals, such as the USA, have also allowed healthcare personnel to practise in other states. The State of Idaho, for example, allows physicians with valid licenses from other countries as well as from other US states to practice their profession during emergencies. The State of New York now gives access to foreign-trained doctors a limited permit with one year of approved postgraduate training instead of three, and physicians licensed in other US states and Canada can now practice in that state (Batalova and Fix, 2020). Similar measures have been adopted by the State of Massachusetts reducing to two years the otherwise three required years of postgraduate resident medical training. New Jersey has created a pathway for foreign-licensed physicians to get a temporary emergency license to practice medicine. In Utah, foreign medical graduates no longer have to repeat their residencies if they practiced in Australia, the UK, Switzerland, South Africa, Hong Kong, China, or Singapore. In other states such as California, Colorado and Nevada, authority has been delegated to the Chief of Medical Services to provide waivers regarding licensing of healthcare professionals (OECD, 2020a:4).

Several countries in other parts of the world have expanded temporary market access to migrant health professionals (Batalova and Fix, 2020). For example, in Ontario, Canada, foreign-trained doctors who passed their exams to practise in Canada or have graduated from medical school in the past two years can now apply for a supervised 30-day medical licence to help fight COVID-19. In British Columbia, foreign-trained doctors with at least two years of postgraduate training and who have completed the Licentiate of the Medical Council of Canada qualifying exams can now work as associate physicians under the supervision of a fully certified doctor (OECD, 2020a:4; ILO, IOM and UNECA, 2020:4).

In Europe, before the pandemic, there were an estimated 14,000 foreign-trained physicians in Germany waiting for their medical qualifications to be recognised, many of whom arrived as refugees in 2015 (Williams et al., 2020a:54; OECD, 2020a:4). Two German states took steps to enable physicians trained outside the EU and not yet licenced to practice in the country to assist the COVID-19 frontline response. Italy adopted a decree enabling temporary licensing of foreign-trained health professionals (OECD, 2020a:4). In France, non-licensed foreign-trained health professionals were permitted to work as support staff in non-medical occupations (ibid.). Similar skills recognition measures for migrant health workers were adopted in Belgium, the Czech Republic, Luxembourg and Spain (OECD, 2020a:4; Williams et al., 2020a:55).

Granting temporary access to the health workforce of refugee and asylum-seekers who are qualified health professionals has been a key policy response. In the UK and Germany, refugee health workers have had their recognition fast-tracked during COVID-19 (Dempster et al., 2020). In Ireland, refugees and asylum seekers with medical qualifications were able to work in support roles such as healthcare

assistants (Williams et al., 2020a:55). In Canada, similarly, the government explored a route to permanent residency to health workers who are refugees and who have worked a minimum number of hours providing direct care to patients during the COVID-19 pandemic (Moriarty et al., 2022:18). Taken together, these policies can be seen as a loosening of tight skills recognition regulatory systems (Batalova and Fix, 2020). Authorities hope that cutting through existing regulatory thickets as regards skills recognition would lead to credentialing and rapid employment of international health professionals not employed in healthcare or employed in much lower-skilled work (ibid.). These efforts are welcomed as the recognition of health workers' skills is the *sine qua non* condition for workers to then be in a position to negotiate appropriate working conditions in their country of destination. The lack of such recognition is often what locks qualified nurses and doctors into jobs below their education level (Yeates and Pillinger, 2019). According to the New Zealand Confederation of Trade Unions, nurses educated in the Pacific Islands struggle to have their skills recognised in New Zealand or Australia (ILO, 2022a:381).

2.1(C) DIASPORA AND SOLIDARITY MEASURES

The pandemic has also prompted a range of diaspora and solidarity operations among countries regionally and between states or provinces in federal states. Diaspora initiatives, involving first and subsequent generations of emigrants who share common cultural, ideological, political and religious values and ongoing connections with their countries of origin, proliferated during the pandemic, including among migrant health workers who are part of the diaspora. At one level, they took the form of traditional trans-local fund-raising and donations. For example, the American Association of Physicians of Indian Origin mobilised resources to send oxygen concentrators, ventilators, Remdesivir (an anti-viral medicine) and PPE to their colleagues in India. The organisation reports having been flooded with donations and having "raised a few million dollars in less than two weeks" (Kallingal, 2021: n.p). Similarly, the Ethiopian diaspora raised more than USD1 million from over 25,000 donors abroad to support frontline health workers in Ethiopia (IOM, 2020:21).

At another level, appeals were issued to emigrant health workers to return home during the pandemic. Thus, in Serbia, a non-governmental organisation (NGO) invited Serbian physicians abroad to temporarily return home (Williams et al., 2020a:55). The government of Ireland issued a pandemic-related call for Irish doctors practicing abroad to return to Ireland to provide health care (Humphries et al., 2021). Romania registered an increased number of returns of its healthcare professionals during the pandemic (European Parliament, 2022:45), while some nurses from Barbados opted return home to 'lend a hand' to support the country's overstretched health system (Interview, trade union representative, Caribbean).

Solidarity initiatives between nations and groups of health professionals also flourished during the pandemic. These have involved sharing resources, including health care professionals. Ukraine, Albania, Tunisia, China, Cuba, Poland, Norway, Romania and Russia all sent significant numbers of medical staff, both specialised and general nursing teams to Italy, which was among the first officially-affected countries in Europe (Williams et al., 2020a:54). Cuba sent hundreds of doctors and nurses to countries in the Caribbean Community (CARICOM) region (Mottley, 2020). Teams of physicians from France, Lithuania and Italy were sent to Armenia to provide care to COVID-19 patients (Williams et al., 2020a: 54). Such movement was orchestrated under the European Civil Protection Mechanism, an EU mechanism established in 2001 to enable prompt sharing of resources among EU and other participating member states to respond effectively to emergencies within or outside the EU[3].

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3 This mechanism does not specifically target health emergencies. Since foundation, it has been activated more than 600 times to respond to emergencies. https://civil-protection-humanitarian-aid.ec.europa.eu/what/civil-protection/eu-civil-protection-mechanism_en (Accessed 22 August 2022).

The policy responses reviewed here show that it is feasible to lift the skills and skills-related restrictions that bar the entry of overseas-born and -trained health workers into the domestic health workforce in destination countries and their full integration into the health workforce there. There is a significant opportunity to explore how policy makers can build on this to address the fragmented global health workforce governance framework (ILO, IOM and UNECA, 2020:3; Yeates and Pillinger, 2019). At the same time, it will be important to track how these pandemic-induced permission to work policies fare in the 'post-COVID' era, while ensuring that they do not become a reason to reduce wages and working conditions, nor replace investments in public health services. Whether these emergency measures will be revoked or become a permanent feature of the regulatory apparatus, and whether responses will be directed at all groups of migrant health workers, including asylum seekers and refugees, or just some of them are issues that will require on-going close monitoring.

2.2 INTERNATIONAL MOBILITY AND MIGRATION

2.2(A) TRAVEL RESTRICTIONS

Measures to limit the movement of health workers have been adopted by both source and destination countries, albeit for different reasons. This has been of profound significance for migrant health workers whose families reside in the source countries (Interview, International Organisation, Europe).

The fourth review of the implementation of the WHO Code reports that 17 countries limited the exit of health personnel during the COVID-19 pandemic, though most had no mechanism to adequately monitor movements (WHO, 2022a). Israel is one such country that adopted specific legislation prohibiting health workers from leaving the country (Williams et al., 2020a). Although not specifically targeting migrant workers, Canada, the Czech Republic, Greece, Luxembourg, Norway and Spain cancelled international travel, measures that would have affected migrant health workers (Williams et al., 2020a: 53). In the Philippines, a country with a historically high rate of emigration of health workers, a Philippine Overseas Employment Administration memorandum suspended the deployment of doctors, nurses and health workers abroad in the hope of retaining the local frontline force against COVID-19. However, the Foreign Affairs Secretary reversed the ban on the grounds that the ban only makes sense if "we pay them foreign rates" and if the government negotiates "first class work contracts for them" (Elmaco, 2022; Cheng, 2020). Instead, a cap on the number of health workers who could emigrate (7,000) was introduced. Such bans did not go uncontested, not least by recruiting countries such as the UK (Interview, trade union representative, Asia).

Within the EU, where international borders between many Member States are normally fluid, COVID-19 travel restrictions significantly disrupted health workers accustomed to traveling between their countries of origin and employment on a regular basis. For example, upon the closure of borders between Switzerland (a European Economic Area member and part of the Schengen Agreement) and its neighbouring countries early on during the pandemic, it became increasingly difficult for those migrant health workers, approximately one third of all staff working in Swiss hospitals, to travel to work if they lived in neighbouring countries. Switzerland was forced to negotiate special measures with its neighbours to maintain its health workforce (ICN, CGFNS and Buchan, 2022: 36). Austria faced the same situation (Kuhlmann et al., 2020: 23).

