



Mobility of health professionals Between the Philippines and Selected EU member states: A Policy Dialogue

23 July 2013

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ACRONYMS

Ang NARS	Ang NARS Party list
CFO	Commission on Filipinos Overseas
CHED	Commission on Higher Education
DFA	Department of Foreign Affairs
DILG	Department of the Interior and Local Government
DILG-BLGD	Department of the Interior and Local Government-Bureau of Local Government Development
DOH	Department of Health
DOH –BIHC	DOH-Bureau of Health International Cooperation
DOH-HHRDB	DOH-Health Human Resources Development Bureau
DOH – HPDPB	DOH-Health Policy Development and Planning Bureau
DOH – NCPAM	DOH-National Center for Pharmaceutical Access & Management
DOLE	Department of Labor and Employment
DOLE – NRCO	DOLE-National Reintegration Center for Overseas Filipino Workers
DWAB	Decent Work Across Borders
EDI Staffbuilders	EDI Staff Builders Recruitment Agency
EU	European Union
HRH	Human Resources for Health
IHP	International health professionals
ILO Manila	International Labour Organization (Manila)
ILO-DWAB	International Labour Organization-Decent Work Across Borders Project
IRN	Internationally recruited nurses
LBC	LBC Recruitment Agency
NEDA	National Economic and Development Authority
NCRO	National Reintegration Center for OFWs
OECD	Organization for Economic Cooperation and Development
OFW	Overseas Filipino Workers
OWWA	Overseas Workers Welfare Administration
Pag-IBIG	<i>Pagtutulungan sa Kinabukasan: Ikaw, Bangko, Industria at Gobyerno</i>
PGEA	Philippine Government Employers Association
PHC	Philippine Heart Center
PhilHealth	Philippine Health Insurance
PNA	Philippine Nurses Association
POEA	Philippine Overseas Employment Administration
PPA	Philippine Pharmacists Association
PPTA	Philippine Physical Therapy Association
PRC	Professional Regulation Commission
PSLink	Public Services Labour Independent Confederation
SSS	Social Security System
TESDA	Technical Education Skills Development Authority
WHO	World Health Organization
WHO Philippines	WHO Philippine Office
WHO WPRO	WHO Western Pacific Regional Office

EXECUTIVE SUMMARY

The International Labour Organization (ILO), with support from the European Union (EU), launched the project Decent Work Across Borders (DWAB) that has brought together the sectors of government, workers, professional organizations, and recruitment agencies to promote safe and ethical migration of health-care professionals from the source countries of the Philippines, India, and Vietnam. Little information is available on the various aspects of health professionals' migration from inside the country of destinations, as well as from the country of origin. Acknowledging the importance of evidence, such as in policy sciences, the ILO-DWAB Project commissioned research projects that looked into the mobility of health professionals from their country of origin to the European Union, such as in the case between the Philippines and the United Kingdom.

The ILO-DWAB Project team organized the Policy Dialogue on 23 July 2013 at the Mandarin Oriental Hotel, Makati City on the theme "Mobility of health professionals between the Philippines and selected EU member states". This aimed at sharing the research results and to better understand the effects of health professionals' migration on the destination country and the migrants themselves, and specifically to draw policy implications and recommendations. This was attended by 71 representatives from the ILO's tripartite constituencies of trade unions, government and employers, as well as from professional organizations, civil society non-government organizations, recruitment agencies, and academia.

Four commissioned research projects were presented by the lead research experts, respectively. Reactors and participants gave comments on the research and suggested action steps for the ILO and its tripartite constituencies.

Ms Agnieszka Makulec, Researcher at the Centre of Migration Research, University of Warsaw in Poland, looked at the effects of the Philippine bilateral arrangements with selected countries. From the data Ms Makulec concluded that bilateral labour agreements should not be limited to recruitment, but also include protection and brain drain damage. Monitoring and evaluation are essential, without which bilateral agreements often fail. Ms Makulec highlighted the Philippines' "something is better than nothing" approach, where participants called attention to the need for further discussion on possible alternatives. In terms of circular migration, she pointed out that if there are possibilities, there are also challenges that need to be addressed, including social protection, access to training, and costs of circularity.

