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Making the WHO Global Code of Practice Actionable for International Healthcare Recruiters

CGFNS International, Inc.

Prepared for the 2nd Review of Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel

Making the WHO Code on Global Practice Actionable for International Healthcare Recruiters

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While migration is not a new challenge for global policymakers, evolving trends and heightened awareness have catalyzed the development of new approaches

1. The phenomenon of migration is not a recent development, but the trends and patterns have evolved. These new trends include changes in migration patterns, historically from global south-north, to greater intraregional, south-south, and north-north mobility. National and global policy has generally been ill-equipped to address migration challenges. Yet the evolution in migration trends requires a change in approach to policy development that is apt to address the challenges that may arise within the migration context.
2. As a response to the evident changes within the migration diaspora, in 2016, the international community gathered to provide critical feedback to the United Nations during inter-governmental meetings and to address the issues and challenges that exist in facilitating safe, orderly and regular migration. The meetings ultimately led to the creation of the New York Declaration for Refugees and Migrants, which was unanimously adopted on September 19, 2016 during the United Nations General Assembly (IOM, 2018). After much

deliberation by the various stakeholders involved, on December 10, 2018 in Marrakesh, Morocco the Global Compact on Safe, Orderly and Regular Migration and the Global Compact on Refugees was adopted (IOM, 2018). While the Compacts are not legally-binding, they do address migration on a whole, including the vulnerabilities that migrants face throughout all phases of their journey.

3. In the context of the migration of healthcare professionals, which have historically been a substantial part of overall migration, the Compacts serve as a foundational framework for policy makers to address the serious implications that can arise, including the exacerbation of existing health workforce shortages and emergence of unethical recruitment and employment practices. With an estimated 20.7 million nurses and midwives worldwide representing fifty percent of the global health workforce, experts have witnessed the emergence of new trends in nurse migration (WHO, 2016). It is estimated that by 2035, there will be a shortage of 12.9 million healthcare workers globally. This is a dramatic increase from the current 7.2 million shortage (WHO, 2013). Several factors explain this phenomenon—ageing populations, increased health coverage and demand for healthcare as countries and individuals grow relatively wealthier, and increased risk of non-communicable diseases (e.g., cancer, heart disease, stroke). Health systems around the world are relying on health workforce migration to offset these shortages, and this impacts stakeholders in both sending and receiving countries.

While international healthcare recruitment has become increasingly important to address workforce needs, problems arise that impact all stakeholders

4. International healthcare recruitment, while an important part of addressing workforce needs, presents problems for all stakeholders in the process. The most commonly cited problems involve the health professional and the health workforce from the sending or source country. While there are more extreme instances of coercion and exploitation that might be tantamount to trafficking, even more common forms of recruitment can implicate the vulnerability of foreign-educated health professionals. In most employment contexts, government intervention, such as minimum wage, workplace safety, and maximum hour rules are essential because of the fundamental power imbalance between employers and employees. In addition, there is an asymmetry of information and knowledge about the employment situation between the employer and employee. Both these issues are more pronounced in the international context, where contracts and visa requirements tying immigration to a certain employer can weaken the position of employees. While the empowerment of individuals to make career decisions must be given significant weight when balancing against competing policy requirements, legal protections and education prior to the imposition of contract obligations can help protect individual workers.
5. There are serious implications in destination countries as well. Foreign-educated health professionals need to be positioned to succeed through effective clinical and cultural orientation—failure to do so impacts patients who desire top-quality care, their domestic colleagues who may have to "pick up the slack," and the broader communities in which they live. When employers use foreign-educated workers to address workforce shortfalls that can put downward pressure on wages for domestic employees and reduce the incentive to improve working conditions and benefits. Apart from this, employers and health systems

bear the cost of recruitment failures through turnover, and recruiters—particularly staffing companies—increase their costs and reduce their reliability to healthcare facilities, thereby becoming less attractive to those employers.