2.2(B) TRAVEL FACILITATION

Several countries relaxed travel restrictions for essential workers generally and healthcare professionals specifically that otherwise applied during the pandemic. In April 2020, the European Commission (EC) called on "Member States to facilitate the smooth border crossing for health professionals and to allow them unhindered access to work in a healthcare facility in another Member State" (OECD, 2020a:4). In fact, most OECD countries exempted health professionals with a job offer overseas from travel bans (OECD, 2020a:4). For example, in Australia, a country that adopted some of the most stringent travel restriction measures, the Federal Health Minister was quoted as saying that international nurses who had already applied to come to Australia "would be able to sidestep travel restrictions to secure flights and take up critical jobs" during the pandemic response. The government agreed to cover the cost of flights and quarantine. Australia also targeted health workers from the UK, Ireland and other countries with education qualifications recognised by Australia (Le Grand, 2021). Australia further offered GBP2,400 to Australian nurses working in the UK to tempt them to return to Australia (Ely, 2020).

2.2(C) NATURALISATION

Some countries adopted policies facilitating the naturalisation of essential workers. In France, in the midst of the pandemic, the French Ministry of Interior announced that it would fast-track the naturalisation process of foreigners that worked in the frontline of the battle against coronavirus to show that the French state recognises their commitment to the country (OECD, 2020b:3; Willsher, 2020). Spain, on 20 May 2020, extended residency and work permits for foreigners, which could lead to regularisation pathways (European Parliament, 2022:77). In Canada, similarly, the government explored a route to permanent residency to health workers who are refugees and who have worked a minimum number of hours providing direct care to patients during the COVID-19 pandemic (Moriarty, 2022:18).

2.2(D) DEPORTATION AND REPATRIATION

At the opposite of the spectrum, migrant health workers have sometimes faced deportation. In Ireland, migrant workers were threatened with deportation at the end of their visa, even though workers were in short supply. Following protests by Irish public figures, authorities agreed to review cases (Abucayan, 2020). In the UK, a private members' bill, the Immigration (Health and Social Care staff) Bill 2019-21, calling for migrant healthcare workers to be granted indefinite leave to remain, has been a source of tension, not least because its delay prolongs the risk of deportation for migrant health workers. Indeed, in June 2022, the UK Royal College of General Practitioners reported that it was "regularly contacted by GPs who, once qualified, have received letters threatening 'deportation'" (Thornton, 2022).

In some countries, working conditions in destination countries were under such strict COVID-19 lockdown regulations that health workers found themselves stranded. For example, the United Nurses Association in India organised the repatriation of their Indian members who found themselves in difficult situations in Saudi Arabia (Llop-Gironés et al., 2021:6).

2.3 WORKING CONDITIONS AND RETENTION MEASURES

The sustained efforts of health workers throughout the pandemic have convinced some countries to start correcting long-standing past under-investment, as a way to acknowledge their contribution to the fight against the pandemic, attract and retain health workers, and create more sustainable healthcare systems. Retention measures improve job satisfaction, salaries, working conditions (including dignity and respect), in-service training, career opportunities, rewards for outstanding performance, housing and social protection, and help reduce work-related stress and 'de-professionalisation' in what can sometimes be highly bureaucratic and managerial organisational structures (WHO, ILO and OECD, 2016:37). Initiatives relating to working conditions of health workers, including migrant health workers, are summarily reviewed below.

Some of the most innovative initiatives have emerged through social dialogue and particularly through collective bargaining agreements between employers and trade unions. An ILO survey of collective bargaining agreements entered into by trade unions during the pandemic found that agreements were principally focused on occupational safety and health (OSH) measures and enhanced employment guarantees (for example, measures to secure wages/income, additional benefits to specific categories of workers, such as health workers, temporary flexible working arrangements and the prevention of collective dismissals) (ILO, 2021a). More specifically, health service unions negotiated agreements to extend social protection to mitigate the immediate socio-economic impact of the crisis on workers, including OSH and other measures related to working time and paid leave, through collective bargaining and bilateral agreements at various levels (ILO, 2021a:19). In some cases, as discussed above, additional benefits have been granted to specific categories of workers through sectoral agreements or unilaterally through government awards. For example, an agreement for full payment of salaries during quarantine and free transport was negotiated by the Argentine federation of health workers' associations. This enabled health workers to continue to earn full salaries during quarantine and rendered them eligible for government-subsidised free transport to and from work during the pandemic (ILO, 2020b). In some cases, trade unions negotiated agreements to protect the rights of nursing and medical students (Llop-Gironés et al., 2021:6), and to protect the workers where there have been violations of rights, such as in cases of non-payment of wages or lack of compliance with OSH regulations (ILO, 2021a).

Strike action increased across the world in response to excessive workloads as was the case in several European countries (EPSU, 2021a, 2022). Canada (CUPE and SEIU, 2022) and the UK (UNISON, 2022), leading to pay increases, improvements in working conditions for health workers and measures to ease staffing shortages (EPSU, 2022). In the Philippines, PS-Link negotiated for workers to receive hazard pay, free transport, board and lodging, food and laundry for health workers, along with sick leave for workers infected by COVID-19. In the first six months of 2022, European Public Service Union (EPSU) affiliates in 15 countries took unprecedented actions, strikes and negotiations for new agreements (EPSU, 2022). Examples include a collective bargaining agreement (CBA) agreed between Verd.i and six university hospitals in North Rhine Westphalia (Germany) with a commitment to tackle excessive workloads and understaffing. EPSU also reports an employer commitment to improvements in pay and measures to address staffing shortages in Finland. An agreement in Portugal resulted in negotiated pay increases and more resources and staffing for the health service (EPSU, 2022). In the Netherlands in April 2022, unions negotiated pay increases and better conditions of employment in the public sector; while in the same month Bulgarian unions CITUB and Podkrepa signed a collective agreement with the Ministry of Health leading to pay rises for doctors and nurses, helping both to recruit new workers, but also to deter emigration. The Italian federations FP-CGIL, CISL-FP and UIL-FPL negotiated a three-year agreement in June 2022, covering 550,000 health workers, with higher pay amongst other improved conditions (Rogalewski and Freeman, 2022).

2.3(A) HAZARD PAY AND INCOME SUPPLEMENTS

Several countries have responded to the hardships facing health workers, including migrants, through measures to maintain or increase their incomes. Such measures as were instituted were often the result of dialogue and negotiation between social partners. On the one hand, there were agreements to assure health workers, including migrant health workers, among others, the continued payment of their salary. In Malta, migrant health workers, amongst others, who were required to stay at home under preventive quarantine arrangements (Protection of Vulnerable Persons Order (LN 111 of 2020)) continued to receive their basic pay and class/grade allowances (Williams et al., 2020b:60). In Argentina, an agreement between the federation of health workers' associations and the government guarantees that all health workers would continue to earn full salaries while in quarantine (ILO, 2020b).

On the other hand, hazard pay measures were instituted. These tended to take the form of a one-off payment or monthly bonus payment for the duration of the pandemic. In Ireland, migrant health workers benefited from bonuses paid to all health workers. The government granted health workers a bonus payment of €1,000, the actual payment of which appears to not yet have been made (Phealan, 2022), while all migrant workers, including health workers, were eligible to receive a government pandemic unemployment payment (European Parliament, 2022:48). Some German States implemented pay increases and added resources to the federally-agreed package (Williams et al., 2020b:61). Bulgaria adopted a monthly support bonus of BGN 1,000 (€500) for medical staff, paid between March and December 2020 (Dimitriva, 2020). The French government offered a one-off payment of €1,500 to health workers in hospital departments with COVID-19 patients. Other healthcare personnel received a tax-free one-off €500 bonus payment and all hospital staff were granted a 50% increase in overtime pay (Eurofound, 2020:18). In Lithuania, all health workers in the national health system were granted a temporary pay rise ranging from 60 to 100% (ibid.). In Greece, the government granted a bonus amounting to half of the basic monthly salary to its health workers (ibid.; European Parliament, 2022:76). In Poland, health care employees who were in contact with COVID-19 patients were prohibited from working in more than one place. To compensate them for the lost income due to this restriction, authorities provided them with cash benefits calculated at 80% of what they would have normally received had they not been forbidden to work (Williams et al., 2020b: 60). Some hospitals supplemented this by about 20% for health workers exposed to COVID-19 (Eurofound, 2020:18).

