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Chapter 13

Policy responses facilitating mobility or mitigating its negative effects: national, EU and international instruments

Sherry Merkur

13.1 Introduction

When considering health professional mobility, the international and European landscape must be considered alongside national policies and guidance. Two types of instrument will be identified and discussed in this chapter: (1) tools which aim at mitigating potential negative effects of migration in sending countries, which are non-binding; and (2) instruments which aim at facilitating mobility/migration and are binding. The former includes codes of practice, guidance and policy statements related to the ethical recruitment of health professionals, which started to emerge at the national level around 2000 and have also been produced by professional bodies and other institutions. Since then, some countries have provided guidance to their national health system and health employers. On the supranational level, the European Health Policy Forum (2003) recommendations on the mobility of health professionals, the European Commission's Green Paper on the European Workforce for Health (European Commission, 2008b) and the *WHO Global Code of Practice on the International Recruitment of Health Personnel* (WHO, 2010a) have taken discussions on ethical recruitment to an international audience. The second

group, tools that facilitate mobility and migration, includes EU legislation and GATS (WHO, 1995), which allows for a freer flow of service workers (mode 4) and has the potential to be used for health care professionals. Within the European Single Market, health professionals have the freedom to move and to provide services in another Member State. The Directive on the recognition of professional qualifications has been undergoing modernization since 2011 (European Commission, 2011b), and the various stakeholders have different perspectives on the proposed changes.

This chapter is intended to provide a detailed exposition of the evolution of national and international instruments that relate in different ways to the mobility of health professionals. The focus is mainly on EU Member States for the national instruments, but organizations around the world are included under the international instruments presented in Table 13.1.

The material for this chapter was compiled using searches of the literature. Articles needed to have been written in the English language and relate to health professional mobility, international ethical recruitment, and instruments, codes of practice, guidance or policy statements. Preference was given to peer-reviewed articles in well-respected journals, although literature and web sites from relevant professional bodies, associations, organizations and ministries (the "grey literature") were also considered. The main limitation of this chapter could be that sources in languages other than English were not considered.

The first section maps national codes and global instruments that aim at mitigating the potential negative effects of migration in vulnerable countries. Following this, the tools that focus on facilitating the mobility of health professionals are presented: the relevance of GATS to health services and personnel, and the importance of the recognition of professional qualifications in the EU to support mobility.

13.2 Ethical international recruitment: mapping national codes and global instruments

Recently, many developed countries, including some in Europe, have been undertaking large-scale, targeted international recruitment efforts to address domestic shortages. Although working abroad can benefit recruited health care professionals in terms of enhancing professional experience and a chance to increase their quality of life, concerns related to the impact upon the health systems of developing countries also need to be addressed. Emigration is thought to be one cause of skills shortages in developing nations, the "brain drain" (Wiskow, 2006; Robinson, 2007). This phenomenon has led to calls to protect developing countries' health systems from losing their skilled health personnel.

Table 13.1 Selected European and international instruments for ethical recruitment, presented chronologically

Instrument	Aim	Organization	Date Adopted	Type
International Council of Nurses (2007): *Position Statement: Ethical Nurse Recruitment*	Call for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices	The International Council of Nurses represents more than 130 national nurses associations	2001, revised and reaffirmed in 2007	Position statement
World Organisation for Family Doctors (2002): *A Code of Practice for the International Recruitment of Health Care Professionals* (*Melbourne Manifesto*)	To promote the best possible standards of health care around the world; to encourage rational workforce planning by all countries in order to meet their own needs; to discourage activities which could harm any country's health care system	The World Organisation for Family Doctors has 120 member organizations (national colleges, academies or organizations concerned with the academic aspects of general family practice) in 99 countries	May 2002	Code
Commonwealth Secretariat (2003): *Commonwealth Code of Practice for the International Recruitment of Health Workers*	To discourage the targeted recruitment of health workers from countries that are themselves experiencing shortages; to safeguard the rights of recruits and the conditions relating to their profession in the recruiting countries	Adopted by the Commonwealth Health Ministers, representing 54 countries	May 2003	Code
World Medical Association (2003): *Statement on Ethical Guidelines for the International Recruitment of Physicians*	Calls for every country to do its utmost to educate an adequate number of physicians taking into account its needs and resources; a country should not rely on immigration from other countries to meet its need for physicians	World Medical Association represents physicians; members include 95 national medical associations	September 2003	Position statement
European Federation of Nurses Associations (2004): *Practice Guidance for International Nurse Recruitment*	Sets out the key considerations for ensuring both ethical recruitment and employment of internationally recruited nurses in Europe (based on the Royal College of Nurses *Good Practice Guidance*)	The European Federation of Nurses Associations represents more than 1 million European nurses	May 2004	Guidance