The Shortcomings of National Laws in Addressing Problems

6. National laws, regulatory frameworks, and other legal protects are needed to mitigate the problems and concerns that result from health workforce migration and recruitment. Unfortunately, national laws are poorly positioned to address these issues. Recruitment issues across borders present numerous jurisdictional issues; establishing laws or implementing legislation in one country cannot be practiced or enforced in another. Apart from jurisdictional issues, laws can exacerbate recruitment vulnerabilities. Tying of visa status to specific employers or contract damage calculations for breach of contract that benefit the employer or recruiter can essentially tie individuals to specific jobs for years, even if they are subject to mistreatment or harassment. In the United States, visa retrogression has meant several years waits between filing immigration petitions and having a visa issued; this makes direct hire or long-term placements untenable, so as to make the staffing firm model more pervasive. Finally, dependence on some health systems on foreign or temporary labor makes it difficult for policymakers to address problems if they will threaten the flow of needed labor.

Voluntary codes, developed outside of normal national (and sub-national) legislative and regulatory processes, have emerged in the last decade to address those issues and mitigate the harms and accentuate the benefits of international healthcare recruitment

7. The Alliance Code was launched to address some of these issues. A multi-stakeholder, voluntary Code for migration of nurses to the U.S. launched in 2008 (and expanded to all foreign-educated health professionals in 2011), and the Alliance for Ethical International Recruitment Practices was established to advance and support it. The Code specifically involved American stakeholders and international recruiters involved in U.S. recruitment, with regard to the recruitment of health care professionals to the U.S. The unique health care market economics of the U.S. and country-specific immigration and labor law mean that while the multi-stakeholder model—aligned with the principles of the WHO Code of Global Practice—could be applied in any country, the provisions themselves will vary given the legal landscape and the relative market power of each stakeholder group.
8. Subsequently, the *Health Care Code for Ethical International Recruitment and Employment Practices,* an updated version of the Code, was launched in 2017. The Code provides best practices for all stakeholders, but in practice, Code enforcement and certification regime applies to recruiters (i.e., staffing and placement firms). The Alliance Code provides parameters that connect with the WHO Code's principles: contract transparency and time to review (WHO Code Articles 3.5, 4.3, and 4.4), focus on clinical and cultural orientation (WHO Code Article 4.6), and fair and equitable treatment (WHO Code Articles 4.5, 4.6, and 4.7).
9. Many recruiters have been reluctant to sign up for the Code and be subject to third-party oversight. In 2013, five years after the launch of the Alliance, only four recruiters had received Alliance certification. In 2014, the Alliance was acquired by CGFNS International, Inc. (CGFNS), which conducts credential evaluation for health professionals and others to

bring their experience and education across borders through visa and licensure processes. Since CGFNS acquired the Alliance, it was able to offer services to entice recruiters to pursue certification, including concierge-level customer service (known as Alliance firm support) and bundled status updates for all of a recruiter's applicants. Since then, the number of recruiters that are certified by the Alliance has more than tripled to thirteen, representing 20 – 25% of the foreign recruitment market, according to Alliance estimates. Of course, a critical mass of support for a voluntary initiative—or a market shock like legislation or litigation—is necessary to catalyze broader market evolution and establish new standard practices.

10. In 2010, the WHO Code of Global Practice was adopted. It is a voluntary code, modeled on elements of, and embodying the same foundational principles, of the Alliance Code. While the Code speaks to all parties involved in foreign recruitment, including private agencies, it is a process driven by member states. Countries are supposed to provide updates through the reporting mechanism every three years, but there is wide variance in compliance and compliance approaches. Moreover, there is no clear mechanism for individual-level complaints about violations of the WHO Code by private actors independent of relevant laws.
11. These Codes are symbiotic and complementary. The WHO Code provides guidance to member states, while the Alliance Code provides best practices to effectuate the WHO Code's principles for recruitment actors. Ideally, a regime with multi-stakeholder, sector-specific codes that address national and regional needs and legislative and regulatory frameworks would be ideal. However, even without regulatory authority to ensure

stakeholders apply these principles, the Codes have substantial utility in terms of providing countries, employers, recruiters, and health professionals with best practice models.