Such measures were not confined to EU countries. In Kyrgyzstan, the bonus amount varied according to profession. In Barbados, the government granted health workers in the capital's largest hospital a hazard pay allowance, but this was not awarded to health workers in regional hospitals or health centres. In Ghana, the government developed an incentive package to retain its health workers, comprising non-taxation of salaries, salary increments and insurance for health workers infected by COVID-19. These were all initiatives to persuade health workers to stay in the health workforce, especially those working in critical care, in treatment centres and contract tracing (Interview, nursing union and professional association, Africa).

It should, however, be noted that in some countries, bonuses promised by central governments have yet to be received by health workers (Williams et al., 2020b: 61). And, notwithstanding the plethora of hazard pay schemes, globally, there were only marginal improvements in pay and, importantly in pay equality between men and women. Although female healthcare professionals were often working on the frontline in the role of nurses, male doctors tended to be paid the highest amount even if they were often likely to be removed from frontline work (Williams et al., 2020b: 61). An analysis of data from 54 countries where 40% of the health workers are active found that women were generally paid 20% less than men. This gap jumps to 24% when accounting for factors such as age, education and

working time. The average earnings of those in the health sector are lower than those of other comparable sectors, a fact that is commonly attributed to the feminisation of health care and the consequential undervaluation of that care (ILO and WHO, 2022:viii-ix; ILO, 2022a:112).

2.3(B) FLEXIBILITY IN WORKING TIME AND FAMILY-RELATED MEASURES

The onset of the pandemic prompted numerous governments to adopt new working time regulations or to modify existing regulations. Employers, public and private, pressed for changing working time legislation or relevant regulations at the workplace level. Reviews of measures introduced (Williams et al., 2020a; HOSPEEM, 2020; OECD, 2020) highlight: increasing working time, including moving from part-time to full-time work, increasing the number of permitted working hours per week and allowing extra overtime; cancelling leaves of absence, and suspending work exemptions after night shifts or on-call activities. For residents in training, on-going or scheduled external rotations for residents in training were suspended. International nursing students in Australia were allowed to work more than 40 hours every two weeks to alleviate pressure on the workforce (OECD, 2020:4). Other measures of note to increase surge capacity were to redeploy healthcare personnel - whether from rural communities to cities where needs were deemed to be more pressing, to new disciplines, and from private to public healthcare institutions. In England, for example, the government purchased services from private hospitals for the duration of the crisis, resulting in tens of thousands of clinical staff mobilised to fight the pandemic (Williams et al., 2020).

These measures were instituted with varying degrees of worker consent. In Sweden, for example, social dialogue between trade unions and employers was used to negotiate emergency arrangements, notably by activating the 'crisis clause' integrated in sectoral collective bargaining agreements to allow the extension of the working week to 48 hours for four weeks with corresponding monetary compensation for the health workers (European Parliament, 2022:78). At the opposite end of the spectrum, in Finland, Greece, Portugal and Slovenia, governments enabled employee overtime in critical sectors, including healthcare, without having to seek workers' consent (Eurofound, 2020:18).

In order to enable health workers with family responsibilities to work, measures to ensure children were cared for following the closure of schools/day care, were instituted. These included facilitating complementary shift work, supporting telework by home-based parents/ guardians, and financial support in terms of paid leave. Thus, day care facilities continued to receive the children of health workers in Austria, Belgium, Canada (Ontario and Québec) Czech Republic, Denmark, France, Germany, Lithuania (some cities), Monaco, Netherlands, Norway, Portugal and UK (Eurofound, 2020:18; Williams et al., 2020b:61). In Malta, a free childcare centre was opened by the government to care for children of health care professionals and other emergency sectors (Williams et al., 2020b:60). In Italy, the government offered a voucher of up to €1,000 for health workers with family responsibilities, as an alternative to being able to use parental leave (Eurofound, 2020:44). Similar measures were available in Romania (Williams et al., 2020b:61).

It remains unclear if and for how long measures adopted during the crisis will outlast the acute phase of the pandemic.

2.3(C) SOCIAL PROTECTION AND COVID-19 COMPENSATION

Although migrant health workers are often included in destination countries' social protection systems, this is not the case in all countries. The consequences of such exclusion have been made more evident during the pandemic. Some governments stand out as having adopted new policies to protect their nationals as well as migrant workers, including in the health sector. Notable examples

include Saudi Arabia, where agreements with some private health insurance companies ensured that all migrant health workers were covered. In Turkey, the government signed general bilateral social security agreements with 35 countries ensuring migrant workers, including migrant health workers, full access to social protection entitlements (ILO, 2022a: 383). Lithuania increased its sickness benefit to 78% of the average wage to healthcare and other workers infected with COVID-19, including migrant workers, in carrying out their work duties (Eurofound, 2020:41).

Perhaps the most significant development is recognition of COVID-19 as an occupational disease, an essential step for frontline workers, including migrant health workers, to avail of social protection. In addition to many EU countries, Switzerland and Norway also recognise COVID-19 as an occupational disease (EC, 2022a). In Kyrgyzstan, Lithuania, Romania, Spain and the UK, COVID-19 is not yet listed as an occupational disease, but health workers' families are awarded a lump sum payment should their relative working with COVID-19 patients die due to COVID-19 infection. In Spain, the social security system recognises COVID-19 as the cause of death if the fatality occurs within five years after the onset of the infection (Williams et al., 2020b:61). In the US, 34 States passed laws or changed policies to allow for workers' COVID-19 compensation claims (ITUC and UNI, 2021:3). Canadian and Australian states, provinces and territories have not recognised COVID-19 as an OSH issue but have clarified guidance on how to submit claims for compensation (ibid.). Turning to Asia, in Malaysia individuals contracting the virus have been made eligible for workers' compensation under the country's social security legislation (ILO, 2020b), while in the Philippines, a strong trade union campaign resulted in the recognition of COVID-19 as an occupational disease (ITUC and UNI, 2021).

2.3(D) WELL-BEING SUPPORT

Throughout the COVID-19 pandemic, many health workers, including migrants, worked extremely long hours in high-pressured and stressful environments. They have been exposed to the trauma of having to deal with high mortality rates from the start of the pandemic alongside delivering high quality care to patients when very little support and personal protective equipment (PPE) was available to them and doing so in a context of depleted staffing numbers and experience. A longitudinal survey of the UK nursing and midwifery workforce carried out at three time points during the first wave of the pandemic in 2020 found high levels of psychological distress, including post-traumatic stress disorder (PTSD), stress and anxiety (Couper et al., 2022). Further research corroborated this, and also found high levels of substance misuse and suicide (Greenberg, 2020; see also Vaillancourt-Laflamme, Pillinger and Yeates et al., 2022).

Recognition of the disproportionate impact of the pandemic on Black, Asian and minority ethic (BAME) workers, who may also be migrant workers, led to wellbeing support provided by NHS in England. The NHS health and wellbeing framework was stepped up at the start of the pandemic through a national health and wellbeing support programme, with dedicated support, including help-lines and counselling, targeted to BAME workers and migrant workers and their families affected by COVID-19. At the early stages in the pandemic, specific bereavement support in the form of a separate dedicated telephone helpline was put in place for Filipino workers and family members, although take up was low and it appears that Filipino workers relied on peer support and their own networks for support. Beyond the UK, guidelines promoting mental wellness for health workers in Germany, Ireland and Norway were put in place, as were special measures in many countries such as helplines and remote counselling staffed by psychologists and psychiatrists to offer stress management, burnout prevention and other mental health support (Williams et al., 2020b:60).

The effectiveness of what are often employer-led initiatives to relieve health workers of COVID-19 related stress is unknown, although measures introduced by NHS England are currently being evaluated. One study reported that the well-being support interventions proposed in guidelines have not always responded to the lived experiences of staff, limited as they are to general well-being

statements and tips such as investing time in meditation and other self-care techniques. These were impractical for health workers as they were unable to act on these due to understaffing, exhaustion or clashing schedules (San Juan et al., 2021). In fact, there is very little robust evidence yet that these guidelines or measures addressed the specific situations of migrant healthcare professionals. In particular, such measures tend to place greater emphasis on individual mental health and psychological support rather than on the structural conditions at work and responsibilities outside the work environment.

2.4 DISCRIMINATION, VIOLENCE AND HARASSMENT

Health workers, including migrant workers, have faced a sharp increase in harassment and violence at work (Vaillancourt-Laflamme, Pillinger and Yeates et al., 2022). Although there has been a huge amount of activity on this issue, there has been little focussed on the vulnerabilities faced by migrant health workers. Employer-led initiatives and collective agreements agreed in many countries have led to the establishment of workplace complaints systems, risk assessment to prevent violence and harassment and policies to provide support, and protection for victims of domestic violence in the workplace (Pillinger/ILO, forthcoming).