Table 13.1 contd

Instrument	Aim	Organization	Date Adopted	Type
World Federation of Public Health Associations (2005): *Ethical Restrictions on International Recruitment of Health Professionals from Low-income Countries*	Recommends health employers voluntarily adopt a code of ethics to judiciously manage the employment of health professionals from abroad, including not recruiting from developing countries (based on the United Kingdom's list of countries) unless a bilateral agreement is in place; governments should take an active lead by clearly requiring all public health services to adopt the code of ethics	The World Federation of Public Health Associations has 70 members including national and regional public health associations and regional associations of schools of public health	May 2005	Code
International Labour Organization (2006): *Action Programme on the International Migration of Health Service Workers: The Supply Side*	Presents the ceding nation's perspective on the management of health services migration that could be shared with other supplying countries	The International Labour Organization (ILO) is a United Nations tripartite agency with government, employer and worker representatives and 185 Member States	2006	Action programme
World Dental Federation (2006): *Ethical Recruitment of Oral Health Professionals*	Calls on national dental associations to collaborate with governments to ensure that an adequate number of dentists are educated and licensed to practise; promote policies and strategies that enhance effective retention of dentists in their countries; promote strategies with partners to lessen the adverse effects of emigration; and encourage their governments to provide employment rights and protections equivalent to other oral health professionals in their countries	World Dental Federation represents more than 200 member national dental associations and specialist groups, covering more than 1 million dentists worldwide	September 2006	Policy statement
European Commission (2006): *Programme for Action (PfA) to Tackle the Shortage of Health Workers in Developing Countries 2007–2013*	To protect against health personnel shortages in non-EU countries	Economic and political partnership between 27 Member States	December 2006	Action programme

EPSU–HOSPEEM (2008): *Code of Conduct and Follow up on Ethical Cross-border Recruitment and Retention in the Hospital Sector*	To establish in the European hospital sector social dialogue a full commitment to promote ethical recruitment practices at European, national, regional and local level; fully implemented in EU Member States by April 2011	European Federation of Public Service Unions (EPSU) includes 8 million public service workers from over 250 trade unions and the European hospital and health care employers' association (HOSPEEM)	April 2008	Code
WHO (2010a): *Global Code of Practice on the International Recruitment of Health Personnel*	To establish and promote voluntary principles and practices for the ethical international recruitment of health personnel; to serve as a reference for Member States; to provide guidance for the formulation and implementation of bilateral agreements and legal instruments; to facilitate and promote international discussion and advance cooperation	WHO is the directing and coordinating authority for health within the United Nations and is made up of 194 Member States; its decision-making body is the World Health Assembly	May 2010	Code

Since 1999, codes of practice and other instruments for ethical international recruitment have been produced by countries, international organizations and professional associations with the aim to reduce the negative impact of health professional mobility on vulnerable health systems in developing countries. Codes may be directed at a particular health professional (e.g. nurses) or at the spectrum of health personnel and can have multiple aims, such as protecting specific countries from aggressive recruitment of their health personnel, ensuring that professionals are properly prepared for the job (e.g. participate in supervised practice) and protecting professionals from dishonest employers.

This section explores the codes, guidance and policy statements at the national, European and international level.

13.2.1 National codes of practice, guidance and policy statements

On the national level, some European countries have introduced codes of practice and other instruments to discourage the active recruitment of health personnel from developing countries and to promote recruitment via bilateral agreements. Examples are in place in England, Scotland and Ireland, while the Netherlands and Norway provide a clear policy stance.

