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Regional Harmonization Processes of Health Professional Regulation:

Status, Challenges, and Policy Directions

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Rupa Chanda[1]

1. Background and motivation

> "Development is about more than money, or machines, or good policies- it's about real people and the lives they lead." [2]

This quote is nowhere more apt than in the context of health worker migration which not only shapes the lives of real people, those delivering and those receiving health care, but also the sustainability of national health systems, which is so critical for development. Migration of healthcare professionals has become critical in a world which faces a health workforce crisis due to widespread shortages of health care workers. This shortage is acute in underdeveloped and developing countries which carry the highest burden of disease. Africa which bears more than 24% of the global burden of disease, has access to only 3% of health workers (WHO) and the Sub-Saharan region has the lowest ratio of doctors per 1000 population in the world. Meanwhile, in developed countries, demographic trends and burdened healthcare systems have caused demand to outstrip the supply of health workers. It is estimated that 40 million new health sector jobs will be created by 2030 worldwide alongside a projected shortage of 18 million health workers to fill these positions, particularly, nurses and midwives. The WHO estimates a shortage of 9 million nurses and midwives worldwide today, a gap that is expected to narrow only slightly to 7.6 million by 2030.[3] As skilled and motivated health workers are essential for access to healthcare, cross-border mobility of health workers has a bearing on these shortages, as a cause and as a solution.

Health worker migration has traditionally been from low and middle-income countries to developed countries, driven by traditional push and pull factors.[4] However, the dynamics have become more complex over time. Increasingly, the movement is within regions, including among developing and low-income countries, driven by a growing private sector and opportunities for South-South migration. Recent evidence from low income countries shows that a large proportion of health care workers in developing countries and LDCs is foreign born and foreign trained. Reflecting these trends, sub-regional integration schemes have emerged to regulate intraregional mobility, including of healthcare workers, by establishing principles, policies, and institutions. These arrangements vary in terms of the freedom of movement, establishment, and employment they permit, the rights they grant, and in their actual implementation. The intraregional dimension of health worker dimension and the emergence of such schemes makes it important to focus on the role of regional rules, processes, regional harmonization, integration and reintegration efforts in shaping the availability of health workers in both sending and receiving countries.

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[2] Paul Kagame, President of the Republic of Rwanda, Africa 2016 Summit.

[3] Trines (2018)

[4] These push and pull factors include higher remuneration in rich countries, better working environment and infrastructure, training and specialization opportunities, incentives offered by host countries and aggressive recruitment drives by rich countries while the push factors include low wages, poor human resource management practices and work environment, political and economic instability, among others.

The aim of this policy brief is to describe these regional harmonization processes for the regulation of health professionals and to assess to what extent they complement and support multilateral governance mechanisms such as the WHO Global Code of Practice on the International Recruitment of Health Personnel. The larger objective is to provide insights on the effectiveness and relevance of the Global Code. The brief is structured as follows. Following this introduction, Section 2 briefly outlines existing multilateral governance mechanisms for the regulation of health professionals to provide a context for the regional initiatives. Section 3 discusses the experiences with regional and sub-regional harmonization processes and initiatives which regulate the mobility of health professionals. The discussion outlines the rules established under these regional arrangements, implementation status, outcomes, and challenges and highlights facilitating and constraining factors. Section 4 concludes by highlighting the key insights from the review of regional processes, the gaps in implementation, and steps to address these gaps, facilitate the adoption of best practices and enhance the relevance and effectiveness of the Global Code.

2. Brief Overview of Global Governance Mechanisms [5]

Several global governance mechanisms and frameworks exist which have a bearing on the regulation of health professionals and health worker mobility/migration. These include the WHO Global Code of Practice which was adopted in 2010 as a key global governance instrument to better understand and manage health worker migration, the Commonwealth Code of Practice for the International Recruitment of Health Workers, the NHS Guidelines, the Melbourne Manifesto, and the Global Compact on Safe, Orderly and Regular Migration by the OECD and IOM.

These codes discourage the international recruitment of health personnel from countries that face acute shortage and encourage improved education and training, better retention strategies, and better distribution of health workers to ensure a sustainable healthcare system. Ethical recruitment which safeguards the interests of sending countries and the rights of recruited health workers is a key concern. These governance instruments also encourage destination countries to collaborate with source countries on training, technology and skill transfer, recognition of qualifications, return and circular migration, and sharing of information and best practices, so that the international migration of health personnel is mutually beneficial. Member states, international organizations, international donor agencies, and others are encouraged to support developing countries that experience critical health workforce shortages by providing financial and technical assistance. Some codes such as the NHS and the Melbourne Manifesto discourage active international recruitment of healthcare personnel from developing countries unless there is an explicit government-to-government agreement or a MoU with the source countries. Some include guidelines advising recruiting countries to develop more training posts at home so as to reduce reliance on international recruitment from developing countries, to establish active links with training institutes and schools in source countries to augment capacity in the latter, and to encourage health professionals to return to their home countries.

While these other instruments are based on guidelines and provide frameworks that are to be adopted on a voluntary basis, the GATS is a legal instrument with binding commitments that can have a bearing on the temporary cross border mobility of health workers. Under the GATS there are also provisions for the mutual recognition of qualifications and harmonizing domestic regulations through discussions in the Working Party on Professional Services. Till date, however, very few countries have scheduled health services given

[5] See, WHO (2010a), (2010b), Commonwealth Code of Practice (2003), Department of Health (2004), Melbourne Manifesto (2002)

its public good nature, and there are virtually no liberalization commitments in mode 4. Progress on Mutual Recognition and Domestic Regulations has also been slow.

3. Regional and Sub-regional Experiences

There are various kinds of initiatives at the regional and sub-regional levels to regulate the mobility of workers, including of health workers. These initiatives address different aspects, such as recruitment, standards and qualifications, visas, mutual recognition, training, capacity building, regulatory cooperation, data sharing, return and reintegration, that shape this movement. The following discussion outlines initiatives under formal regional blocs such as CARICOM, EAC, Mercosur, ASEAN, and SADC which have arrangements to govern intraregional mobility of health professionals. The discussion also touches upon regions such as the South Pacific where such mobility is an important issue and some arrangements exist. The discussion does not cover harmonization initiatives in the context of *bilateral* comprehensive economic partnership/cooperation agreements within regions or cross-regional bilateral agreements.

3.1 Mercosur

The Southern Common Market (MERCOSUR) is a regional integration process, initially established by Argentina, Brazil, Paraguay and Uruguay, and subsequently joined by Venezuela and Bolivia.[6] Decisions in MERCOSUR are made by intergovernmental institutions with direct participation from representatives of all states. As free movement of persons is an important theme in Mercosur, several regional institution, mechanisms and forums have been created which focus on regional mobility of healthcare workers and students, their education, practice, transfer, etc. Working groups along with professionals and institutes together form policies related to healthcare and ensure harmonization of legislation and guidelines, as summarized in the following table.

Table 1: Integration and Harmonization Initiatives Concerning Health Workers in MERCOSUR

Forum/mechanism	**Purpose/Objective and Steps Taken**
Meeting of Health Ministers of Mercosur (RMS)	• Main political body for discussing and framing health policies and strategies for the bloc, established in 1995 • Comprises of national health ministers with PAHO as the technical advisory body • Defines negotiating guidelines based on projects through joint inter-governmental commissions • Promotes cooperation between health ministers and decides policies based on views of all member states.
Health Working Groups-SGTs (approved by the Common Market Group (CMG)) Three main areas covered **health products,** **health surveillance** **health care services**	• Main technical body established in 1996 which brings together leaders, specialists and technical experts from national Health Ministries and public bodies. [8] • Focuses on the harmonization of legislations in areas already defined, promotion of technical cooperation and joint action between member states

[6] See, https://www.mercosur.int/en/about-mercosur/mercosur-countries/
[8] See, Bianculli and Hoffman (2014), pp. 4-5