These initiatives are in response to significant increased levels of discrimination, violence and harassment against front-line health workers, greater visibility given to the problem of third-party violence and harassment during the pandemic, including mobilisation from civil society and trade unions, and greater international attention to the problem in the adoption of the ILO's Violence and Harassment Convention No. 100 and Recommendation No.206 (Pillinger et al., 2022; EMO, 2022; ICN et al., 2022). Furthermore, the shortage of health care professionals, such as doctors, nurses and health care assistants reported in most EU Member States, has led to increased levels of work pressure and stress, which have added to risks of violence and harassment.

In the UK, the dignity and respect framework aims to ensure that all hospitals and health facilities promote more respectful working environments, while the #Work Without Fear campaign for NHS ambulance staff protects NHS ambulance staff from assaults and violence. Some unions have advocated for better security and safety measures. The US National Nurses United called for improved data collection, to identify and address racial disparities during the COVID-19 pandemic, and for a better understanding of the intersection between 'race' and gender. UNISON (2021a) has reinforced the importance of employers' obligations under OSH laws and regulations for employers to systematically assess the risk of violence and abuse from third-parties and put in place a zero tolerance approach, along with support for staff affected by third party violence and harassment (TPVH). In Ireland, the implementation of the Health Services Executive policy on preventing and managing work-related aggression and violence was stepped up during the pandemic to ensure that employees were provided with support in recovering from the effects of violence and harassment. The Irish Nurses and Midwives Organisation (INMO) highlighted serious levels of TPVH against health care staff in 2022, leading the national Health and Safety Authority to establish an occupational health division with responsibility to address workplace violence and harassment (Murray, 2022). In the Netherlands, the Safe Healthcare programme has drawn up protocols to address aggression from third-parties in hospital settings, with better coordination with the police and training and awareness raising for workers and patients (Pillinger/ILO, forthcoming). A Polish hospital launched a campaign to reduce discrimination against health workers (Williams et al., 2020b:62).

2.5 LABOUR ORGANISING AND SOLIDARITY INITIATIVES

As noted in previous sections, health care trade unions have stressed the importance of organising health workers generally and migrant health workers in particular. A PSI-OU survey found that national affiliates prioritised various actions to represent migrant health workers: campaigning to raise awareness raising and advocacy about fair and ethical recruitment; organising and representing health workers; inclusion of migrant health and social care workers' rights in collective bargaining agreements; raising awareness about race and gender discrimination and their intersection; campaigning against racism, aggression and violence directed towards migrant health and social care workers; collaboration with NGOs to provide services to migrant workers, and defending the rights of undocumented migrants, for example, to have access to the COVID-19 vaccine (Pillinger, Gencianos and Yeates, 2021a, 2021b).

Specific examples include the launch of a cooperation programme between the INMO and Migrant Nurses Ireland. The latter supports Indian nurses in Ireland and works closely with INMO's overseas section to support the wider community of migrant nurses to improve their welfare and access to union support as workers in Ireland (INMO, 2020). Trade unions in Brazil, India and Ireland have been successful in increasing the number of nurse-centred and nurse-safe spaces to raise concerns and thus improve nursing working conditions during COVID-19 crisis (Llop-Gironés et al., 2021:7). In some countries, working conditions in destination countries were such under strict COVID-19 lockdown regulations that professional associations and trade unions stepped in to help stranded health workers. The United Nurses Association in India organised the repatriation of their Indian members who found themselves in difficult situations in Saudi Arabia (ibid: 6).

Section 3 International level responses

This section reviews policy initiatives and measures taken by international governmental and non-governmental social actors within and through cross-border spheres of governance to address the risks of COVID-19 infection faced by migrant health workers during the pandemic. The discussion is organised thematically regarding international responses to health workforce capacity; health worker mobility and migration; strengthening working conditions; occupational safety and health; skills recognition; data, monitoring and research; the role of social dialogue; and future pandemic preparedness.

3.1 HEALTH WORKFORCE CAPACITY

International organisations among others have long highlighted how health workforce shortages, especially in poorer countries of origin such as South-East Asia and Sub-Saharan Africa, adversely compromise those countries' ability to scale up medical, nursing and therapeutic interventions and innovations (Yeates and Pillinger, 2019). In Africa, for example, the approximately 135,000 African-born doctors and nurses working overseas in high-income countries represent about 70% of Africa's health workforce (Jato et al., 2022:5). The pandemic complicated and aggravated the already-high burden of disease shouldered by African populations: co-infections (with HIV, TB, and other pathogens) increase the risk of more severe (and fatal) forms of COVID-19 infection, while impacting on the ability of already-weak health systems to address existing epidemics (Jato et al., 2022:4). The WHO once again reaffirmed the systemic connection between health workforce shortages and the quality (including adaptability) of health services in Africa and elsewhere in the world. Three WHO global pulse surveys, aimed at gaining critical insights from key country informants (August 2020, April 2021 and February 2022) confirm that in most Member States,

> ...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 (vaccines, diagnostics and therapeutics). (WHO, 2022d, para 5, p.2)

In May 2022, the WHO published its *Working for Health 2022-2030 Action Plan* which draws from and updates its *Global strategy on human resources for health: workforce 2030* (WHO 2016) in the light of COVID-19 (WHO, 2022e). *Working for Health* goes beyond the immediate guidance the WHO provided to health authorities throughout the pandemic on how to best manage health workers through COVID-19 (WHO, 2020b). It operates as a "platform and implementation mechanism for accelerating investments in health and care worker education, skills, jobs, safeguarding and protection" (WHO, 2022e:1). It makes numerous references to giving effect to the guidance in the WHO Code but pulls back from identifying the impacts of recruiting from countries with weak health systems. The WHO will monitor the implementation of the Action Plan in 2025, 2028 and 2030 and how far Member States' actions align with the WHO Code (WHO, 2022c).

Concerns about staffing shortages led the Pan-American Health Organization (PAHO) (2020) to recommend new policies to support human resources for health (HRH) in twelve countries of the Caribbean region, including staffing in the framework of priorities established in the *Caribbean Roadmap for Human Resources for Universal Health 2018–2022*. The concerns about COVID-19

led CARICOM to launch the Human Resources for Health Action Task Force in response to the negative impact of the pandemic on staffing. A more detailed mapping study carried out in Belize, Grenada and Jamaica (WHO & PAHO, 2022) reveals that responses mainly focussed on short-term budgetary increases, redeployment and temporary recruitment of new staff, longer shifts and working hours, recruitment of volunteers, reassignment of staff, external financial support from international organisations, and bilateral agreements with the Government of Cuba in each of the three countries for the supply of specialist medical doctors and nurses. While these temporary measures helped address critical staffing shortages, they failed to build resources and planning for long-term health systems building and sustainability, including the creation of comprehensive health care systems. The report notes that outward migration is a long-standing problem in the region:

> Migration of staff has been one of the drivers of staffing shortages in the Caribbean subregion. The loss of skilled health workers has created a deficit that is difficult to fill with the current number of graduates entering HRH. (WHO & PAHO, 2022:x)

The report called for urgent responses that address the multi-dimensional factors that impact on human health resources, including the availability and distribution of health workers. The outcomes of similar mapping studies in five Latin American countries (WHO & PAHO, 2021) and Africa further reinforce the urgent need for longer-term measures to build workforce sustainability and preparedness for future pandemics. Similar lessons were learnt about the need for policy priorities and objectives to be aligned around the protection and care of the health workforce and the need to improve investment in the health workforce as a priority strategy to strengthen resilience of health systems.

The ICN, a long-time advocate of the risks of over-reliance on foreign-trained nurses to plug nurse shortages, has also taken up the mantle on the matter of health workforce shortages to highlight how the pandemic exacerbated ingrained health workforce shortages and health system weaknesses. In January 2022, it argued that the COVID-19 pandemic made the fragile state of the global nursing workforce much worse and indicated that 13 million more nurses would be required over the next decade (ICN, CGFNS and Buchan, 2022). In June 2022, ICN drew attention to the rise in nursing workforces taking strike action as a direct response to governments' failure to tackle the root causes of severely weakened and, in some cases, collapsing healthcare systems, stating that,

> ...one of the fundamental root causes is the global shortage of nurses, which is putting unsustainable pressure on the nurses currently working in healthcare systems that have been disrupted by staff shortages, the COVID-19 pandemic and historical chronic underfunding. (ICN, 2022:1)

ICN also warned that "the shortage of health workers is the greatest threat to global health" (ICN, 2022:1), repeating the call at the 2022 WHA for greater investment by recruiting countries in nursing education as a significant step towards national nurse self-sufficiency plus stronger international action on international nurse recruitment, in particular through better monitoring and enforcement of ethical codes governing international recruitment.