The Department of Health in England was the first organization to produce an international recruitment guidance; this covered the NHS and was based on ethical principles, including being sensitive to local health care needs abroad. It was also the first to develop a robust code of practice for international recruitment (1999).[1] In its 1999 code on nursing recruitment (Department of Health, 1999), NHS employers were instructed to ensure that they did not actively recruit nurses and midwives from developing countries who were experiencing nursing shortages, in particular from South Africa or the West Indies. In 2001, the Department of Health widened the scope to discourage the recruitment of all health personnel from developing countries unless there was a formal agreement between the Department of Health and the country in question.

The Department of Health published the revised *Code of Practice for the International Recruitment of Healthcare Professionals* (Department of Health, 2004) to promote high standards of practice in the ethical international recruitment of health care professionals. It covered a wide range of health personnel including medical staff, nurses, dentists, radiographers, physiotherapists, occupational therapists and all other allied health professionals. The Department of Health also identified a list of developing countries from which health professional recruitment should be restricted (Box 13.1) (NHS

1 Earlier guidance was produced on the immigration and employment of overseas medical and dental students, doctors and dentists (Department of Health, 1998), recruiting overseas physiotherapists (Chartered Society of Physiotherapy, 1998) and international nursing recruitment (Department of Health, 1999).

Box 13.1 *Developing countries restricted for recruitment of health professionals*

In 2004, the English Department of Health identified 153 countries for restricted recruitment (Department of Health, 2004). Since then, a few countries have asked to be removed from the list, including all Indian states (except the four that receive aid from the Department for International Development), China (except in small rural areas), Pakistan (for a period of time) and the Philippines (except the United Kingdom can recruit registered nurses and other health care professionals that are regulated by appropriate professional bodies in both countries, e.g. physiotherapists, radiographers, occupational therapists, biomedical scientists).

This list is dynamic such that NHS Employers have been charged with reviewing and updating the list over time (NHS Employers, 2013).

Employers, 2013). This edition further applies to recruitment through agencies of temporary/locum health care professionals as well as permanent staff and also applies to all health care organizations, including the independent sector.

Compliance with the Code was required if recruitment agencies were to act on behalf of the NHS, and recruitment agencies were given one year to comply. A review of the new Code was planned for June 2011, but no additional information on this process was available at the time of writing. The NHS Employers web site (2013) provides information on organizations that comply with the Code. Additionally, the Department of Health provides further guidance on its web site and has also adopted a related code of practice for the supply of temporary staff (Department of Health, 2013a, b).

The Scottish Executive introduced a *Code of Practice for the International Recruitment of Healthcare Professionals in Scotland* in March 2006. The Code endeavours to guide Scottish health care organizations and recruitment agencies in ethical international recruitment practices; raise awareness of health worker migration and to mitigate the adverse effects; and set benchmarks to support the international health care professional by recommending robust induction procedures, mentoring support and provision of professional programmes (Scottish Executive, 2006). Furthermore, NHS Employers has a partnership agreement with the Scottish Executive to monitor arrangements for the Code of Practice.

Other countries, as discussed below, implement guidance rather than a formal code. For example, in Ireland, the Department of Health and Children recommended in 2001 that Irish employers only actively recruit (nurses and midwives) in countries where the national government supports the process (Department of Health and Children of Ireland, 2001).

The Netherlands' Ministry of Health, Welfare and Sport produced an action plan in 2007 called *Working on Care*. The plan stated that the recruitment of health workers from outside the EU should be a last resort and only undertaken when all institutions have extensively tried the other solutions nationally, such as retaining and training. The Ministry encourages employers to establish a code of conduct and not proactively recruit health workers from developing countries or from countries with their own health worker shortages.

In 2007, Norway developed a framework on global solidarity, where it pledged to refrain from recruiting health workers from developing countries (Norwegian Directorate of Health, 2007). Actions were proposed for three areas: balancing domestic capacity, targeting development assistance at measures to increase receiving countries' capacity for training and retention, and creating both national and international guidelines with mechanisms for compensation.