Case study: Jamaica

12. Jamaica is a case study of how the Codes work together. In 2017, Jamaica complained to WHO about the depletion of Advanced Practice nurses. In 2016, an estimated 20% of the specialized nurses left the country, despite its chronic shortage of healthcare workers (ADD DATA ON JAMAICAN SHORTAGE). Even with Jamaican pay increases and overtime, a nurse could easily make double or triple by going abroad to other English speaking countries.

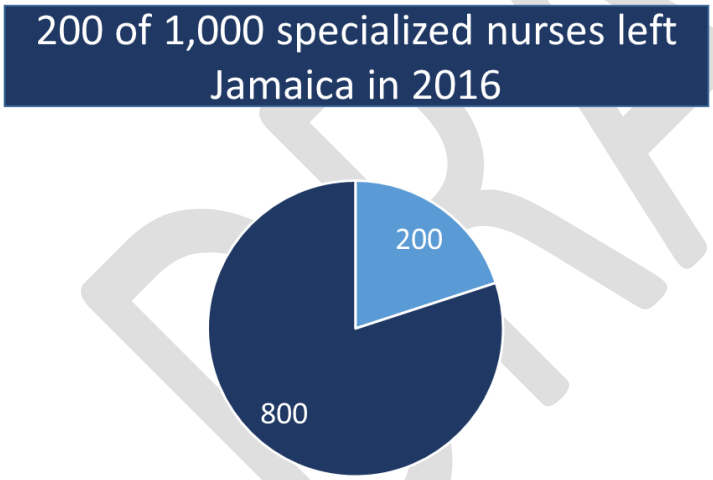

Figure 1

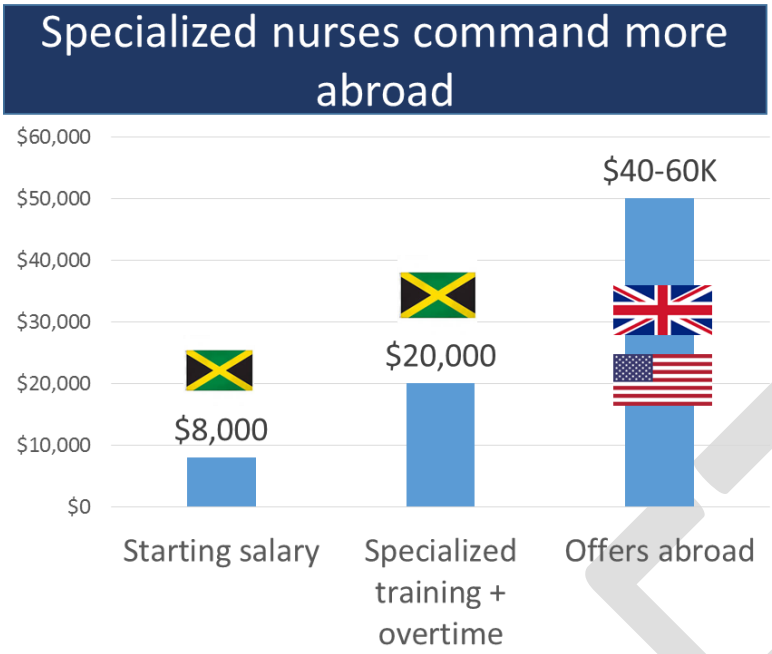

Figure 2

13. The Alliance launched a guidance directive to certified ethical firms, who commit to abiding by the Alliance Code which balances competing considerations. Ethical firms do not want to damage systems that are already facing chronic shortages, but the right of individuals to make career decisions that are best for them and their family are also important. Moreover, from a business perspective, the Alliance Code is voluntary—if certified ethical firms pulled out of the market entirely, then people who wanted international opportunities would only work with companies that have not committed to ethical practice and accountability to an independent third party. As a result, the guidance involved three practices that certified firms are expected to follow which align closely with the WHO Code. First, certified ethical firms should not engage in outbound advertising, in line with Article 5.1, discouraging active recruitment. This mitigates the risk of a recruiter poaching the country's domestic