3.2 HEALTH WORKER MOBILITY AND MIGRATION

The pandemic has witnessed a surge in international recruitment by a range of countries and, correspondingly, new measures to fast-track migrant health workers' integration into country-level active health workforces (See 2.1 above). This has been largely supported, implicitly or tacitly, by a range of international policy actors to varying degrees. The issues at stake are the conditions under which recruitment occurs and how extant policy tools can be optimised to ensure a fair distribution of

risks, costs and benefits across the global health labour chain in ways that respect the individual right to migrate and to decent work as well as collective rights to health care and development.

Starting with the EU, although shortages of health workers are a critical challenge, the EC has supported Member States' recruitment responses by implementing measures to ease health worker mobility, variously supporting the modification of existing regulations and/or providing coordination through the "deployment of medical teams to most affected areas" during the pandemic (EC, n.d.). Specific interventions include ensuring that, during the pandemic, health workers trained in one member state could more easily cross borders to work in another one when travel mobility restrictions were otherwise in place (see Section 2, above). Regarding health workers from third countries, an EC Communication clarifies that

> a third-country qualified nurse whose training does not meet the minimum harmonisation requirements [of the EU] may be allowed to work as a health care assistant carrying out limited tasks as specified for such activities in national law. (EC, 2020:3)

The EC is amongst several organisations that have made proposals for the employment in EU Member States of Ukrainian refugees with professional health qualifications (CGFNS, 2022; EC, 2020).

Such clarification was paralleled by its promotion of health worker mobility pacts. In June 2021, the EC announced EU Talent Partnerships as part of the EU Pact on Migration and Asylum. The avowed aim of this initiative is to promote legal pathways to entering EU labour markets while addressing health and social care skills shortages which have resulted from under-investment in health and social care workforces (Jahnz, Berard and Bottomley, 2021). A year later, in April 2022, the EC launched the first Talent Partnership with North African countries, in particular Egypt, Morocco and Tunisia. The Talent Partnerships document itself does not refer specifically to the recruitment of health workers, although associated EU documents do highlight the health sector and the need to comply with the WHO Code (EC, 2022b).

Civil society organisations in Europe have grouped around the Pillars of Health initiative[4] to identify ways of addressing the negative effects of excessive health worker recruitment from poor countries and migration. A coalition of European NGOs spanning the Netherlands (Wemos and VU Athena), Romania (Centre for Health Policies and Services), Serbia (Media Education Centre) and other partners in France and Germany aims to support policies mitigating and reversing the negative effects of health worker migration and mobility in countries of origin and promoting a strong and sustainable health workforce in destination countries across the EU. In this, the focus of the initiative is to promote sustainable health workforce solutions not reliant on international recruitment and to support decent work initiatives in countries of origin to reduce the lure of job offers from rich recruiting countries. There is scope to improve the effectiveness of regional-level initiatives too, notably of the EU, through increased monitoring of health labour markets and trends in mobility and migration, promoting cross-country learning, and stimulating health systems strengthening.

As far as global organisations are concerned, the mantra is business as usual. The WHO, for its part, has been active on the issue of international recruitment. In keeping with its pre-pandemic approach, rather than condemning the surging recruitment drives, the WHO strove to renew and update its approach to the use of 'soft' law to regulate and monitor international recruitment and migration of health workers. Three specific initiatives stand out. First, in November 2020, it updated its 'safeguard list' which now contains 47 countries (WHO, 2020a).[5] Such countries, it recommends, should prioritise health personnel development and health system-related support, and provide safeguards that discourage active international recruitment of health personnel. Countries not on the safeguard

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4 https://www.wemos.nl/en/pillars-of-health-launch/ (Accessed 1 October 2022).
5 A list of countries with critical healthcare workforce shortages was first established in 2006. Listed countries have a universal health care (UHC) Service Coverage Index lower than 50 and a density of doctors, nurses and midwives below the global median of 48.6 per 10,000 population. The list is due to be updated in 2023.

list should "apply the precautionary principle in international recruitment" (WHO, 2022a:6). It recommends that such recruitment drives should *only* take place through government-to-government agreements.

Second, the WHO, in collaboration with the OECD and the ILO, is developing a Guidance on Bilateral Agreements on Health Worker Mobility and Migration. The aim of this guidance is to provide Member States with practical recommendations and key considerations for the design, implementation and monitoring of bilateral agreements, in line with the WHO Code of Practice. Supporting the WHO in the development of the guidance is a Technical Expert Group (TEG) comprised of experts from Member States, international and regional organisations, professional associations, employers and trade unions who have experience in the design, negotiation and implementation of bilateral agreements in the health sector. At the time of this writing, the Guidance is yet to be finalised.

Third, given the severity of health workforce shortages in some countries, in May 2022, beyond the normal triennial reporting on the WHO Code, the WHO pledged to assess the implications of the international recruitment of health workers throughout COVID-19. Such additional reporting will consider how COVID 19 and -related disruptions and impacts on health systems, especially in countries already suffering from low health workforce densities, might require the revision to extend safeguards against active international recruitment of health workers (WHO, 2022a:6).

Throughout the pandemic, the UN Network on Migration (UNNM) has been vocal in its recognition of the strong role migrant workers have played in pandemic responses and has called for ensuring access to healthcare, vaccines and decent work for migrants, alongside challenging forcible repatriation and the non-payment of migrant workers' wages and benefits (UNNM, 2020 & 2021). Where the network's focus has fallen on migrant health workers, it has been in relation to bilateral agreements as an effective policy tool benefitting source and destination countries (UNNM, 2022:58). The network developed a UN Guidance on Bilateral Labour Migration Agreements[6] consistent with international labour standards and the WHO Code, recommending a fair and balanced approach to regulating mobility of health professionals by: taking account of health sector labour shortages in countries of origin; upholding the right to equal treatment with national health workers (including equal access to health care and social protection); instituting measures relating to qualifications and skills recognition to combat de-skilling, and supporting adequate investment in health and care systems in countries of origin.

Representing the international labour movement, the Global Unions have consistently been campaigning for rights-based global migration governance, highlighting that the triennial International Migration Review Forum of the Global Compact on Migration in 2022 did not sufficiently protect migrant workers' (including in the health sector) fundamental rights[7]. The labour movement reaffirmed its called on governments to move beyond circular (and temporary) migration programmes and put the focus on regularisation, humanitarian resettlement and sustainable development in countries of origin, transit and destination (ITUC, 2022).

The key international organisation advocating on behalf of migrant health workers during the pandemic has consistently been PSI, the global union federation of public service unions (PSI, 2020a, 2020b). It has been active in carrying out research on how migrant health workers were impacted by the pandemic and responses to the pandemic, undertaking policy advocacy through its *Public Health Once and for All* campaign to support public universal health services that are sufficiently funded, staffed and equipped to respond to public health challenges, and engaging in global social dialogue to leverage better conditions for migrant health workers (PSI, 2020a, 2022b;

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6 https://migrationnetwork.un.org/sites/g/files/tmzbdl416/files/resources_files/blma_guidance_final.pdf (Accessed 1 October 2022).
7 https://publicservices.international/resources/news/the-international-migration-review-forum-progress-declaration-must-strongly-reaffirm-the-crucial-role-of-ilo-core-labour-standards?id=13053&lang=en (Accessed 1 October 2022).

Pillinger and Yeates, 2020; Pillinger, Gencianos and Yeates, 2021a, 2021b, 2021c). A particular focus of its attention has been on the need to strengthen

> 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. (Pillinger and Yeates, 2020:3)

PSI is also a member of a coalition of 800+ trade unions and NGOs called *Nurse Manifesto – No going Back* (PSI, 2020). This calls on governments to recognise the role nurses and other health workers have played in the pandemic, by respecting their fundamental rights at work and how health workers, including migrant health care workers, have worked in hazardous conditions for which they are neither adequately compensated nor protected. PSI and its partners stand out among civil society actors for their wider perspective on the relationship between international health worker recruitment and migration and health systems strengthening. For example, it campaigned for the International Finance Corporation to stop promoting the privatisation of health care and Public Private Partnerships, and for the World Trade Organization (WTO) to waive COVID-19 vaccine patents to ensure universal access to vaccines (PSI, 2020c). As a report for PSI stated, the health workforce crisis during the pandemic is one manifestation of health systems failures more generally:

> 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. (Pillinger and Yeates, 2020:12)

3.3 STRENGTHENING WORKING CONDITIONS

The working conditions of health (and social) care sector workers have been a key and regular item on the policy agendas of international organisations over the last two years. From the start, the ITUC campaigned for a new social contract with measures to protect the health, incomes and jobs of all working people, and for better support for developing economies in sustaining health services for all and laying the foundations of social protection, including unemployment income, child protection, maternity protection and pensions (ITUC, 2020a, 2020b). International organisations' responses have been almost entirely at the ideational level, whether it be through research highlighting the extent of decent work gaps and reaffirming decent work norms, or by promulgating recommendations on actions to realise decent work for all in practice. Although none of these organisations make specific or exclusive reference to migrant health workers, this group is implicitly covered in recommendations regarding the health workforce generally and/or migrant workers.