13.2.2 European and international instruments

Other efforts towards the international ethical recruitment of health professionals include initiatives taken by the EU and WHO. Additional instruments, including codes, guidance, policy statements, position statements and action programmes, by other organizations are listed in Table 13.1. Since 2000, there has been a surge of these instruments, which signals increased awareness about ethical considerations when recruiting health professionals from abroad. Professional bodies, including those representing family doctors, nurses, dentists and health workers, have all produced guidance, which principally cover three areas: (1) to limit the recruitment of health professionals from countries which are at risk of (or are already) experiencing a shortage; (2) to promote good recruitment and retention practices in these countries; and (3) to encourage rational workforce planning. There is great diversity in the signatories, such as trade unions, professional organizations and countries themselves (Table 13.1).

EU

The EU has recognized its responsibility to protect some non-EU countries from worsening health personnel shortages in several initiatives. In December 2005, it adopted the *Strategy for Action on the Crisis in Human Resources for Health in Developing Countries* (European Commission, 2005b), and in 2006, the *Programme for Action to Tackle the Shortage of Health Workers in Developing Countries (2007–2013)* (European Commission, 2006). Furthermore, the European Commission's vision for a common immigration policy presents approaches to avoid undermining development prospects of third countries by instead promoting circular migration (European Commission, 2008a).

Circular migration is defined as when a health worker moves to another country to obtain training or gain experience and then returns to their home country with improved knowledge and skills; however, the benefits of circular migration continue to be debated in the literature (Agunias & Newland, 2007). Following this, the 2008 *Green Paper on the European Workforce for Health* (European Commission, 2008b) trialled the possibility of a more broad-reaching EU-level code, but the European Commission has indicated that it will put this on hold until the *WHO Global Code of Practice* is assessed.

Specifically for the hospital sector, the agreement in 2008 between EPSU and HOSPEEM included a code of conduct and follow-up on ethical cross-border recruitment and retention (EPSU–HOSPEEM, 2008).

WHO Global Code of Practice

A resolution to adopt the voluntary *WHO Global Code of Practice on the International Recruitment of Health Personnel* was unanimously passed in May 2010 at the 63rd World Health Assembly (WHO, 2010b). The *Global Code of Practice* applies to all health personnel and to all WHO Member States.[2] It discourages countries from actively recruiting from poor nations facing critical staff shortages and also calls for countries that recruit staff from poorer countries to provide technical assistance, support and training of health professionals in those countries, although there is no explicit mention of financial compensation.

The Code builds on existing regional and bilateral agreements, memoranda of understanding and national and regional codes of practice, the collaborative work of many stakeholders, a public hearing and input from the WHO Executive Board. Intense negotiations in the Assembly included strong inputs from countries with both positive and negative net migration of health professionals, including Botswana, Brazil, Kenya, Norway, the Philippines, South Africa, the United Kingdom and Zambia as well as the EU (Zarocostas, 2010).

The *Global Code of Practice* is based on 10 articles that outline a range of issues, including guiding principles (article 2), health workforce development and health systems sustainability (article 5) and implementation of the Code (article 8). Emphasis is placed on the need for Member States to build on bilateral agreements and improve their workforce planning and retention of staff, with the aim of achieving a sustainable workforce. The key argument in the *Global Code of Practice* is that there is a need for Member States, where they are able, to take more responsibility for planning and meeting their staffing requirements from their own resources (WHO, 2011).

2 In 1981, the World Health Assembly voted to adopt the WHO's only other voluntary code of ethical practice, the Code of Marketing of Breast-milk Substitutes.

Although the Code is voluntary, WHO Member States are asked to periodically report on measures, results, difficulties, lessons and data on the international migration of health workers (see Chapter 5). The first report on the *Global Code of Practice* to the World Health Assembly was planned for 2013, with further reports produced every three years (WHO, 2010a).

13.3 Instruments facilitating the international free movement of health professionals

13.3.1 GATS

GATS is a treaty of the World Trade Organization that was created to extend the multilateral trading system to the service sectors. The General Agreement on Tariffs and Trade (GATT) provides such a system for merchandise trade. Before the World Trade Organization's Uruguay Round negotiations began in 1986, public services such as health care, postal services and education were not included in international trade agreements. As a result of the Uruguay Round negotiations, GATS entered into force in January 1995.

GATS may relate to health through its four modes of liberalization of trade in services.