workforce, but enables motivated, proactive professionals that want to leave their country to work with ethical recruiters rather being only left with unethical or non-certified agencies. Secondly, there is a provision prohibiting the recruitment of those under public service commitments, in line with WHO Code Article 4.2's dictate for recruiters and employers to be aware of and not seek to recruit health workers with a legal obligation to their national health system. Under Jamaican law, and those of many other developing countries, nurses receive free or subsidized education with the promise to serve in the public health system for a specified duration of time. If a person does not complete the commitment, they must pay a fee. However, with fees of $5,000 or $6,000 in Jamaica, many recruitment firms would willingly pay off such a fee. An ethical firm cannot support the abrogation of an individual's national commitments. Finally, as part of giving back for foreign recruitment, support for healthcare in developing countries is important. As part of the Alliance's directive on Jamaican recruitment, support for Jamaican nursing was encouraged through scholarships for nursing students in Jamaica and facility 'twinning', whereby a U.S. facility can provide assistance or aid to a healthcare facility in Jamaica. These provisions align with Articles 3.3 and 5.2 of the WHO Code, whereby developed countries are encouraged to provide technical and financial assistance to developing countries with respect to strengthening health systems and to implement cooperative arrangements, including twinning arrangements. While the impact of the Alliance directive is unclear, certified recruiters who have business ties to Jamaica were spoken directly to about the provisions, their purpose, and asked if there were any questions or obstacles to adhering to any of the provisions. One issue, of course, is intergovernmental communication; while the

labor department was informed about the Alliance directive, the health department was not.

14. It can be very difficult to get traction, especially as laws—let alone voluntary agreements and Codes—are often ignored. But collaborative efforts across governments, non-profit organizations, labor groups, and recruiters and employers can lead to improvement. For example, with Jamaica, the United Kingdom has pursued an agreement whereby Jamaican nurses will come to the U.K. for a period of time, and gain experience that they can bring back to Jamaica.

Recruiters generally support the concept of ethical recruitment, but are concerned about efforts that could reduce profitability or fully disrupt their business models, and other stakeholders are worried about competitive disadvantage

15. On July 23, as part of the effort to understand recruiters' perspectives, CGFNS convened a Human Resources for Health "Think Tank" for staffing and placement firms that recruit foreign-educated health professionals to the U.S. The think tank included many of the largest staffing and placement firms. One of the key agenda items was to understand recruiters' perspective on the WHO Code, both in relation to and separate from the Alliance Code.
16. Every firm representative was familiar with the WHO Code, but to varying degrees. One placement firm representative attended a CGFNS webinar in the spring 2019 about the subject. During the Think Tank conversation, one representative of a large staffing firm said that he is familiar with it, "but not sure how much it applies to our" business practices.

17. Overall, most recruitment firms support the principles underlying the WHO Code. Nevertheless, even as they support the rationale for the WHO Code, there was less awareness that the Code applies to all parties to the process, not just member states. In this way, voluntary codes by independent multi-stakeholder groups like the Alliance can serve as a bridge between the WHO Code and business practices. Where the Alliance model is not tenable, recruitment industry associations could serve a similar role, though ensuring that such efforts are actually about minimizing the harms of recruitment rather than serving as a marketing gimmick are essential.
18. Regarding WHO Code Article 4.2 and acknowledging obligations in the home country, most firms endorsed the view stated by one firm, that firms "should not employ a healthcare professional who has an existing agreement / contract with their home country until that commitment / obligation has been fulfilled." With that exception, all representatives agreed that "we fully support the right of each individual to make their own career determinations."
19. Article 5.3 of the WHO Code states "Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country." In the context of the UN Global Compact on Migration and the WHO Code, this often relates to leveraging skills through 'circular' migration. However, the CEO of a major staffing firm stated, "I believe there is also benefit to the home country clinical environments as the nurses prepare to

come to the U.S. The process to come to the U.S. is much longer than to go to most other countries. We hear many stories of how the nurses' practice changes as a result of the NCLEX review and the online/virtual clinical preparation program provided."