Each dealt by specialized commissions with specific objectives [7]	• Commissions are further structured into sub-commissions and ad-hoc groups, guided by particular negotiating mandates based on member countries' common interests [9] • SGT resolutions to be implemented nationally after consensus among member states
Health care services committee further subdivided into 3 sub committees- Health Services Evaluation and Use of Technologies in Health Services Professional Development and Practice (SPDP)[10]	• Regulatory harmonization in health services domain [11] • Create a glossary of common terms, requisites to the habilitation of emergence mobile health units, intensive adult therapy, and basic information for children health pass • Medical specializations and minimal matrix for professional health register • Methodologies for validation of health technologies
SPDP	• Established in 1996 to enable recognition of the specialties of healthcare professions in Mercosur to enable cross-border practice by health professionals among member states. • Has identified problems arising from conflicts in national legislations on the regulation of health professions. • Established mechanisms for controlling, supervising, registering disciplinary sanctions on professionals, created a code of ethics for each healthcare profession.[12]
The Specialized Migration Forum (SMF)	• Created in 2004 to help frame migration policies in MERCOSUR (but not specific to health workers)-overarching forum on migration
A Minimum Matrix of Registration for Mercosur Healthcare Professionals (approved by the SPDP)[13]	• A document created in 2004 to serve as an integrated registry of healthcare professionals in the region • Document contains personal and professional data and sanctions of healthcare professionals • Updated in 2012 • Successful program, though physicians from member states do not have free transit in Brazil, even after the approval of the Minimum Matrix and the orders of the Ministry of Health 2014. Validation of professional qualification documents required in Brazilian institutions[14] • But has not been able to overcome all the restrictions imposed in member countries o Healthcare professionals from other countries yet to validate their qualification documents in Brazil o Medical institutions in Brazil used their veto power to prevent free transit of doctors from other member states o But matrix has enabled progress in some areas where consensus among member states

[7] There are similar harmonization and regulatory cooperation objectives in the other areas of the SGT (products and surveillance), in terms of developing a common glossary of terms and definitions, best practices in production, control and distribution, licensing, and disease surveillance.
[9] See, Bianculli and Hoffman (2014), pp. 4-5
[10] Pereira et. al (2018)
[11] See, Bianculli and Hoffman (2014), p. 7
[12] See, de Paula (2009)
[13] Pereira et. al (2018)
[14] Pereira et. al (2018)

Regional Coordinating Committee for Higher Education (RCCHE)	• Established in 2001 to regulate academic mobility programs for students among member states. • Forum allows members to exchange information about their policy experience, initiate policies and shape the final proposal.
The Experimental Mechanism for Accreditation of Courses for the Recognition of University Degrees in the Mercosur Countries (Mexa)	• Created in 2002 to facilitate the accreditation of courses for the recognition of university degrees among the Mercosur Countries.
Regional Academic Mobility Program- MARCA and Regional Accreditation System for Mercosur Undergraduate Courses- ARCU-SUL	• This program includes inter-university cooperation projects with the involvement of institutions from Argentina, Brazil, Paraguay, Uruguay, Bolivia, Chile for encouraging exchange programs for students. • The Marca program through RCCHE has seen participation from medical and nursing institutes of all the member states. • Since 2013 inter-university cooperation projects are also being run in the region. • The joint model has worked well in terms of synthesizing and disseminating public policies.
Regional Council of Nursing (Consejo Regional de Enfermeria, CREM)	• Comprises of national associations, serves as a political forum for professional and educational issues and nursing research in the region • Aims to improve the quality of education and quality of nursing care by upgrading the qualifications of nurses and improving the quality of the nursing force • Aims to address adverse impact on quality of nursing force and national health systems when highly qualified nurses migrate[15]

Source: Compiled from various documents

As seen above, there has been considerable investment in intergovernmental and regulatory cooperation in the health sector within Mercosur. These efforts have addressed several important aspects, such as mutual recognition, accreditation of qualifications, information sharing and harmonization of related legislations and systems, that have a bearing on the mobility of health workers and medical students. These efforts have been institutionalized through the creation of regional bodies, platforms for dialogue, and coordination mechanisms, the key ones being the SMF, the RCCHE and the SPDP which govern policies related to migration, education and healthcare and under which programs have been initiated. The focus has primarily been on educational qualifications and the validation and acceptance of credentials among member countries. There has been less direct focus on migration per se, though the need for educational systems to address the consequences of health worker migration on the availability and quality of healthcare workers is evident in these initiatives. The efforts have also mostly targeted nurses among health workers, the main focus being to upgrade the qualifications of the nursing pool in the region so as to meet domestic needs taking into account the effects of migration. These efforts have also been assisted by PAHO, the regional body of the WHO which has supported nurses' associations and governments in the region in their efforts to upgrade educational facilities and standards for nurses.[16]

It is difficult to gauge the success of these initiatives and to what extent they have been supported by or drawn upon the WHO Code of Practice. On the positive side, the various MERCOSUR platforms have allowed member countries to frame consensus-based policies and to retain their sovereignty in

[15] Fagen (2009)

[16] PAHO has provided technical training to a large number of persons who previously had only in-service hospital training and has qualified them as auxiliary nurses, supported their conversion into nursing technicians and progressively converted auxiliaries and technicians to professional nurses.

implementing these policies according to their social and political interests and preparedness.[17] This has meant greater acceptance of the regional programs and initiatives. The Regional Accreditation System, ARCU-SUL has played a positive role in terms of contributing towards an understanding of the nursing education system in the region by assessing differences in training across accredited institutions and identifying the health sector needs of the region, thereby enabling changes in practices and bridging of differences to enhance intraregional academic and professional mobility in healthcare.[18] There has been some progress in coordinating health services in border areas in some member states, with regard to the provision of services at the Borders and tracking the movement of workers, including health workers.

However, there appear to be more challenges that successes. While the Minimum Matrix and the SPDP forum have helped some member states to reach a consensus on the healthcare profession and critical requirements in education and training, implementation of the Matrix has varied across member states, due to differences in national laws and regulations, political differences within the bloc which affect cooperation, and the continued attractiveness of the OECD countries as a destination for health professionals. Available reports and other evidence suggest that deeper harmonization of national legislations has been lacking. Member states still do not recognize each other's regulatory standards and procedures as deeper governance arrangements are not yet in place. Member states continue to have different obligations relating to health and have different systems for university, equity and health coverage and also vary in their organization, health systems (mixed, public, private), regulation, capacity, and financing of the healthcare sector.[19] Barriers to trade in health services (and products) continue as implementation of commitments undertaken in services and the last package of services negotiations are still not complete. There are also roadblocks to the harmonization process and coordination due to a lack of clarity and consensus on what a regional health policy should constitute, including the movement of health professionals (and the recognition of graduate and postgraduate degrees and specializations), movement of health system users (including tourists and non-permanent resident) and circulation of health services within the region. As resolutions from the SGT Working Group on Health can be implemented nationally only if there is a consensus among all member states, the intergovernmental decision-making process can act as a constraint. The extent of legalization of the various programs and institutions remains weak and in the absence of independent monitoring and enforcement mechanisms, implementation is patchy. If services liberalization were to progress in MERCOSUR, it would help deepen some of the regulatory arrangements concerning health worker mobility.[20]

3.2 CARICOM

The Caribbean region has small size economies with limited resources. Lack of health infrastructure (particularly in rural areas), shortage of health workers and a large informal structure are major problems.[21] Migration of health professionals in the public healthcare system is a major challenge for this region, triggered by pull factors such as economic growth in some countries driven by US investments, larger markets, and the growth of the tourism and service industries, and push factors such as poverty, lack of career opportunities, lack of resources to fund hospitals, implement and maintain complex medical procedures or even maintain the services of qualified and trained staff.[22] This condition has been aggravated

[17] Pereira et. al (2018)
[18] Gonçalves et al (2017), Jurje and Lavenex (2015)
[19] Bianculli and Hoffman (2014), p. 10 and pp. 21-23
[20] Bianculli and Hoffman (2014), pp. 16-17
[21] See, HECORA (2008), p.15
[22] A 2009 World Bank study found that 15 years after graduation about half of the trained nurses from English Speaking CARICOM countries were working abroad. Three times as many CARICOM trained nurses work outside rather than within the region (one of highest levels in the world). The regional shortage of nurses was expected to triple to over 10,000 within 13 years. See, Trines (2018)

by the heavy recruitment of healthcare workers by international and commercial intermediaries in UK, Canada and the USA and the lack of training capacity in the region. The region is expected to face critical shortages of health workers unless the trend of low in-migration and high out-migration levels is reversed.

The CARICOM Single Market and Economy (CSME) was launched in 2005 with the aim of promoting intra-regional mobility in and development of the region. Given the problems plaguing the health sector in this region, regional coordination efforts concerning health worker training, quality upgradation, sharing of best practices, and movement of health workers have been important focus areas under CARICOM. Among the categories of workers who are allowed to move freely and work across the region, are nurses.[23] The directorate of Human and Social Development of the CARICOM Secretariat and the Department of Health Sector Development coordinate health at regional level. The regional policies and planning are done by the Caribbean Cooperation in Health (CCH).[24] The region has adopted a policy of free mobility of health professionals between member states, though this is yet to be fully implemented. There is a Managed Migration Program to address nursing services capacity. Steps have been taken to standardize nursing training and examinations and to institute harmonized quality assurance systems. Table 2 summarizes some of the main features of the regional coordination efforts and frameworks to manage health worker mobility in CARICOM.