1. Cross-border delivery of services: e-health (Oh et al., 2005).

2. Consumption of services abroad: health tourism.

3. Commercial presence: foreign direct investment in hospitals, clinics, insurance or contracts for such facilities, which can be a joint venture between foreign and domestic partners (Smith, 2004).

4. The presence of natural persons, as in the temporary movement of health professionals from one country to another.

GATS mode 4 deals with the movement of natural persons who supply services in the territories of other World Trade Organization members. Proponents of GATS argue that the Agreement has the potential to liberalize the temporary movement of people between countries, enhancing skilled people's knowledge and competence as well as raising their earnings. The GATS process claims to be one of "brain circulation" not "brain drain". However, an opposing view, specifically for public services, considers that professionals will move from vulnerable countries to richer countries, thus increasing the brain drain, even though GATS only applies to those working on a temporary basis. Also, through increased efforts towards privatization, governments could lose their ability to manage some public services. Opponents of GATS argue that it has the potential to push the privatization of services that are currently provided

by governments and minimize the ability for state regulation of health services (WHO, 1995).

There is little evidence of the effects of the Agreement on the movement of health workers (WHO, 2006). Smith, Chanda and Tangcharoensathien (2009) have emphasized the need for those engaged in the stewardship of a domestic health system to have an advanced understanding of how trade in health services affects a country's health system and policy, both now and in the future. Although mode 4 can relate to health professional mobility directly, the effects of European legislative frameworks are considered more important in the context of EU Member States.

13.3.2 The recognition of professional qualifications in the EU

In the EU, the mutual recognition of diplomas, certificates and other evidence of formal qualifications exists in order to assist the free movement of professionals throughout the EU. This upholds one of the fundamental freedoms of the single market – the right of EU citizens to establish themselves and to provide services anywhere in the EU.

Directive 2005/36/EC on the recognition of professional qualifications (European Commission, 2005a) facilitates the mutual recognition of professional qualifications and enables the free movement of health care professionals across the EEA. The intention is to make it easier for qualified professionals to practise their professions in European countries other than their own with a minimum of bureaucracy but with appropriate safeguards for public health and safety and consumer protection. The Directive was adopted on 7 September 2005 and was meant to be transposed into domestic law by Member States by October 2007; however, it was not until September 2010 that all 27 Member States had complied with the Directive (European Commission, 2010).

According to the Directive, individuals must submit an application along with documents and certificates to the competent authority in the host Member State. The authority then has one month to acknowledge receipt of the application and flag up any missing documents, and it must make a decision within three months after the full application has been received. Individuals are then entitled to use the professional title from the host Member State. However, if a profession is regulated in the host Member State by an association or organization, the individual has to register with or be approved by the professional regulator, council or chamber. For doctors, this means registering with, for example, the General Medical Council in the United Kingdom, Bundesärztekammer (the German Medical Association) in Germany, or Conseil National de l'Ordre des Médecins (the French Order of Doctors) in France.

The Directive provides for the harmonization of minimum training requirements and the automatic recognition of professional qualifications. Specifically for health professionals in the EU, Directive 2005/36/EC considered the so-called "sectoral" directives, which covered doctors, general nurses, midwives, veterinary surgeons, dental surgeons and pharmacists up until transposition.[3] However, the 2005 Directive went further to specify both the minimum number of years and the minimum number of hours for training doctors and general care nurses (the sectoral directives only specified the former).

Regarding transposition for the EU12, differences in training requirements have been largely compensated by recent professional experience – the acquired rights regime. Also, bridging programmes have been in place to upgrade qualifications, specifically for nurses and midwives who qualified in Poland prior to accession.

The revision process for Directive 2005/36/EC on professional qualifications

At the time of writing, Directive 2005/36/EC was under review by the EU legislators with a view to modernization (European Commission, 2011a). In March 2010, the European Commission initiated an evaluation process to review the Directive. Following a first report on national implementation (European Commission, 2010), the Commission launched a consultation process from January to March 2011 to gather suggestions for amendments to the Directive. Some 400 responses from competent authorities, professional associations (for medical doctors, nurses, pharmacists, dentists, etc.), the public and other stakeholder groups were collected. In June 2011, the Commission published its Green Paper on modernizing the Professional Qualifications Directive, followed by a legislative proposal at the end of 2011 (European Commission, 2011b).