The European Parliament (EP) launched a review of the working conditions of essential and vulnerable workers. Its particular focus was on women and migrants who represent 46% and 14% respectively of the critical workforce in the EU, including in the health and social care sector, and are most likely to work on non-standard employment contracts (European Parliament, 2022). The EP's recommendations included ensuring fair recruitment practices, extending social protection coverage, increasing investment in essential sectors and occupations, promoting social dialogue and adopting sector-specific regulations and policies to support improved working conditions.

Similarly, in the WHO and its regional offices, interventions have been mainly declaratory. In America, the Director of PAHO emphasised the importance of clear policies to develop and retain the health workforce, though she made no specific reference to migrant health workers (PAHO, 2022). Otherwise the principal initiative of the WHO is its agreement of a 'global health and care worker

compact' (hereafter, care compact) in May 2022. This collates *existing* international guidance and standards whose focus is to "protect health and care workers and safeguard their rights, and to promote and ensure decent work, free from racial and all other forms of discrimination and a safe and enabling practice environment" in line with the WHO Code (WHO, 2022b:2). Such responses by Member States would "mitigat[e] the disruptions to essential health services experienced since 2020" (WHO 2022c:1). The Compact did not extend the regulatory scope or strengthen enforcement powers. It provides recommendations to stakeholders on how to translate the above into practice, and remains above all 'a reference document' that has strong moral force but which is "not legally binding" (ibid.:2). The care compact will be used to operationalise the WHO's action plan to 2030 (WHO, 2022d:4).

In Europe, the social partners responded with an updated Framework of Actions on Recruitment and Retention in health care, signed in June 2022 between EPSU and the European Hospital and Healthcare Employers' Association (HOSPEEM). It stresses the importance of the healthcare system being "adequately staffed by a continuously well-trained and motivated workforce", amongst other measures to ensure healthy and safe workplaces (HOSPEEM & EPSU, 2022b:2). Aimed to further reinforce social partners' commitment to strengthen the attractiveness of work in the health sector, a rights-based approach to recruiting migrant workers was emphasised, as were promoting diversity and gender equality, increasing staffing levels and enhancing the role of social partners in workforce planning.

These issues have been at the fore of debates in the WHO's European region where a report *Health and Care Workforce in Europe: Time to Act* (WHO Europe, 2021) underscored the importance of working conditions and professional development to the recruitment and retention of health workers, along with better data capacity, management and strategic planning, and workforce development. The 2022 WHO Europe conference also saw NGOs and unions supporting a statement calling for governments to reduce heavy workloads, staffing shortages and burnout, particularly at a time when many health workers were leaving or considering leaving their jobs (The Lancet, 2022; UNISON, 2021a & 2021b). The Joint Statement called on governments to:

> ...provide all healthcare staff and healthcare students with a safe working environment and adequate mechanisms to prevent any type of violence so as to decrease the risk of exhaustion and burnout for all healthcare professionals, and to deploy all necessary means to protect the physical and psychological integrity of our colleagues during this pandemic and beyond. The health sector should be, and must remain, a safe and attractive place to work. (WHO Europe, 2022:1)

From early on in the pandemic, ILO research publications on impacts of COVID-19 on health and care workers have highlighted the vulnerable situation of migrant health workers and the extent of investment needed in health systems and workforces to recruit, deploy, retain and protect sufficient numbers of well-trained, supported and motivated health workers (ILO, 2020a, 2020b). Respect for labour rights and decent conditions of work are crucial to give these frontline workers the protection they need to save lives (ILO, 2020b:1) and to address health workforce shortages globally. Along with trade unions in the sector, international organisations (ILO, OECD, WHO, ICN) have identified low pay as a key factor to redress in tackling high health and social care migration to fill job vacancies in the sector. However, an otherwise-comprehensive joint ILO-WHO report on gender pay gaps in the health and social care sector (ILO and WHO, 2022e) contained very limited analysis of gaps pertaining to migrant health workers, even though global data confirms the existence of a migrant pay gap (ILO, 2020c). The only recommendation specifically pertaining to migrant health workers referred to their inclusion in social dialogue processes, especially with private sector employers which play an increasing role in the delivery of health and social care services.

The 2022 International Labour Conference (ILC) discussion on care work led to conclusions reflecting the urgency brought about by the pandemic to ensure that countries have the tools to develop health and care systems able to respond to the present crisis and future ones. Thus, the report of the ILO's standard review process on the application of international labour standards in Member States paid special attention to the devastating impacts of the COVID-19 pandemic on nursing personnel and domestic workers (ILO, 2022c), and highlighted the urgency of addressing the "unequal distribution of the nursing workforce globally, primarily due to large migration flows of nursing personnel who leave their countries of origin in search of better opportunities and working conditions" (ibid:2). It subsequently endorsed commitments on health workforce shortages, working conditions, and freedom of association and collective bargaining to improve decent work for health workers, specifically nurses[8]. The ILC discussion emphasised the need to do more to ensure practical compliance with existing international standards, and tasked the ILO to develop an action plan "addressing the causes and assessing the impacts of the global nursing shortage on working conditions of nursing personnel and on the quality of nursing care provided" (ibid.:4). The report concludes on the need to pursue the conversation further and prepare for the discussion on decent work and the care economy, including on health workers, at the 2024 ILC.

3.4 COVID-19 AND OCCUPATIONAL SAFETY AND HEALTH

Of all the initiatives undertaken through the pandemic, occupational safety and health has been a prime area in that we can see an actual strengthening of workers' rights (ILO, 2022f, 2022g). Early in the pandemic, a World Medical Council (WMC) Resolution regarding the Medical Profession and COVID-19 (WMA, 2020)[9] highlighted the need for COVID-19 to be recognised as an occupational disease, and for violence against doctors in health care settings to be recognised as an occupational safety and health issue. COVID-19 catalysed on-going campaigns by the global labour movement and global union federations to strengthen OSH. On World Day for Safety and Health at Work, 28 April 2020, the Council of Global Unions, made up of Global Union Federations and the OECD Trade Union Advisory Committee (TUAC), issued a statement calling upon governments and occupational health and safety bodies around the world to recognise COVID-19 as an occupational disease. It emphasised that:

> such recognition would ensure the right to worker representation and occupational safety and health (OSH) rights and the application of agreed measures to reduce risk. These rights include the right to refuse to work under unsafe working conditions. (ILO, 2020a:9)

The June 2022 session of the ILC widened the scope of existing fundamental rights and principles at work by endorsing the right of workers, including healthcare and migrant workers, to a safe and healthy working environment (ILO, 2022f, 2022g). The principle of a safe and healthy working environment, supported by two related International Labour Organization (ILO) Conventions[10], was added to the *1998 Declaration on Fundamental Rights and Principles at Work*[11] and now binds ILO Member States to ensure their national laws and practices comply with this international labour standard. This broadened ILO fundamental rights framework is as timely as it is significant. It was the result of an extensive campaign mainly by trade unions and a tripartite dialogue process over many years. The pandemic served to catalyse the conclusion of the process. The significance of this landmark decision means that all ILO Member States have now committed to respect and promote the fundamental right to a safe and healthy working environment. It signifies the recognition that health

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8 https://www.ilo.org/ilc/ILCSessions/110/committees/standards/general-survey/outcome/WCMS_847822/lang--en/index.htm (Accessed, 1 October 2022).

9 https://www.wma.net/policies-post/wma-resolution-regarding-the-medical-profession-and-COVID-19/ (Accessed 1 October 2022).

10 These are the Occupational Safety and Health Convention, 1981 (No. 155) and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187).

11 The Declaration's significance lies in the fact that irrespective of whether a country has ratified any of the core Conventions, by virtue of their being a member of the ILO, a country is legally bound to comply in law and put into practice the fundamental principles and their corresponding Conventions.

and safety at the workplace brings significant human and economic benefits and goes hand-in-hand with inclusive economic growth.