Table 2: Integration and Harmonization Initiatives Concerning Health Workers in CARICOM

Forum/mechanism/institutions	**Purpose/Objectives and Steps taken**
Regional collaboration in nursing led by PAHO/CPC (Caribbean Program Coordination) CNO (Caribbean Nurses' Organization), RNB (Regional Nursing Body) University of the West Indies	• To advance nursing in the region by developing educational standards and competencies • Makes use of successful partnerships outside the regions and strong leadership of nurses who have come back after their education outside the Caribbean to boost regional collaboration among nurses • PAHO/CPC provides technical assistance and other resources • CNO brings together individuals and national nursing associations at regional level • RNB comprising of chief nursing officials and other collaborators and the University of the West Indies (UWI) help in developing educational standards
Managed Migration Program of the Caribbean'	• Develop a multilateral, cross-sector, multi-interventional, long-term strategy for maintaining adequate human resources for nursing in the region • Allows stakeholders to develop interventions to ensure that migration is moderated and macro managed through trade and other agreements • Each country receives information on maintaining a healthy workplace to design suitable interventions • Most arrangements focus on migration outside the region, but a few cover intra-regional migration o "in 2003 Grenada opened up its excess training capacity to train nurses from Antigua. 20 individuals from Antigua receive nurses training in Grenada at minimal cost."

[23] Tokman (2008)
[24] See, HECORA (2008), p.29 and 32

The Regional Examination for Nurses Registration (RENR) and the Common Nursing Education Standards in the Caribbean	• Allow easy mobility of nurses by standardizing the examination system and establishing common standards for licensing nurses in the region • To standardize nursing in the region a common exam, RENR was started in 1993 • Initiative of RNB (Regional Nursing Body) to establish common standards for licensing, though implementation uneven • In 2006 COHSOD (Council for Human and Social Development) agreed that as RNB had suggested, BScN (Bachelor of Science in Nursing) should be the minimum requirement for a registered nurse • Following this agreement, a series of workshops held from 2006 to 2011 with participation of selected nurse educators, representatives from WHO/PAHO and RNB • Accomplishments from the workshop were: o "a review of the Blueprint for the RENR, o a review of the standards for nursing education, o preparation of the administrative manual and guidelines for the RENR and, o preparation of the 2011 CARICOM Model BScN curriculum" • Draft BScN curriculum sent to member states for feedback, incorporated into the curriculum. The expectation was that "the curriculum would be delivered through a baccalaureate four-year credit-based program." • Model curriculum was supposed to help member states transition from their general nursing program to a baccalaureate program at the regional level.[25]
The Caribbean Association of Medical Councils (CAMC) was formed in 2003	• Facilitate mobility of doctors in the region • Introduced CAMC examinations to "assess for registration purposes, the general body of medical knowledge and clinical skills of trained doctors whose basic medical qualifications are not recognized by the regional medical councils, i.e. doctors trained in medical schools that have not been formally reviewed and accredited by the CAMC."[26]
Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP)	• Maintain a uniform accreditation system
Harmonization of Medicine Regulation in CARICOM	• Includes movement of medical regulatory professions (HERA Report)

Source: Compiled from various documents

The CARICOM region has taken significant steps to collaborate on mobility of health workers and their training and credentialing processes to facilitate such exchange and movement. There is a clear overall goal of managing human resources of health more effectively keeping in view both intraregional flows and

[25] Brathwaite (2017), pp. 27-31 and p. 116

[26] See, Kimm et. al (2013), p.11. There are two types of medical schools in Caribbean-regional (training graduates for the country in which they are located) and offshore schools (satellite campuses for students of foreign universities mostly in the US). Most countries in CARICOM region have their own medical board. In some of the countries, professionals from accredited universities in the USA, UK and Canada can register for the license, whereas some countries have their own licensing exam. The Caribbean Association of Medical Councils (CAMC) was formed in 2003. Its exams assess medical qualifications of doctors trained in medical schools that have not been formally reviewed and accredited by the CAMC and thus not recognized by the regional medical councils.

migration to countries outside the region. There has been progress in developing regional associations and bodies which play an active role in the harmonization efforts as well as in establishing minimum standards for licensing of nurses and for recognition of doctors trained outside the Caribbean Association of Medical Councils system and in developing a model curriculum through a participatory approach at the country level. Skills, networks and partnerships developed through returning migrant health workers (nurses) have been used to strengthen standards and capacity in the region, indicating that migration has been seen in a holistic manner, both in terms of outflows and inflows and that return migration related benefits have been leveraged. The Managed Migration Program includes arrangements between countries for subsidized training and for information sharing. The coordination efforts have also extended to other health professionals such as pharmacists and regulatory authorities (for medical products) with efforts to establish harmonized norms for inspection, distribution, registration and quality control for medicines and related information sharing and technical support.

These efforts have also been backed by studies to identify the needs of the health sector in the region and frame policies accordingly. For instance, under the Regional collaboration initiative, the University of West Indies has conducted a study on training capacity in nursing so that governments can collaborate to share resources and plan the production of nurses and capacity building for training. The BScN reform along with the development of a curriculum that meets national and regional standards and quality assurance requirements, has been a key step in harmonizing nursing education in the region. Prior to this, as per a 2009 World Bank study, there was a shortage of trainers in nursing and there was a lot of fragmentation and variability in the nursing training that was being provided in the region affecting quality and capacity.[27]

But harmonization efforts have not been without challenges. For the Regional Examination and BScN reform program, as multiple organizations have been involved, there have been problems with coordination, arranging of funds and infrastructure. It has been difficult to develop proper evaluation and measurement mechanisms. According to the World Bank study, the reform has been only partially adopted by member states as required legislative changes have not been made.[28] Implementation remains uneven as some territories have not been able to deliver the pre-registration BScN degree program. None of the countries has established the BSc Degree as the required qualification to be able to practice nursing in the region. Accreditation is not a component of the reform process. As most colleges do not have sufficient capacity, the program has not guaranteed a minimum standard of nursing education and has failed to deliver baccalaureate nursing education, making the region susceptible to continued out-migration of nurses for better education opportunities. Interviews of nurses in the region indicate that while countries were willing to engage with the CARICOM reform, they were not fully committed to it as they are not obliged to comply with regional agreements. The World Bank study notes that the implementation pattern does not serve the purpose of harmonization and easy mobility of nurses in the region or the quality of nursing services delivered in the region. The problem is compounded by the fact that different states have different capabilities in terms of leadership, finances, human resources, education and placement, a problem that can only be resolved through partnerships to address deficiencies in capacity.

Implementation of these reforms requires legislation in the countries to formalize the BScN degree as the qualification for practice of nursing in the region. An assessment of the quality of BScN programs is

[27] Prior to the introduction of BScN reform, a 2009 World Bank study had found that there was an insufficient number of tutors for nursing and a variety of training programs had existed despite the harmonization efforts of RNB. The study revealed 43 pre-registration general nursing programs in the region. Some territories had a mixed system of training and the student could opt for any particular program and delivery was considerably fragmented. See, Brathwaite (2017), pp. 33-34

[28] According to CARICOM's governance procedures, agreements by organs of the Community must be entered into a member state's municipal law in order to take full effect in that state. But none of the member states have taken this step. See, de Paula (2009)

required and accreditation of all degree programs is also needed to ensure continuous quality improvement. In addition, the capacity of member states has to be enhanced particularly in terms of nursing leadership along with infrastructure, finance and human resources, enablers such as government support, interest group participation and greater communication are needed, and concerned bodies, such as the RNB, nursing councils and relevant ministries have to be strengthened alongside, with support from the WHO/PAHO.[29] It is expected that with CARICOM now taking charge of the program as a regional policy, such implementation gaps and coordination issues can be resolved as CARICOM would be responsible for funding and overseeing the program to ensure that the harmonization of training and equivalency mechanism can be sustained.[30]

Similar challenges have confronted the region in implementing the registration process for foreign doctors through the introduction of a mandatory bi-annual exam. There have been difficulties in establishing the association as a legally constituted body and establishing an intergovernmental agreement which legalizes CAMC's licensing role, in clearly defining the roles of CAMC and of the separate National Medical Councils and clarifying the latter's sovereignty, in allocating sufficient resources to the program and issues relating to the establishment of the secretariat. As with the CAMC, the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) has faced difficulties in maintaining a uniform license system due to issues of financing and variability in fees collected for the registration and licensing process depending on the number of institutes and professionals involved and differential fees for foreign versus domestic graduates.