From the Commission side, the proposed changes to the Directive as presented in the June 2011 Green Paper included the introduction of a European Professional Card, improved communication between Member States regarding information held on professionals, and modernizing automatic recognition. The underlying principle of all these changes is to make recognition of qualifications easier in order to make working in another Member State simpler and faster (European Commission, 2011b).

During the consultation, even between the different professional groups, similar challenges and potential benefits have emerged in several areas, including outdated standards for training, the lack of exchange of information between Member States on fitness to practise, the recognized potential of the Internal

3 Directive 2005/36/EC abrogated previous sectoral directives relating to the recognition of diplomas for the purposes of establishment from 20 October 2007.

Market Information system to facilitate information sharing between Member States; support for the assessment of CPD across the EU; and consideration of the language skills of health professionals crossing borders (Goodard, 2011).

Much of the discussion for doctors has focused on the need to move forward from simply acknowledging the length of professional training and rather to focus on competencies stemming from experience and ongoing professional development. Despite this apparently positive step, challenges remain with the Green Paper's proposals on key issues. First, the expertise of, and reliance on, "National Contact Points" for each Member State (who are meant to serve as a central point of access, and provide advice and individual assistance for professionals) is uncertain given the wide diversity of medical specialties. Next, although the need to demonstrate CPD in the home country is proposed, there remains huge diversity of requirements in different EU Member States (Merkur et al., 2008). Furthermore, some doctors have argued that rather than developing a new European Professional Card or similar system, thus increasing bureaucracy, the Internal Market Information system could be used to improve communication, such as providing alerts regarding individual doctors (Goodard, 2011).

For nurses, who are the single largest professional group affected by Directive 2005/36/EC, some wide-reaching positive effects have been observed since transposition, including extending the years of education for girls and women, with positive societal effects; providing an impetus to establish regulatory functions and authorities where they were previously lacking; and protecting the professional title of nurse. Nevertheless, concerns have been raised about the proposed increased reliance on, and competency of, the variety of regulators for nurses as well as acknowledging the importance of retaining and potentially updating the minimum content of nurse education and training (the Annex) particularly for the newer Member States (Keighley & Williams, 2011). For nurses and midwives, the Commission has proposed an increase to the minimum duration of general education from 10 to 12 school years, and the minimum training required remains set at three years.

From the perspective of the regulators and competent authorities, some specific challenges have been identified concerning the need to strike the necessary balance between protecting the public by ensuring professionals are appropriately fit to practise while being required to accept a professional's qualifications without being able to check their education, training, practical experience or language skills (Dickson, 2011). On the latter point, the General Medical Council in the United Kingdom has expressed concern as under Directive 2005/36/EC it is prevented from testing the language skills of doctors applying for registration from EEA countries even though international medical

graduates from elsewhere are required to show that they have the necessary knowledge of the English language to practise (Bruce et al., 2011). On this point, the Green Paper does flag the potential for language testing for doctors who have direct contact with patients.

Some regulators have also showed interest in increased sharing of information through the Internal Market Information system, which they consider a more cost-effective resource than the introduction of professional cards, particularly in relation to suspended doctors through the implementation of proactive sharing of information and obligatory alerts.

The European Council, in its conclusion of 23 October 2011, underlined that all efforts should be made to ensure agreement on the 12 priorities of the Single Market Act (to which a modernization of Directive 2005/36/EC belongs) by the end of 2012 (European Council, 2011). A few weeks later, on 19 December 2011, the European Commission released its legislative proposal (European Commission, 2011b). The Commission suggested simplifying the recognition and registration procedures for doctors from the EEA and increasing the use of e-government tools, such as the European Professional Card and the Points of Single Contact. The Commission identified the Internal Market Information system as having considerable potential to facilitate communication between competent authorities. In an attempt to combat public concerns about patient safety, the Commission proposed provisions on effective and proportionate checks of migrant health professionals' language knowledge and the introduction of an EU-wide proactive alert mechanism for professionals who have been banned from practice (Tiedje & Zsigmond, 2012).