20. Regarding bilateral agreements, there was minimal awareness of the existence of the types of agreements that are encouraged by the WHO Code. Part of this may be due to the U.S. government not participating in such negotiations, as the U.S. health care system is much more privatized and decentralized than many other nations'. However, as many firms have international operations with multiple origin and destination countries targeted, one major Alliance-certified firm stated they "would like more information on bi-lateral agreements and how Staffing companies could locate them in a centralized location."

Participation by a sending government entity to address issues faced by migrating health professionals

21. The Philippines government has sought to take some action to address the complaints by Filipino nurses of unfair contract practices and treatment. The economic model of the Philippines, in producing labor for export and relying on remittances, has meant that the vast majority of foreign-educated health professionals who migrate to the U.S. are Filipino. In the U.S. federal Fiscal Year of 2018 (October 2017 – September 2018), for example, 67% of health professionals who were educated outside the U.S. and Canada and who needed a *VisaScreen* certificate from CGFNS as a precondition of receiving an employment-based visa to the U.S. were from the Philippines.. Partly as a result of this, the government has developed infrastructure not found in most other countries to protect the interests of its migrant workers. The Commission on Filipinos Overseas (CFO) offers pre-departure

orientation before Filipino workers migrate; since 2019, the Alliance has provided materials to be included in the orientation with the goal of empowering migrants to understand their rights and options and to make better informed decisions. The Philippines Overseas Employment Agency (POEA) certifies recruiters. The Philippines Overseas Labor Office (POLO), a division of the Department of Labor, is housed in Philippines embassies around the world and seeks to protect Filipino workers abroad. Nonetheless, these efforts—while helpful in specific cases—have not served to discernibly shift the character of recruitment from the Philippines versus other developing countries.

22. In 2017, after receiving numerous complaints from Filipino nurses, the POLO Labor Attache in Washington, DC, and the Philippines Nurses Association convened a Task Force to propose model contract provisions on termination and breach. Despite the development of recommended provisions by the Task Force, the POEA did not formally accept or reject the recommendations. While Article 8.6 of the WHO Code states that "Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code," in practice some countries worry that mandates on contract provisions could put their citizens at a competitive disadvantage in the international labor market. Moreover, developing a model contract can be difficult during business desire to draft contracts for their needs, and varying laws within a country (such as state law in the U.S.). Following the principles of the WHO Code, and the more prescriptive principles of the Alliance Code, could prove a more palatable rubric by which to evaluate contracts that require government approval.

With effective support from member states, recruiters and employers that want to embody the principles of the WHO Code can be enabled to be ethical firms

23. The principles of the WHO Code can be articulated in subordinate codes, such as the Alliance's Code and alternative regimes, such as the Code of Ethics developed by a U.S. international healthcare recruiter association. However, codes with vibrant, independent enforcement mechanisms and strong incentives for code adherence are more likely to result in effective implementation of Code principles. Member states can pursue policies that symbiotically can advance the work of the WHO Code and more localized operational codes that further those principles:

    23.1. Enforce laws around discrimination, pay, and contract practices and provide opportunities for legal redress

    23.2. Provide incentives for recruiters and employers to follow the Code (e.g., support for multi-stakeholder agreements through preferences for contracting or immigration purposes, bi-lateral agreements that provide fast track for migration with Code principles baked in)

    23.3. Collect, aggregate, and synthesize data to highlight systemic issues and address the charge of the WHO Code (as well as the UN Global Compact for Migration) to promote data as a way to share knowledge and enhance transparency

    23.4. Look for "win-wins"—unlike in many policy situations, stakeholders collectively benefit from ethical recruitment; incentives and policy corrections may be required to address issues that can lead to negative externalities

23.5. Provide recruiters with information on bilateral agreements and support and incentivize recruitment patterns that adhere with WHO Code principles

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