There has not been much progress with the regulatory harmonization of medicines and related movement of regulatory professionals. Shortage of staff, lack of training and development programs for professionals, outdated legislations and guidelines, lack of regulatory cooperation frameworks, inadequate infrastructure, and lack of data management systems and data sharing persist. If mobility of regulatory authorities is to be facilitated while developing the capacity of individual countries, then there needs to be a continuous training program for medical regulators with resource sharing through joint training programs, evaluations and inspections. A network has to be created among the various national regulatory authorities in the region through data and information sharing to enable mutual recognition of regulatory decisions.[31]

Overall, the CARICOM experience indicates progress in creating institutions and forums for harmonization and the importance of a consensus and participatory approach to such efforts. However, differences in capacity and conditions among member countries, failure to change national legislations and ensure national compliance with regional processes, lack of political will and leadership in the health sector, continued aggressive recruitment by some countries outside the region and absence of specialization opportunities in the region, have hurt progress. While intraregional mobility of health workers has been addressed, the focus has been mainly through education, training and accreditation initiatives, while aspects such as visas, border coordination, integration and return do not seem to feature explicitly.

3.3 East African Community (EAC)

The EAC comprises of Kenya, Uganda, Tanzania, South Sudan, Rwanda, and Burundi. The members have agreed on a Common Market protocol, which aims to widen and deepen economic, political, social and cultural integration among the East African countries. The protocol has been in force since 2010 in line with provisions of the EAC treaty and builds upon an earlier Customs Union among these countries. It

[29] The study corroborated the view that the Caribbean's policymaking tends to be over-ambitious. See, Brathwaite (2017), pp. 257-62, pp. 266-69
[30] See, Salmon et. al (2007)
[31] See, HERA final report (July 2009), p. 35, pp. 53-56

focuses on freedoms of movement for all the factors of production, including the free movement of persons and of labour/workers, along with the right of residence (and establishment).[32]

Health sector regulation and harmonization is an important focus area in the EAC given the serious shortage of qualified medical specialists in the region as well as the rising demand for healthcare services, including specialized healthcare, demographic changes, rising costs of care, and pressures arising from out-migration from the region.. The bloc currently has less than 44.5 physicians, nurses and midwives per 10,000 people.[33] While the region's population has grown tremendously, corresponding investment in health care training has not kept pace. There are several institutions which have been created to advance regional harmonization. These include the Inter University Council of East Africa, the East African Health Research Commission and the EAC Secretariat to promote the integration of services. For medical and dental practitioners, several regional boards and councils have been established, including for nursing and midwifery, radiographers and radiologists, physiotherapists and occupational health practitioners, environmental health Practitioners and for allied health professionals. Table 3 summarizes a number of policies and frameworks that have been developed in the EAC to regulate health professionals.

Table 3: Integration and harmonization initiatives concerning health workers in the EAC

Forum/mechanism/institutions	**Purpose/Objective and Steps taken**
Protocol of Health signed by Ministers of Health	• Establish and harmonize regional health policies and frameworks to enable regional cooperation on health • Regulation of training, licensing and practice of health professionals
Various harmonization initiatives concerning training and resulting frameworks/agreements/regulatory bodies Mutual Recognition Agreement (MRA) EAC QA system and Qualifications Framework Separate regulatory authorities set up in the region for Medical and Dental Practitioners, Nursing and Midwifery, Medical Laboratory and Pharmacy, etc. Various decisions to strengthen national regulatory authorities in health including establishing an "East African Community Health Professions Authority (EACHPA)" and "National Health Professions	• Facilitate mobility of medical and dental practitioners • Set up standards of education and practice in member states • Laid down training needs and methods • Requirement check list for all medical schools and teaching hospitals covering facets of infrastructure, staffing, governance, student welfare measures, research and innovation facilities • Joint inspection of 27 medical schools and 5 dental schools carried out with the new requirements. • Core curriculum developed and steps to harmonize the same across member countries. • Minimum Standards and competencies expected in medical graduates laid out clearly • Uniform standards for the region have been developed keeping in mind the cultural and socio-economic differences. • These standards specify what is expected from doctors. • Curriculum has been harmonized to produce a core curriculum. • developed to manage this harmonization. • Harmonization interventions by EAC in treatment guidelines, policies and strategies, admission, registration, medicines regulation and registration.

[32] See, http://www.eac.int
[33] The Citizen (June 14, 2017)

Authorities (NHPAs)" in each Country. [34]	
EAC Health Systems Research and Policy Unit	• Enable regional integration in the area of health systems, development and strengthening health research, policy formulation and practice among the EAC Partner States • Coordinate efforts of the EAC partner states • Lobby partner states to invest in human resources in the provision of safe, quality, affordable ad efficient health care services • Joint inspection and monitoring of training and service delivery institutions • Establish forums for sharing best practices, standards of education, professional qualifications and recognition ethical practice • Defines the roles of various stakeholders and governing bodies including the standards for recognition of Medical and dental training institutes • Convening of Knowledge, Expertise and Innovations sharing platforms/studies –Expert Working Groups
Various institutes, councils • Inter University Council of East Africa • East African Health Research Commission • EAC Secretariat (to look after health services in the region) • Different Centres of Excellence for Healthcare (in each member country) East African Kidney Institute in Kenya • East African Heart Institute in Tanzania Plans to establish a college of medicine and health professionals	• To harmonize the health sector in domains like education and research
Launch of Digital REACH (Regional East African Health) initiative in 2018	• Leverage digital technology for improving health and training of health workers in the region • Technology driven initiative at the core of the health care initiatives of EAC • To affect the quality, training and accreditation of the workforce to support Health worker capacity and capabilities through knowledge sharing, training and performance management

Source: Compiled from various documents

As seen above, several frameworks, agreements, protocols, and institutional support structures have been established to govern health care workers, mainly with a view towards standardization of training and qualifications in order to ensure quality, enhance capacity and facilitate intraregional mobility. According to some reports, these steps have resulted in easier movement of healthcare workers in the region and better access to quality healthcare services. Registration and licensing of doctors has been expedited.[35] The regulatory councils have become stronger and training standards in medical and dental schools have

[34] EAC (March 2008)

[35] Some 111 doctors have been registered, though the time frame is not mentioned.

improved. The mutual recognition of institutions has improved access to quality healthcare and education services. Economies of scale have been attained through regional investments like the EAC Regional Centres of Excellence. Overall there has been reduction in cost of doing business in healthcare sector. As in Nursing and midwifery services, which has been an important focus area, fundamental changes have taken place in both training and practice. The changes have been more pronounced in education, with a proliferation of training institutions across the countries preparing nurses at certificate, diploma, undergraduate and graduate levels.

Discussion with a senior expert in the region confirmed the progress made by the EAC in harmonizing medical education and training and shed light on the steps that were taken in this process. During 2014-16, the regulatory bodies of all the countries studied the medical education curriculum of each of the member states, met with the teaching faculty, and assessed the gaps and differences among them. They arrived at a core curriculum and developed checklists for medical schools, dental schools and teaching hospitals for various dimensions, such as governance, curriculum, training facilities, staffing, lab infrastructure, students, financing, research and development, and IT integration, among others. A team of regulators visited 27 universities, 5 dental schools and 27 medical schools, discussed with teaching staff, administration and students to assess each institution. The findings were shared with the medical schools, the Ministries of Education, Finance, and Health of each country. The aim was to identify best practices in the region. The findings and recommendations were discussed at the highest level and led to the review and even closure of some schools in a timebound manner. Significant efforts had to be made to ensure compliance with the standards that were developed, with financial support from the regulatory bodies themselves and some funding from the World Bank. The regional boards and councils which spearheaded this process and carried out the inspections, worked with the Inter University Council of East Africa to develop the harmonized curriculum. More recently, the EAC member state have concluded a legal document on MRAs for dental and medical professionals, while discussions are underway for MRAs in other areas.

According to the expert, there have been many benefits to the EAC member countries due to these harmonization efforts. There has been increased resource mobilization at the highest levels for medical education and training and for the overall improvement of medical schools in the region. Governments have released funds to address the gaps identified by the regulators. There has been increased recruitment of staff and increased investment in labs for training and equipment. Intraregional movement of health professionals and students has also been made easier, with universities finding it easier to request teaching staff from each other following harmonization. More doctors are now registered in other EAC member countries. Discussions are underway to develop a common exam in the region. The harmonization initiatives have also focused attention on issues of training of doctors at the highest level. Similar efforts are being made with nursing and midwifery services. These harmonization processes have also enabled sharing of expertise with other regulators and countries within and outside Africa. An association of regulators has been formed which meets every year and presents its harmonization efforts to other regions in Africa.