In response to the Commission proposal, the European Parliament published two reports in July 2012 on the recognition of professional qualifications Directive from the Internal Market and Consumer Protection Committee (Vergnaud, 2012) and the Environment, Public Health and Food Safety Committee (Weisgerber, 2012). These reports put forward some amendments to the legislative proposal as follows: stronger recommendations for verifying language competence following recognition, slight increases to the deadlines for recognition under the European Professional Card, and the extension of an alert mechanism to all sectoral professionals. Furthermore, the Internal Market and Consumer Protection report proposed additional proportionate (post-recognition) controls on professionals if they had not worked for the previous four years. The two Committees plan to adopt their final reports in November 2012 and agree the final text by 2013.

It is expected that formal adoption of the modernized Directive will take place in 2013, with national transposition planned for 2015–2016 (Tiedje, 2011).[4]

13.4 Discussion

When examining the multitude of instruments to promote the ethical recruitment of health personnel, certain trends can be identified. These include:

- pressure by governments and professional organizations on employers to not recruit from developing countries, particularly those with health worker shortages, unless intergovernment bilateral agreements have been negotiated;
- the promotion of improved employment rights and protections by governments facing health worker emigration in order to retain their health personnel;
- pressure by organizations such as the Commonwealth and WHO on countries to focus on self-sufficiency and sustainability of their health workforce; and
- the need for monitoring uptake and adherence to guidance.

Taking each of the above points in turn: first, since 2000, a surge in the development of instruments can be observed, which signals the increasing importance placed by national bodies, governments and international organizations on the ethical dimensions of international recruitment. At the national level, it seems to be only northern European countries that are developing codes and other tools. Further, these ethical recruitment principles do not apply to mobility between EU Member States, but rather only to migration from outside the EU.

Second, governments can provide incentives for circular migration, such that agreed career pathways are determined so that when a migrant health worker considers returning to their home country there are relevant posts available and a salary level that reflects their experience gained abroad.

With regard to self-sufficiency and sustainability, the onus is placed back on to the countries themselves to work to achieve a sustainable workforce (Little & Buchan, 2007; Buchan, Naccarella & Brooks, 2011). Towards this

4 Since the writing of this chapter, Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System was published on 20 November 2013. Relevant features include: a pro-active fitness to practise alert mechanism; the ability for competent authorities to assess the language competence of professionals after recognition but before access to the profession; a requirement for member states to encourage CPD; the option of a European Professional Card; and continuing professional education and revised minimum training requirements for some health-care professionals.

aim, countries need to focus on workforce planning and retention of staff, in particular from their own national resources, where possible.

Finally, although many instruments recognize the need for monitoring uptake and adherence, very few can actually take these forward because of the voluntary nature of most codes. Few countries have codes of ethical recruitment in place, and many EU Member States rely on developments of the *WHO Global Code of Practice*. Furthermore, the EPSU–HOSPEEM Code of Conduct (2008) has received little attention on the national level. Only the Departments of Health in England and Scotland actually share prescriptive country lists for non-recruitment. Therefore, there are challenges facing whether these codes and other instruments actually work in practice. Because these instruments are voluntary, feasibility depends largely on the developed country adhering to the Code (Scott et al., 2004) given that incentives or sanctions for adherence or non-adherence remain highly unlikely.

The weakness of codes is also related to difficulties in implementing and monitoring them (Buchan et al., 2009; Connell & Buchan, 2011). To better facilitate implementation, more information needs to be disseminated to the competent authorities on the desired aims of any code of practice. Support systems need to be put in place; specifically, this may entail explaining to health care managers the practical application of the code for their organization. This can be achieved through additional written information or training. Moreover, because the implementation of voluntary codes of practice on a country level requires extensive systems development, countries in the process of major structural reforms are at risk (Martineau & Willetts, 2006). In countries with a federated regulatory structure or multiple independent sector providers, a single country code may not have the required reach. For developing countries, good visibility of codes is necessary for all stakeholders involved: policy-makers, employers and potential recruits (Buchan et al., 2009).

Despite the continued interest in developing these instruments, research is lacking on the effectiveness of implementation. Research in this area is particularly challenging because of the dynamic nature of health workforce recruitment patterns, which vary greatly over time.