At the European level, the EU and its member states reached an agreement

> to recognise COVID-19 as an occupational disease in health and social care and in domiciliary assistance and, in a pandemic context, in sectors where there is an outbreak in activities with proven risk of infection, and supported an update of the EU list of occupational diseases. (EC, 2022a:1)

This represents an important element of the EU Strategic Framework on Health and Safety at Work 2021-2027 (EC, 2022b), and means that workers in relevant sectors, including health care workers, who have contracted COVID-19 at work acquire specific rights according to national rules such as the right to compensation. Though this is a welcome development, the new EU policy does not make any specific reference to migrant health workers or of ensuring the portability of newly-acquired rights.

3.5 SKILLS PROGRAMMES

The pandemic highlighted the need to upscale initiatives to enhance training and skills development, particularly in areas such as critical care, where some of the biggest shortages of critical care staff led to recruitment drives for health professionals. Various skills exchange programmes have been developed in recent years, including global skills partnerships, and underpin global debates about how to ensure that health workers have the package of skills required by countries of destination. These developments are, however, highly controversial (Pillinger and Yeates, 2020; Yeates and Pillinger, 2019) and raise afresh questions about compensation for international recruitment (PSI, 2018; Dempster, 2022). An example of skills initiatives in countries of migration origin is the Burkina Faso Government P10 programme on human resources in the health sector. Established by the West African Health Organization (WAHO), it aims to facilitate the training, use and free movement of health professionals in the Economic Community of West African States (ECOWAS) region. Any national of the ECOWAS community area can train and practice in their country of choice, subject to registration with the professional order of the ECOWAS host country (ILO, 2022a).

Of note, is the EC's Care Strategy to realise affordable access to universal high-quality long-term social care services, while also addressing significant workforces and skills shortages, particularly in the long-term social care sector (EC, 2022c). The Strategy refers specifically to care and domestic workers and signals the importance of legal migration and ethical recruitment in the care sector. These issues have been addressed in more detail in the EC's Communication *Attracting Skills and Talent in the EU* which underlines the need for sustainable and legal pathways for migration from non-EU countries to work in the care sector. Member States struggle to attract and retain care workers and that an estimated 7 million new jobs for health associate professionals and personal care workers will be needed by 2030 (EC, 2022d). The policy challenge is to find EU tools to facilitate the "admission of migrant care workers to the EU, to the mutual benefit of all Member States and countries of origin, while ensuring the ethical recruitment of migrants" (EC, 2022d:19).

3.6 SOCIAL DIALOGUE AND COLLECTIVE BARGAINING

Social dialogue has played a critical role in pandemic crisis responses. The ILO reinforced the importance of bipartite (dialogue between workers and employers) and tripartite dialogue (dialogue between government, workers' and employers' organisations), including in the health sector, in contributing to forging effective policy responses to the crisis (ILO, 2020b). Such dialogue, including collective bargaining, has been important in negotiating working time agreements, compensation,

hazard pay, and other supporting measures for health workers, including migrants (ILO, 2021b). However, it has been less clear, at least outside of Europe, that collective bargaining was as successful in securing agreements aiming at revaluing frontline sectors, including healthcare, and delivering wage increases to workers (ILO, 2022d:8). In a European context, the updated European sectoral social dialogue agreement in the hospital sector, the EPSU and HOSPEEM agreement of an updated framework on hospital recruitment and retention, is a case in point (HOSPEEM & EPSU, 2022). It reflects both the heightened urgency attached to recruitment and retention and the need for improved workforce strengthening responses to the pandemic and future pandemic preparedness.

3.7 DATA, MONITORING AND RESEARCH

Data collection and analysis of the impacts of COVID-19 have assumed a large share of responses to the pandemic. All policy actors we examined have issued declaratory statements evidencing the health, social and economic disruption caused by the pandemic and responses to it. For example, HOSPEEM has been active in collecting and sharing such information (HOSPEEM, 2020). Although it tackles the challenges of healthcare workforce during the pandemic, it fails to pinpoint the specific issue of migrant health workers.

Several trade unions representing workers in the health sector have been active in monitoring, documenting and researching the effects of COVID-19 on their members and workers (Pillinger, Gencianos and Yeates, 2021a, 2021b, 2021c; NNU, 2020). Only PSI and some of its affiliates have consistently focused on migrant health workers, and have pointed out the paucity of data about migrant health workers. The following quote exemplifies this point:

> …our research team has literally had to bring together inadequate data at state and federal. We are one of the few organisations trying to get the data…even at the level where we have gone into social media to track deaths and verify. It's hard to get racial and ethnic data, but it's harder by migration. (Interview, trade union representative, North America)

Amongst the problems are inconsistent recording and definitions of nurses, precarious and informal employment conditions, limited transparent and reliable data, lack of mass testing data, all of which adversely impact on the quality of data (NNU, 2020; see also Tipping, Murphy and Yeates et al., 2022). In this regard, trade unions have joined the call by specialist researchers and international organisations for better data on health workforces including migrant health workers (Llop Gironés et al., 2022; ICN, CGFNS and Buchan, 2022; OECD, 2020; Documentos Enfermería, 2020).

3.8 FUTURE PANDEMIC PREPAREDNESS AND OTHER STRATEGIC POLICY RESPONSES

The COVID-19 pandemic has catalysed discussion on pandemic preparedness and responses and the adequacy of the global health governance institutional architecture. For example, in March 2021, 25 heads of government plus the WHO and the European Council issued a joint calling for "a new international treaty for pandemic preparedness and response" to build a more robust global health architecture and "foster a comprehensive, multi-sectoral approach to strengthen national, regional and global capacities and resilience to future pandemics" (WHO, 2021:1). The difficult passage of amended International Health Regulations (IHR), the current global framework for preparing for and responding to health emergencies[12], at June 2022's WHA has laid bare their limited power to ensure that governments comply with their responsibilities and report accurately their core capacities to

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12 The IHR is a legally-binding agreement requiring countries to improve their core capacities to detect and respond to national health emergencies. It identifies the steps for reporting disease outbreaks to the World Health Organization (WHO) and disease control measures taken by countries.

prepare for and respond to health emergencies. It exposes how overlooked the health workforce is as a core capacity affecting countries' ability to detect, respond to and prevent health emergencies, for it features neither in the amended IHR nor the proposed pandemic treaty. This neglect seem consistent with other reviews of pandemic responses. For example, although the Lancet Commission recommended 'investment in a skilled workforce' as one essential component of national pandemic preparedness plans (Sachs, Karim and Aknin et al., 2022), it totally overlooked the need to strengthen the global governance of international health worker recruitment and migration as part of a reformed global health architecture. By the same token, the World Bank-based Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response ('Pandemic Fund') aims to mobilise investments in health security (e.g. global surveillance, emergency countermeasures, R&D in pandemic prevention), but it "neglects the basic health systems components required to comprehensively address public health threats, including … well trained and supported local and community health workers" (Lal, Abadalla and Chattu et al., 2022:e1675).

More often than not, it is left to the trade union movement to inject a health workforce perspective on the efficacy of health systems and governance, financing and support reforms. Under the banner of the *People Over Profit* campaign, PSI and its affiliated trade unions issued its five key demands in negotiating a new Pandemic Treaty at the WHO [13]. PSI's demands include: universal public healthcare; better staffing and working conditions for health workers, including migrants; stronger health stockpiles and supply chains; suspending patents on lifesaving supplies and medications, and reshaping the global economy to serve health outcomes. The ITUC adds its demand for a 'post-pandemic global economy' (ITUC, 2020b) by anticipating a new global social contract based on social dialogue that provides a universal labour guarantee for all workers (ITUC, 2020a, 2022b). This means institutional renewal – "a new commitment to sharing the world's wealth and a renewed investment in compliance and the rule of law" (ITUC, 2020b:2) – and institutional strengthening, especially of public services, to realise more effective global redistribution, global regulation and global social rights. This intervention brings health as a public good and the importance of global solidarity and social equity to the centre of debates about global health governance (see also Yeates and Pillinger, 2019, ch. 8).

Around the world, many trade unions, employers' organisations and professional organisations have played an important role in responding to COVID-19 by providing guidance and regular updates to their members and engaging in social dialogue (ILO, 2020d). Amongst employers' and workers' organisations, these actions include international policy dialogues, bipartite and tripartite national-level dialogue, bilateral exchanges with governments, collective bargaining at various levels – as documented and described earlier in this paper. At the national level, trade unions have made policy proposals and negotiated for action in areas such as employment retention schemes and social protection, retrenchment benefits and unemployment benefits for workers who lost their jobs, including additional benefits for health care workers and improved levels of safety and health for workers, such as adequate PPE (ibid.). Globally, PSI has highlighted the importance of migrant healthcare members' access to fair recruitment, free healthcare, access to protective equipment, access to collective bargaining, preventing violence and harassment, promoting social security, sick leave and hazard pay, sharing information and ensuring other migrants' rights (Pillinger, Gencianos and Yeates, 2021a, 2021b, 2021c).