However, there have also been several challenges and striking a balance between out-migration and intraregional migration has been difficult. Full implementation of the MRA has not happened. While there is an improvement in the Councils, they are not strong enough for enforcement. Legal frameworks still differ across countries. Data on the migration of health workers is not robust due to the absence of an integrated information system among the countries. National regulatory mechanisms remain poorly resourced and weak and lack enforcement capability. There is limited representation by Nurses and midwives at various levels of policy input and decision making within the Ministries of Health and lack of coordination among regulatory stakeholders persists.

Harmonization also remains lacking on many fronts.[36] There are gaps in education and training across the EAC partner states. Most Nursing Schools in the region follow different curricula for similar programs. The entry requirements and duration of training for the same academic programs vary across countries. There are limited mechanisms in place to assess the competencies of graduates at higher levels of academic programs to ensure that they meet a common minimum level. The governance structure and job titles differ in EAC partner states both in Ministries of Health and Universities. There are different cadres in different countries. Some of them have a lot of lower level cadres with certificate training which might be non-existent in other countries.[37] Criteria for inspection of academic institutions are not similar. The scope of practice and scheme of service implementation is at different levels in member states.

Some of these issues were also echoed by the senior expert. One major challenge has been financing. While the initial plan was to conduct such an assessment and benchmarking exercise every few years, this has not been possible due to lack of funding. Another challenge has been in getting the acceptance of the medical schools and administrators. Universities have not always been cooperative as they do not want to be seen in bad light, though eventually, with sensitization, they have cooperated once they understood the value of these harmonization efforts.

Overall, much progress has been made in the EAC, though there remain gaps between proposed initiatives and implementation. Progress has been enabled by understanding at the highest levels of government and political will, cooperation from various training institutions, both public and private, and a shared vision on training among the member countries and regulatory authorities. However, both the secondary and primary evidence suggest that more needs to be done, including developing competence through a standardized assessment system, focusing more on post graduate training, introducing a tracking system for health worker migration, creating a system for monitoring the implementation of the healthcare protocol, increased resourcing of regulatory authorities and improving their governance capacity, and establishing the Umbrella National Health Professions Regulatory Authorities.[38] There is a need to revisit the institutions in the region to take stock of progress in the identified areas and the challenges that have been faced.

3.4 ASEAN

The Association of Southeast Asian Nations (ASEAN) is the geo-political and economic cooperation body across ten countries in Asia, namely, Brunei, Darussalam, Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand and Vietnam. The health systems in ASEAN countries are at different stages of development. Studies point out that the ASEAN region suffers a shortage of physicians due to supply gaps and immigration to Western Countries. The national distribution of workforce is uneven in these countries with shortages in rural areas. Health worker migration is a matter of concern for the ASEAN member states. There is both migration within the region from the less developed to the more developed member states like Brunei, Malaysia and Singapore and to countries outside the region. The Philippines exports nurses to other countries but has itself faced a severe shortage of highly skilled nurses which led to the closure of domestic hospitals. In Thailand, there is concern about in-migration of both doctors and patients from the region along with concerns over migration of Thai doctors to other ASEAN member states that provide better opportunities.[39] Thus the migration scenario is complex and the situation varies across the countries in the region.

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[36] See, Brownie and Kambo (2016), p. 21

[37] Some of the differences are as follows: Heads of Nursing/Midwifery services at Ministry of Health level differ in some EAC states; Positions/job titles for Heads of Nursing/Midwifery services in National, Regional, District Hospitals and Health Centers differ

[38] See, Okullo (2018) and Ayiko (2016)

[39] See, Te et. al (2018), p. 958, 962 and Kanchanachitra et. al (2011)

The ASEAN framework agreement on services was signed in 1995 to promote free trade in services in the region, including in healthcare. In 2015, an initiative was taken to set up the ASEAN Economic Community (AEC), wherein the flow of health care professionals and cross border health services were central to achieving the SDGs of Universal Health and well-being of ASEAN countries by strengthening the region wide healthcare systems. Under these framework agreements, some initiatives have been taken, mainly with regard to harmonization of training and qualifications. Table 4 summarizes the main steps that have been taken in ASEAN for this purpose.

Table 4: Harmonization initiatives concerning health workers in ASEAN

Initiatives/Frameworks/Agreements	Purpose and Steps taken
ASEAN Framework Agreement on Services and ASEAN Economic Community	• Broader framework agreements to promote free trade in services, including professional mobility in the region • services commitments • MRAs • Agreement on Movement of Natural persons
MRAs and related institutional structures ASEAN Joint Coordinating Committee on Medical Practitioners	• Enable free flow of healthcare workers by 2010 • MRA in nursing services signed in 2006 • MRA for medical practitioners signed in 2008 • At present MRAs for doctors, nurses, dental practitioners to enable them to practice in the region[40] • Recognition of a medical practitioner in the host country subject to several conditions- possession of medical qualification recognized by the PMRA (Professional Medical Regulatory Authority) of the host and origin countries, valid professional registration issued by PMRA of origin country, active practice of not less than 5 continuous years, compliance of other assessment requirements set by the host country • ASEAN Joint Coordinating Committee on Medical Practitioners (AJCCM) consisting of not more than 2 representatives from PMRA of each country established to implement the MRA by standardizing procedures, promoting harmonization at regional level and for information exchange • Member states have upgraded their curricula to meet requirements of a bachelor's degree as per AJCCN (ASEAN Joint Coordinating Committee on Nursing) for nursing MRA. (SEAMEO TROPMED, 2016)[41] • AJCCM and similar committees for dental practitioners and nursing meet thrice in a year to compare policies on registration and licensing • Progress with exchange of information regarding regulation and registration standards • Encouraged members to focus on standardization and certification of courses offered • Some progress with regional collaboration through student associations and medical schools • 55 nurses from ASEAN countries were registered as foreign nurses in other Member States (Fukunaga, 2015)

[40]The other professions covered by MRAs in ASEAN include engineering, architecture, surveying, accountancy, and tourism. There has also been an attempt to harmonize standards for healthcare products (pharmaceuticals, medical devices, health supplements).

[41] See, Te et. al (2018), p. 961

	• In Singapore 5400 nurses from other ASEAN states were registered and 2200 enrolled at the Singapore Nursing Board (Fukunaga, 2015) though without specifically invoking the MRA • MRA principles incorporated into the legislative framework of member states Countries have amended legislation to implement MRA • Brunei amended laws governing the Nursing Board for Brunei Darussalam in 2014; Myanmar created its Dental Council Law in 2011 and Nurse and Midwifery Council Law in 2015; Singapore revised its Dental Registration Act in 2009, Nurses and Midwives Act in 2012, and Medical Registration Act in 2014 [42]
ASEAN Agreement on Movement of Natural Persons	• Improve commitments for MNP, harmonize entry procedures, make process more transparent under the AFAS
ASEAN Qualifications Reference Framework	• Discussions to bridge gaps in qualification to enable intraregional mobility, but work in progress

Source: Compiled from various documents

As highlighted above, ASEAN has taken several steps to facilitate the mobility of health workers and the cross-border trade in health services. In particular, 3 MRAs facilitate the mobility of health professionals in the regional health labour market by enabling designated health professionals to practice in another ASEAN country without needing to pass other market access assessments before being registered to practice.[43] These MRAs allow mutual recognition of medical, dental and nursing practitioners and promote circular mobility and temporary migration. Further, excepting limitations imposed by immigration regimes, there are no limits on the number of health workers who can migrate to other ASEAN countries