Studies on the English codes have flagged up several obstacles in assessing impact, including lack of monitoring, inappropriate data sets and disentangling other reasons for the increase or decline of inflow of health professionals beyond the code (Buchan et al., 2009; Young, Weir & Buchan, 2010). Given these challenges, the potential impact of international codes remains uncertain. However, if a clear link is identified between the explicit objectives and relevant

monitoring capacity, then it may be possible to assess the impact of these instruments in the future (Buchan et al., 2009).

It is also important to highlight that there is additional difficulty when considering a multi-country instrument, as in the case of Europe or the *WHO Global Code of Practice*. A single country code only focuses on the approach of employers and one government, and it can be relatively straightforward to develop, adapt (where necessary) and monitor. However, where many countries are concerned, it can be much more difficult to get agreement, which poses a risk that the final code will be diluted to get universal support.

As the WHO tries to establish the *Global Code of Practice*, WHO Member States are invited to periodically report on its implementation. The first round of national self-assessment reports were to be completed by June 2012 (see Chapter 5). If there is a supervisory or monitoring system in place, then monitoring may be possible and it may create an incentive for countries to provide reports to international bodies. The challenges in attributing changes to the impact of a code are inherent in any code and not related to multi-country or global coverage.

13.5 Conclusions

Health professional mobility, whatever the net direction, is an important policy consideration in many countries. The need to recruit and maintain a qualified, competent and highly skilled workforce, which is up to date in its medical knowledge and fit to practise, is a relevant consideration in every country. Despite this uniform need, the methods by which health professional recruitment is carried out vary greatly.

Although there is increased acknowledgement in many countries of the need to undertake ethical recruitment when hiring medical staff across a border, there is great divergence in whether such efforts are governed by a direct code or through more subtle guidance. Overall, the instruments of international, national and professional bodies that aim at mitigating the potential negative effects of migration in sending countries are non-binding.

Health professional groups – doctors, nurses, dentists – are becoming increasingly vocal in stating their position on ethical recruitment. What was once a domain of national concern has now reached international attention, specifically with the launch of the *WHO Global Code of Practice*. This is an ambitious instrument that will require careful analysis of its success following its implementation and over time. Only longitudinal analysis, both quantitative (on the actual net change of health professionals departing from vulnerable

countries) and qualitative (on any changes in methods used for recruitment) will provide clarity on the effectiveness of such an instrument.

When considering binding tools that aim at facilitating mobility and migration, although GATS provides direct modes of liberalizing trade in services, which clearly relate to the health sector, it does not appear as a prominent mechanism or consideration in European health professional mobility. Rather, in the EU, the Single Market Act, within which the Professional Qualifications Directive sits, provides entitlements for health professionals to take up work in other EU Member States.

At EU level, the legislative process for modernizing Directive 2005/36/EC on the recognition of professional qualifications has been ongoing since December 2011. Clear vested interests became apparent in the position statements of various stakeholders during the consultation process on the Directive. Although there remains some divergence of opinion regarding specific points (e.g. the need for language testing, the need for a professional card), all stakeholders have declared that they are seeking an appropriate balance between protecting the safety of the public (through ensuring the provision of high-quality care by highly qualified health professionals), and further clarifying the requirements for health professionals to practise in a host Member State, and upholding the individual right to move within the EU.

The Internal Market Information system appears to be an underutilized resource for information sharing, but to realize its potential some improvements will be necessary in terms of the type of information and the way this can be shared in order to broaden its use among many national authorities. The use of pilot projects for interested professions has the potential to make some strides in this direction.

A significant divergence between EU Member States, for both doctors and nurses, is their stance on needing to encourage high-quality CPD. Whether such requirements are mandatory, and how often and how much CPD is required, remains a topic that requires additional attention and consideration at the national and then EU level. Next, on the issue of competent authorities, further development is clearly needed particularly in relation to the regulation of the nursing profession, and how the proposed National Contact Points can add additional clarity on the Member State level. As stated by the Commission, the modernization of Directive 2005/36/EC offers the potential for developing new approaches to enhance mobility, but countries and national authorities need to be mindful of how these movements can affect the structure of their domestic health workforce and of the implications of the new EU legislation for health professionals.

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