The International Hospital Federation (IHF) gives a global voice to employers in hospital settings, and has instituted several policy responses to the COVID-19 pandemic (IHF, 2020a, 2020b). It has called for better skills training, psychological, financial and occupational support (IHF, 2020b), but leaves unacknowledged the wider context of health worker migration rooted in uneven development and decent work deficits.

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13 https://peopleoverprof.it/campaigns/five-healthworker-demands-for-the-pandemic-treaty?id=13121&lang=en (Accessed 1 September 2022).

In amongst calls for increased expenditure for health care and measures to address critical problems arising from staffing shortages is the need for the health sector to be more resilient and equipped for future pandemics (Pillinger and Yeates, 2020). In Europe, this means improved support from the EU and cooperation amongst Member States in responding to future pandemic emergencies, including ensuring that funding is available for the public healthcare system under the EU's Recovery and Resilience Facility and enabling the delivery of "high quality, adequately staffed and inclusive public healthcare systems" (EPSU, 2021b:8).

From the vantage point of 2022, the ILO has acknowledged the need to learn from responses to the pandemic and

> renew and enhance its policy and programme responses, engaging with both origin and destination countries to grow decent work opportunities, improve skills recognition processes and enhance social protection for migrant workers. (ILO, 2022f:15)

ILO's scheduled general discussion on the topic of health workers at the ILC in June 2024 provides a prime opportunity for social partners and other stakeholders to coalesce around advocacy of decent work for all health (and social) care workers.

A further development at the global level is the insertion of ''trade'' with regard to health services provision. On the one hand, COVID-19 responses facilitated the rapid advance of digital technologies in providing diagnostic and advisory health care services remotely (ICN, CGFNS and Buchan, 2022:18; Williams et al., 2020a). IOM celebrates diaspora-led business models, most of which promote private healthcare, and facilitates the adoption of e-health technology in low-income country contexts (e.g. IOM, 2021) while the OECD is advocating for how e-health, including tele-medicine, can be more deeply embedded in health care provision (OECD, 2022)[14].

On the other hand, the WHO secretariat has started collaborating with the WTO on its policy thinking towards health labour mobility and migration. For example, a joint WHO-WTO working paper (Carzaniga et al., 2019) explored how a trade in services policy framework can support the increase of health workforce capacity, notably by promoting temporary migration ('mobility' – without the right to permanent settlement and rights of citizenship) of health workers around the world. This idea has much in common with the highly controversial global skills partnership (GSP) proposal taken up by the OECD and inscribed in the UN Global Compact on Migration (Yeates and Pillinger, 2019). Briefly, this envisages a policy mechanism of skills recruitment from developing countries to plug staff shortages of richer countries (Yeates and Pillinger, 2019; PSI, 2018). Though the GSP does not necessarily prescribe temporary migration, it is more about how rich countries can have a 'skills development and extraction tool' from the human resource pool of developing countries. Recruited skilled workers may have the option of permanent migration in the so-called 'away track'. This is also harmful to poor countries when their public health services are already inadequately staffed. Workers are forced to emigrate due to poor working and living conditions. Unless the drivers of insert healthworker migration, such as under-investment, poor staffing and decent work deficits in origin countries, are fully addressed, the 'home track' is neither a viable nor a fair option.

Moreover, major causes for concern are the ethical, moral, labour rights and sustainability considerations which are the common thread between the GATS Mode 4 and GSP. These business models commodify workers, and are often forged on an uneven trade, economic and power relationship between rich and poor countries, notwithstanding the promotion of public-private partnership schemes that are oriented towards profit rather than the right to health of the population in both origin and destination countries. In this respect, it is also worth noting that the eventual

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14 OECD "supports policy makers in harnessing data and digital technology for transforming health systems". https://www.oecd.org/health/digital-health.htm (Accessed 30 September 2022).

adjudication of a trade dispute under Mode 4 (temporary international labour supply) of the WTO's General Agreement on Trade in Services may have implications for health workers in future (Yeates and Pillinger, 2019; Yeates and Voogsgeerd, forthcoming, 2023).

Section 4 Conclusions

COVID-19 has exposed the limitations of and gaps in the world's approach to health crises and strengthened the impetus behind calls from a wide range of state and non-state national and international actors to invest in health workforces to address global inequalities in access to health care. Our comprehensive review of national and international initiatives with regard to migrant health workers shows that there has been no single approach to responding to the pandemic. Indeed, diverse responses by IGOs, governments, employers, trade unions, NGOs, the international labour movement and diaspora communities are evident. Despite the large number of initiatives, they have mostly been ad-hoc and emergency measures to recruit and assist health workers, including migrant health workers. Remarkably few of them have addressed the specific circumstances and needs of migrant members of the health workforce. Migrant health workers, despite being on the front-line of COVID-19 health care services, have been invisible in official data collection and, consequently, in the measures adopted during the crisis.

We end this paper with the four key trends drawn from our review plus a note on the limitations of the research method underpinning our findings and on future research.

First, international recruitment of health workers accelerated during the height of the pandemic, with recruitment campaigns by higher-income countries for health workers from lower-income countries, including, notably from those countries on the WHO's Safeguard List. Recruiting countries rapidly adjusted their domestic regulations on qualifications, licenses and visas that enabled many migrant health workers to practise their profession with immediate effect or to continue to do so beyond the original term specified. These patterns of international recruitment amplified pre-pandemic staffing shortages in many countries of origin, which reported significant problems of infection and death of health workers because of limited staffing, poor access to PPE and other safety measures. The international recruitment of skilled critical care health professionals exacerbated an already difficult situation and led some countries of origin to temporarily restrict outward migration.

Second, in Europe and some other high-income countries, emergency measures were taken to improve the working conditions of occupations designated as essential, including health work. In some cases, these were negotiated and delivered through social dialogue. However, they did not always cover workers in non-standard or irregular positions where migrant members of the health workforce are disproportionately concentrated. Many of the critical problems regarding working conditions, staffing shortages and low pay exist in the social care sector where some of the most significant abuses against migrant health workers exist. This is relevant also because not all migrant health workers had their professional training recognised, resulting in deskilling and work in lower-paid, lower-skilled social care jobs.

Third, long-term policy responses on international migration in the context of COVID-19 responses and recovery are fairly limited in practice, particularly in relation to strengthening rights-based approaches to migration and sustainable health care systems. Policy responses to COVID-19 at the national level involving investments in the health workforce in countries of origin and destination have largely been temporary and limited with regard to long-term workforce and health systems strengthening. One issue is whether these measures will be revoked or continued. Either way, long-term policy responses and sustained investment in health workforces are needed to address the acute skills shortages, especially in critical care in developing countries/countries of origin.

Fourth, international policy responses relating to international migration and COVID-19 responses largely focussed on mobility, skills and training capacities, ethical recruitment and recognising the value of government-to-government BLAs. However, there are no guarantees that BLAs will

incorporate ethical recruitment principles and rights-based approaches to migration. With a few exceptions, BLAs are not drawn up in consultation with trade unions or employers, and are often located in ministries of foreign affairs, trade and business rather than in ministries of health.

Our review of policy responses has been as comprehensive as resources permit, but its coverage is constrained. Most of the available information on collective responses to the COVID-19 pandemic emanates from richer countries of the world – OECD countries in the main, mostly high-income countries in Europe, America, Asia and the Middle East. This review has regrettably, but perhaps inevitably, reflected those extant data biases. A further factor limiting the scope of our review is its exclusion of the social care sector. Many of the migrant workers in this sector are qualified health workers who are employed as social care staff on inferior employment terms. This sector, and the position of migrant health and care workers therein, must be the subject of further research.

Future research should assess the efficacy of the measures adopted during the crisis. Better data collection systems are needed to ensure that information can be disaggregated sufficiently to reveal the contributions and specific hardships migrant health workers have experienced in the past two years. Some measures adopted by employers and government may have infringed on health workers' earlier acquired rights. A 'post-pandemic' assessment is essential to monitor whether (and how) acquired rights are returned to health (and other essential) workers and whether temporary measures have translated into permanent entitlements. Such impact assessments would inform all policy actors to develop their strategies and response mechanisms to address future health crises, including pandemic preparedness and recovery.

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