While many steps have been taken towards harmonization of training and standards, progress has been slow. All the MRAs have not yet been ratified by all member countries. According to some reports, no doctors or dental practitioners have registered or moved to another member state using the MRA provisions. This is because recognition of qualifications remains problematic. Although the national qualifications framework and the ASEAN qualifications framework have been designed keeping regional healthcare interests in mind, the quality of health training, examination and education still varies a lot across Member States on aspects such as language, the number of steps needed, and the method of testing, leading to different Medical Licensing Examinations (MLE). Even though English is used in seven countries, six prefer the local language. For example, in the case of Thailand, the final stage of MLE is conducted in Thai imposing language constraints. Differences in language and competency requirements pose a challenge for low income countries like Cambodia, Laos, Myanmar and Vietnam. The pre-service training for doctors varies from 5 years in Malaysia, Singapore and Philippines to 8 years in Cambodia. Similarly, the required prior work experience for nurses varies across the countries. There continue to be technical differences in nomenclature and classification.[44] Similarly, the degree of nurses in Indonesia is not equivalent to that in other member states because it is a 3-year diploma program at the senior high school level while nurses in Thailand and Philippines hold a bachelor's degree. A medical professional is required to get a license from the country of origin and the host country, which is often difficult. It is worth noting that nursing has been one segment where all member states have imposed language requirements, and 9 require foreign nurses to pass national licensing exams, but it is also the only health profession in which mobility has been reported, suggesting that there is a lot of demand for nurses in the region.[45]

[42] Mendoza and Sugiyarto (2017)
[43] Yeates and Pillinger (April 2018)
[44] See, Kanchanachitra et. al (2011) and https://asean.org/?static_post=asean-mutual-recognition-arrangement-on-medical-practitioners-2 and Te et. al (2018), p.958
[45] Mendoza and Sugiyarto (2017)

Progress has been affected by issues of regulatory setup and capacity. There is no centralized implementation mechanism for MRAs. In some cases, there is no separate council or MRA, as in the case of midwives and thus recognition issues remain uncertain.[46] Regulatory capacity is constrained by insufficient funding, inadequate legislative frameworks, frequent turnover of staff responsible for the MRAs, lack of inter-sectoral co-ordination among the professional bodies and relevant government agencies, and limited data collection and sharing within both the country and the region.[47] It has been observed that there is a complex array of, and overlap between, the various health professional regulatory bodies in some of the countries and the limited public and political support which creates difficulties adapting domestic policies and regulations to meet the MRA requirements. Further, as the recruitment process in these countries is largely under the control of private sector and not the governments, coordination has been difficult.[48]

Another factor has been resistance in some member states to making changes in their medical qualifications which has hindered progress. National associations have seen the ASEAN Qualifications Framework as a threat to jobs for domestic professionals if it results in greater in-migration from the rest of the region. At the same time, there is also concern in several countries about the likely loss of health professionals if there is migration to other countries in the region.[49]

Harmonization efforts have also been constrained by the lack of proper health workforce data particularly in countries like Cambodia, Lao PDR, Myanmar and Vietnam. It is difficult to collect data from private organizations. There is no central body in ASEAN which can track the surplus and shortage of healthcare workers in all member states and migration flows within and from the region, preventing evidence-based regional integration efforts.[50]

Other factors have also been responsible for the slow progress. Disparity in economic conditions among the member countries, the tilting of immigration opportunities towards Singapore, and unemployment concerns in some of the member countries have thwarted regional integration efforts. There have been several gaps, including the lack of coordinated strategic human resource policy, failure to leverage technology for training and tracking worker flows, failure to ensure timebound implementation of the AEC, and lack of understanding of the labour markets in the region. It has been observed that lack of a deeper intra-ASEAN social and cultural understanding among healthcare workers has hurt progress. Experts believe that common licenses for practicing medicine would be difficult to attain in this region given the differences in language, culture and quality of medical education.

Overall, the signing of MRAs has not led to the harmonization of licensing, registration and training, and prior work experience requirements in the ASEAN region. The impact has been minimal.[51] The ASEAN experience shows that MRAs alone cannot be sufficient for facilitating regional mobility of healthcare professionals. They require the support of trade agreements and immigration policies. While the MRAs have provided a framework for aligning the qualification of workers to promote mobility, they have not

[46] Cambodia introduced a 1-year midwifery program in 2003 and students who were recruited to the program needed to have Grade 7 education, which was later changed to Grade 10. Since, there is no separate council or MRA on midwives, it remains uncertain if the midwives council in Cambodia can recognize the midwives from other member states.

[47] "Mendoza and Sugiyarto (2017)

[48] Chia (2011), pp. 264-265

[49] Indonesia resisted changes to its medical degree because of possible competition from foreign nationals. It has also expressed concerns about migration of its best doctors to Malaysia and Singapore. Philippines has imposed constraints on foreign doctors applying to the country.

[50] See, Te et. al (2018), pp. 962-63

[51] See, Kittrakulrat et. al (2014) and Te et. al (2018), p. 962

served as a cross-migration tool. As noted in Mendoza and Sugiyarto (2017), "M*RAs appear to be the main tool for skilled labor mobility in ASEAN. However, negotiating for recognition is a complex and time-consuming process given the wide differences in development levels among ASEAN countries…"*[52] However, the ASEAN member states consider the full implementation of MRAs as crucial for development of AEC (ASEAN Economic Community) despite these challenges. Moreover, lack of data among member states regarding the health labour force has prevented monitoring the implementation of the MRAs.

There have been several suggestions to promote mobility in the region. These include introduction of ethical codes for recruitment, improved retention policies, efficient bilateral agreements[53] and a special temporary ASEAN visa that allows migration and timely return. There also needs to be a strong check on the training being provided to migrating medical professionals, particularly in countries like Philippines and Indonesia where private organizations train health professionals for out-migration. There is a need for region wide collaboration on training, health workers' production and employment capacity and exchange of best practices. Since private providers are involved in training, service delivery, and recruitment, strong oversight and harmonization is needed to promote intra-region mobility. This also requires greater coordination between Ministries of Trade and Ministries of Health and Education as proper implementation of these MRAs requires support from broader trade and migration policies and political commitment. [54]

3.5 South African Development Community

The SADC whose members comprise of Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe, has taken some steps to facilitate intra-regional exchange of health professionals and promote South-South migration. The WHO regional committee prepared a paper to implement a regional health strategy for the region. Six priority areas were identified as necessary for developing an effective health strategy: human resource policy; education, training and skills development; human resources management; managing the migration of skilled health personnel; advocacy; and resource allocation.[55]

In this regard some progress has been made towards developing a regional qualification framework in 2007 and the establishment of centres of specialization in 2009. The aim is to promote intra-regional mobility via exchange programs. Some of the policies the SADC is working on include, sharing research tools, harmonization of key indicators and managing demand and supply of health workers. The SADC Ministries have also called for annual reporting on policies related to recruitment and training of health professionals, managing information systems for HRH and tracking health professionals. SADC has also developed a concept paper on brain drain and skill circulation to be implemented.[56]

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[52] See, Te et. al (2018), p. 960

[53]See, Taylor and Dhillon (2011), Kanchanachitra et al. (2011), Arunanondchai and Fink (2007)

[54] See, Te et. al (2018), p. 962-63

[55] The WHO paper discussed the roles and responsibilities of the member states and the WHO. It recommended countries to foster the retention of health workers, to provide financial resources and to undertake the implementation of policies. The day-to-day management was to be the responsibility of a national human resources development division while the WHO would provide technical support and establish a task force to give advice on mobility issues. The paper also called for monitoring of indicators to track regional and individual country level progress. See, Pagett and Padarath (2007), p. 21

[56] See, https://assets.aspeninstitute.org/content/uploads/files/content/images/health%20worker%20retention%20in%20east%20and%20southern%20africa.pdf, pp. 5-6

One area where the SADC faces a lot of challenges is in the veterinary domain because of the poorly distributed veterinary workforce. The mobility of veterinary professionals is hindered because of different training and registration requirements in the region. A workshop was organized in Johannesburg in South Africa in 2017 to discuss MRAs related to harmonization of training and subsequent registration by veterinary boards. The requirements for ensuring the quality of VSBs (Veterinary Statutory Bodies) were discussed, namely, registration and licensing of veterinary professionals, recognition of diplomas and enforcement of compliance through a code of conduct. Other issues discussed included standards and guidelines as laid down by the OIE (World Organization for Animal Health), core curriculum requirements, MRAs, and building IT systems to support VSBs. Additional steps were also discussed including establishing an electronic forum for VSBs in South Africa, review of applicable legislation and regulations in light of the OIE specified competencies, and sharing procedures for policies, reports and other applicable information and best practices. A working group consisting of registrars of some countries was established to work on the harmonization of skills.[57]

The case of SADC indicates that the focus of regional harmonization efforts has been on training and sharing of information, guided by research and analysis. The role of multilateral bodies is explicit with the WHO providing the background and technical support for some of the harmonization efforts. There are also domain specific initiatives within the health sector. This is also one of the few cases where there is an effort to use management information systems and digital platforms. But once again, visa related streamlining and ethical recruitment or its enforcement do not seem to be major focus issues in these regional efforts.

3.6 European Union

The EU has taken several steps to facilitate the recognition of qualifications of health care workers and their intra-regional mobility through regional harmonization initiatives. The Directive 2005/36/EC subsequently amended by Directive 2013/36/EC, governs the recognition of professional qualifications in the EU. This directive allows for the free movement of doctors (general practitioners and specialists), nurses, midwifes, dental practitioners, pharmacists and veterinary surgeons making the labor markets for these professions flexible. These professions fall under the 'automatic recognition' system of EU qualifications due to the presence of harmonized minimum training conditions. However, licensing is still the prerogative of the professional bodies of the respective countries and the process for recognition of qualifications is not actually automatic, varying from country to country depending on administrative requirements. Countries carry out a check on personality, qualifications and the source registry. For example, the process may require certified copies of documentation which can be difficult to obtain. For health workers coming from EU 12, pre-harmonization and years of experience can lead to recognition of a specific qualification. But for other health workers whose qualifications are not regulated, a case-by-case approach applies as in the case of non-EU workers. Additionally, the directive sets the rules for temporary mobility which allows professionals who wish to establish themselves in other EU countries, based on an advance declaration.[58]

There are several institutional mechanisms and rules to help implement this directive. A regulatory committee helps the European Commission in implementing the directive and a group of coordinators monitors the policies concerning the qualification of these professionals. The group of coordinators appointed by national authorities facilitates cooperation between the national authorities and the European Commission. There is also a Code of Conduct which lays down a common set of rules based on which national authorities decide if they should recognize the professional qualifications obtained in other EU

[57] See, http://www.rr-africa.oie.int/en/news/20171116.html
[58] See, https://ec.europa.eu/growth/single-market/services/free-movement-professionals_en and http://www.icsintegrare.org/wp-content/uploads/2016/02/Regulation-and-licensing-of-healthcare-professionals.pdf, p.11

countries.[59] The EU also has an Internal Market Information System (IMI), which is an official, multilingual channel that allows communication between the authorities and between professionals and authorities and enables the authorities to cooperate with each other while making decisions regarding the recognition of professional qualifications. The European professional card (EPC) for general care nurses, physiotherapists and pharmacists, an online certificate issued for the recognition of qualifications, is based on the IMI. The authorities can also use the IMI as an alert system to warn about professionals with false degrees or who have been prohibited from practicing in the health sector. This is an important element that allows regulators to trust each other and promotes cross-country coordination. However, usage of IMI is voluntary.[60]

Ethical recruitment in vulnerable sectors such as healthcare has been an element of the EU's intraregional policy on migration. There is an Action Plan on health workforce, which promotes compliance among its member states with the WHO Global Code on international recruitment of healthcare professionals. The Plan aims to deal with the effects of free movement of health care workers, such as the fact that health professionals perform tasks much below their actual skill level when they move within EU and that movement to countries offering better opportunities can deepen inequalities within EU. Under this plan, a Joint Action program has been initiated in health workforce planning and forecasting to support EU Member States in their retention policies by facilitating the adoption of good practices that follow the WHO code. The EC has identified the need for bilateral and EU level solutions, regional incentives, cooperation between medical training institutions, investment in language training, and data cooperation among regulatory authorities to improve retention, reduce bran drain and promote circular mobility.[61]

The EU, however, faces several problems with its harmonization initiatives. For instance, the mentioned Directive discusses the hours of training but not the content of training. Medical diplomas acquired in Romania, though recognized in France, are not considered equivalent to medical diplomas in France. This implies that the health professionals are not able to practice at the same level, notwithstanding the automatic recognition clause. Thus, even though the Directive allows recognition, getting a license and practicing might be a challenge for the health professional in other member countries. One ambiguity with the Directive is whether professionals should be recognized even if they do not know the language of the receiving country. For instance, Ireland refuses nurses from Eastern Europe because of language problems. More recently, competency in language practice has been included as an additional consideration in the regulation.[62] There have been other challenges with harmonization efforts. For example, the working time directive harmonizes the working hours of all salaried employees but has not been fully implemented because it would require most countries to recruit a lot more doctors and its full implementation could reduce the earnings of a doctor encouraging him/her to look for options elsewhere. This has happened in Sweden. The working time directive led to a reduction in number of work hours of doctors and a subsequent shortfall of health workers, particularly dentists. In Lithuania, imposing a work week of 38 hours is not practical as most doctors work in more than one medical institution. Such an imposition would lead to doctors looking for medical opportunities outside the country. It could also have a negative impact on the skills of doctors who are undergoing training because of limited working hours.[63] Overall, different recognition and licensing processes have emerged across member countries to deal with health professionals from other member countries, although there is harmonization in principle and considerable intraregional mobility of healthcare professionals.

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[59] If professionals face a problem in the recognition of their qualifications, they can approach the SOLVIT network, national courts, public authorities or as a last resort, even the European Commission to resolve their problem.
[60] See, https://ec.europa.eu/growth/single-market/services/free-movement-professionals_en
[61] Kovacs et. al (2017)
[62] https://publications.iom.int/fr/system/files/pdf/mrs48_web_27march2014.pdf, pp. 39-40
[63] https://publications.iom.int/fr/system/files/pdf/mrs48_web_27march2014.pdf, p.41

3.7 Other regional arrangements

In addition to regional blocs, there are also regional networks and arrangements outside of formal regional integration agreements which address the intraregional mobility of health workers. Some such examples include the Regional Network For Equity In Health In East And Southern Africa (EQUINET),[64] the Pacific Code of Practice for Recruitment of Health Workers in the Pacific Region' to provide a framework for better managing the loss of skilled health workers through migration, the African Health Professions Regulatory Collaborative (ARC) launched in 2011 to support countries in East, Central, and Southern Africa, and the New Partnership for Africa's Development (NEPAD) Health Strategy which prioritizes human resource development and retention and migration strategies in health services. The following discussion provides a brief review of the Pacific Region and progress in implementing the Pacific Code of Practice.

3.7.1 The Pacific Island Countries (PICs) and the Pacific Code of Practice

The 15 countries of the South Pacific region face daunting challenges to their prevailing living conditions and lifestyle in the near future. The region is suffering from a serious human resources for health crisis. Statistics indicate very high rates of emigration from the region and the significant magnitude of brain drain from the region, with a large proportion of health workers (nurses, midwives, doctors) practicing outside the region, in some cases as many as those working in the source countries. There is also intraregional migration of health workers. There is a flow of Fijian nurses to the Marshall Islands, Palau and Nauru, a small but steady flow of nurses from Vanuatu to the Cook Islands, and of SHWs, including doctors, from the Solomon Islands to the Cook Islands. Other examples include nurses from the Solomon Islands working in the Marshall Islands and Vanuatu and the relocation of health personnel following extensive recruitment by American Samoa throughout the PICs (especially from Fiji and Samoa). The Human Mobility Report notes that much of what does occur is often related to education and training, with sizeable flows from some PICs (including Cook Islands, Samoa, Solomon Islands and Vanuatu) to the University of the South. Increasing SHW shortages within PICs have encouraged intraregional movement, with those countries offering higher wages and better working conditions becoming destination countries.
Out-migration and intraregional migration of health workers (driven by climate concerns, lack of employment and career advancement opportunities, and economic prospects) has resulted in shortages of particular categories of health personnel, difficulties in retaining health workers at both regional and national levels, and an uneven distribution of SHWs within countries for most PICs. There are reported vacancies for doctors, nurses, medical specialists, medical laboratory staff, radiologists and other allied health professionals.[65]

Within the region, there is little evidence of regional harmonization efforts and political commitment from source and destination PICs to stem the outflows and to better manage health worker migration among the countries.[66] A recent assessment of the progress with implementing a human resources plan in the Federated States of Micronesia for the recruitment and retention of health workers has highlighted several policy areas where regional efforts are needed. These include the promotion of distance technologies for health workforce training (which was "partly realized" with the creation of distance learning laboratories in each of four states) and "pre-service" hiring of trainees (the practice of hiring unskilled employees into the health service and then training them in the necessary skills), which has been attempted to some extent in certain

[64] This network has been established through Health Systems Trust (HST) South Africa and University of Namibia, Namibia in co-operation with the Regional Health Secretariat East, Central and Southern Africa (ECSA-HC)
[65] Asante, Roberts & Hall (2011) and Doyle and Roberts (2013)
[66] In some countries, like Fiji, retention and health human resource management strategies have been effective. There is a reduction in the number of nurses migrating overseas due to efforts by the government to address the push factors, such as improving working conditions, providing a well-defined career path for nurses, providing more training opportunities at home and abroad. Political commitment

states.[67] Available evidence reveals that although training has a major bearing on migration flows of health workers, coordination has been lacking in this regard among the PICs. The countries have their own robust registration and licensing system for medical health professionals coordinated by their specific councils but as a region, there is to date no well-defined common system for accreditation, licensing and registration in healthcare. Only recently, is a regional system for accreditation and recognition of qualification being considered and the South Pacific Board of Educational Assessment (SPBEA) is working towards developing a regional qualification framework.[68]

As regards other governance frameworks and their implications for the region, as Australia and New Zealand (NZ) play a key role in shaping the human resources for health conditions in the Pacific, the Commonwealth Code of Practice for the International Recruitment of Health Workers (2003) and the Pacific Code of Practice for Recruitment of Health Workers (2007), involving these two destination countries are relevant to the PICs. Both these codes were designed to guide countries in the ethical recruitment of SHWs and recognize the negative impact of international recruitment and the migration of SHWs on source countries. However, as their coverage is geographically limited, it is difficult to engage destination countries which are not part of the Commonwealth or located within the Pacific region.

Studies note several areas where harmonization efforts are needed among the PICs. These include introducing a uniform registration and licensing requirements in the region through collaboration among the national councils of member countries to promote health worker mobility. There is a need to define common competencies for each profession keeping in mind the region's requirements. Medical programs in the region need to be mapped to determine the supplementary training requirements needed to enable health professionals to practice anywhere in the region. To augment capacity, a simplified visa and registration requirements have been proposed for professionals who already have a license to practice in countries with a well-established accreditation system (based on international experiences of such countries) along with additional training/bridging requirements for those professionals having licenses in countries without a proper accreditation system and to enable practice in another country in the region in a specific practice domain and for a specific period of time. A common examination or internship for the region has also been proposed. There is a need to review the current systems and agreements in PICs to identify the scope for improving the licensing and registration mechanisms and to develop a regional mechanism. These efforts will require political commitment by the individual countries as well as financial and technical support to implement the harmonized regulations, given the varying capacities of countries in the region.

4. Key Learnings and Recommendations

The preceding review of the evidence indicates that many regional groupings have focused on ensuring the sustainability of national and regional healthcare systems. Recognizing the interdependence among member countries in ensuring adequate health worker capacity and standards given significant intraregional flows of workers, these blocs have undertaken many harmonization initiatives. The latter have largely addressed aspects such as mutual recognition of qualifications, agreement on common training, screening, licensing and registration requirements, and sharing of information and best practices. The evidence suggests that the outcomes vary across regions in terms of fostering intraregional mobility, return and reintegration of health workers and stemming outflows from the region to ensure sufficient health worker capacity. Market dynamics continue to be the main driver of these flows as there have been difficulties in implementing these regional harmonization initiatives due to national concerns about undermining of sovereignty, local resistance, delays in enacting supporting domestic legislation, weak institutional and regulatory capacity,

[67] http://digicollection.org/hss/documents/s19240en/s19240en.pdf
[68] See, Kimm et. al (2013), p.13

and the persistence of pull and push factors in sending and receiving countries. Thus, while in principle these efforts have been well directed, in implementation they have been lacking.

In terms of ensuring ethical recruitment and undertaking efforts to regulate hiring, return and reintegration in source countries, to monitor and track flows within and outside the region, to map the needs of health systems within the region with available resources in the region and to frame visa, work permit and registration systems accordingly, there appears to be less focus. Harmonization is largely focused on education and training policies and attempts at standardizing credentialing, qualification requirements, curricula, etc. However, the next steps in terms of linking the harmonization of standards to immigration procedures and facilitation mechanisms for selected health workers, or ensuring that intraregional mobility is mutually beneficial, that skills and capabilities are utilized effectively on return, or putting in place systems to enforce return and reintegration in source countries and to prevent the intraregional recruitment of health workers who are in short supply in sending countries, are lacking on the ground (though they may be mentioned as part of the regional strategy). The link between the efforts being made with retention of health workers and addressing the pull and push factors is indirect.

The regional examples also highlight the fact that despite attempts at regional harmonization of qualifications, more needs to be done to reduce the dispersion in the power of regulatory authorities which determine curricula and licensing requirements as well as to reduce the significant variation in second language skills and levels of basic education that currently prevails among the health workforce within regions. This will require exchange programs and capacity building in language, more regulatory cooperation among licensing and credentialing bodies, the institution of bridging programs among countries in a region and the creation of networks among regional stakeholders.[69]

There are important parallels between the guiding principles and overarching goals of these regional initiatives and the WHO's Global Code. The latter has provided a useful guiding framework and starting point for regional frameworks that regulate health worker mobility. However, the evidence suggests that there is a lot more scope for the WHO to play an active supportive role at the regional level. There is a natural synergy between the WHO's Code and regional processes. Article 5.2 of the Code calls upon member states to use the code as a guide when entering into bilateral, regional or multilateral arrangements to promote cooperation and coordination on the international recruitment of health personnel. The focus areas mentioned in the Code, including recognition of health personnel, support for training in source countries, retention strategies, technology and skill transfer, and support of return and integration of health workers, are also important focus areas under regional harmonization processes. There is thus a natural entry point for the WHO to provide technical and institutional assistance to facilitate the implementation of regional harmonization initiatives. A few areas for action are outlined below.

1. The WHO could provide greater attention to harmonization processes being undertaken by various regional groups and could coordinate with the regional secretariats to help them implement their strategies. This could include providing guidance on the development of a monitoring system which keeps track of the number of health professionals being recruited, their details, their location, etc., what should be the features of this system, how should it be coordinated, and other implementation related assistance. The system of National Health Workforce Accounts developed by the WHO can be used for this purpose. Alongside, regional blocs and individual member countries will need to commit to monitoring health worker flows, collecting data, and developing such monitoring and data sharing mechanisms. In other words, the Code should move beyond being a set of principles and guidelines to offering actual guidance on mechanisms and processes which is further supplemented by a pro-active assistance by the WHO in instituting these processes at the regional level. Overall, the relevant provisions of the Code can be used by the WHO to strategically

[69] Rietig and Squires (March 2015)

engage with regional, bilateral, and multilateral trade agreements, so as to facilitate the adoption of more liberal commitments on mode 4 in health services under the GATS and to help guide the discussions on mutual recognition and harmonization of domestic regulations under the GATS.

2. The use of digital platforms and a digital strategy for tracking and monitoring health worker migration within the region and with the rest of the world, could significantly enhance the effectiveness of the Global Code. The review of evidence showed that only a few regional blocs (e.g., EAC) have launched regional Management Information Systems initiatives. Digital mapping and Data Management systems across the Region can be used to capture data about supply and demand conditions, registration of health professionals, and transition and movement of workers within and outside the region. Such information if available on a real time or regularly updated basis can be used to coordinate regional efforts in designing training and exchange programs for health workers, internships, return and reintegration into national health systems, focused programs and targeted interventions for specific categories and skill sets where there are actual or projected shortages and address the pull and push factors. Digital efforts in turn would require coordination across multiple agencies and government departments, including the Ministries of Health, Education, professional councils and associations and immigration authorities, and private recruitment agencies and intermediaries. Such an effort would also help in bringing some control over the private recruitment process and inclusion of these systems into the regional schemes, which is often lacking in current harmonization efforts. The WHO can again play an important role in bringing together different stakeholders and through its own data collection and digitization efforts.

3. There need to be more evidence-based harmonization efforts. Comprehensive regional health reports are needed which map demand and supply conditions, which determine the actual effects of intraregional as well as extra-regional migration flows on the regional and national health care systems, and which capture the status of different categories of health workers in terms of the numbers trained, accredited, registered at home and in other countries of the region, specializations, qualifications, etc. and project trends for the region and for individual countries. In a few cases, there is evidence of such background research work which has guided the framing of regional strategies. The WHO can help by conducting such studies, analyzing the findings, ensuring that the findings are reflected in regional policies and strategies and providing a platform for regional blocs to exchange such research findings and best practices.

The above lists just a few steps that could be taken at the national, regional, and multilateral levels to support the harmonization process for mobility of health workers. These are not independent steps. For instance, digitization efforts can help enrich the evidence base for framing regional policies and can enable better implementation of the Code. WHO efforts to provide guidance on implementation mechanisms and associated technical assistance could also include supporting more research and background studies that provide the evidence base. Finally, it is important to recognize that national and regional policies which address the push factors and enable retention will remain the most important for managing human resources for health.

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