Dr Piyasiri Wickramasekara, former ILO senior migration specialist, presently Vice-President at the Global Migration Policy Associates, examined the effects of health professionals' migration on the labour market and health sector performance in destination countries. He analyzed data showing the critical migration policies in the United Kingdom and the United States and the conditions of the labour market, health sector performance, and quality of care in the United Kingdom. Important directions include critical and credible migration policies, transparency in the fitness of practice, collaboration between country of origin and country of destination, and social dialogue.



Dr Davide Calenda, from the Center of Advanced Studies, European University Institute in Turin, studied the working conditions of Filipino and Indian-born nurses working in Europe, particularly in the United Kingdom. From the data, it is now important to look into motivations, detachment, and desire for immigration and for the return to their home country among Filipinos and Indians as internationally recruited health professionals in the UK. The important considerations are the bilateral agreements, and the monitoring and implementation of the code of ethics to help migrants cope with their working conditions in the country of destination.

Professor Marilyn Lorenzo, from University of the Philippines Manila, looked at services currently available to skilled migrant workers in the Philippines to find possible gaps, and how these can be addressed. The study highlights these gaps and the recommendation for a network organization among the migrant service organizations. Important issues include the streamlining of the many services and the charge/non-charge of placement fee by recruitment agencies.

The policy implications and recommendations derived from the research and comments from reactors and participants suggest directions for the ILO and DWAB team and the ILO tripartite constituencies. For trade unions, there are roles for them to take such as advocacy, support, and organizing roles, which would help them support migrant workers rights, to look at organizational change, and be better able to organize and meet the needs for better working conditions in destination countries. Considering that “health is a public good”, government is identified as a crucial stakeholder in policy making, in forging bilateral agreements, and in monitoring and implementing bilateral agreements in the delivery of migrant services. For employers, such as hospitals, the important concern is for them to ensure decent work for the health professionals, and to care for the health of the health-care professionals. Efforts are underway to develop an ethical business model for recruitment agencies.

The Policy Dialogue concluded with prospects of new topics to initiate, such as on the ethical recruitment model and nursing education. Future steps also include bringing the research results to Europe, for the destination country stakeholders. The proceedings of this dialogue will also be shared with the participants.

In closing, the ILO-DWAB team expressed appreciation for all those that made the Policy Dialogue possible -- the EU in particular for its support, the research experts, reactors, facilitators, documentation team and staff, and participants.

BACKGROUND¹

ILO Mandates on Labour Migration

The ILO is the United Nations' (UN) international organization responsible for drawing up and overseeing international labour standards. It is the only tripartite UN agency that brings together representatives of governments, employers and workers to jointly shape policies and programmes promoting Decent Work for All.

The ILO is the UN agency with a constitutional mandate to protect migrant workers, upon inception in 1919 and re-affirmed by the 1944 Declaration of Philadelphia and the 1998 ILO Declaration on Fundamental Principles and Rights at Work. Since then, it has dealt with labour migration. It has pioneered several conventions, particularly Migration for Employment Convention, 1949 (No. 97) and Migrant Workers Convention, 1975 (No. 143) that gave guidance to policy and to protection of migrant workers. All ILO's major sectors -- standards, employment, social protection and social dialogue, have worked on labour migration within the framework of Decent Work for All. In 2006, ILO constituents adopted the ILO Multilateral Framework on Labour Migration. The non-binding principles and guidelines respond to the demands for practical guidance and action with a view of maximizing the benefits of labour migration for all parties.

With funds from the EU in 2011, the ILO launched the DWAB Project -- *A Pilot Project for Migrant Health Professionals and Skilled Workers*. This project seeks to better understand the schemes in line with circular migration of health professionals. This is done by engaging governments, trade unions, and employers around three main objectives:

1. to strengthen mechanisms of Policy Dialogue among stakeholders;
2. to strengthen employment services for health-care professionals and skilled workers; and,
3. to enhance labour market information with regards to the migration of health professionals and skilled workers.

Through this project, the ILO seeks to facilitate an approach to migration that benefits migrant workers, and the source and destination countries within a rights-based framework for labour migration management. The project focuses its activities on three Asian countries -- India, the Philippines, and Vietnam, which have significant outflows of health professionals and skilled workers for foreign employment.

Context for Policy Research and Dialogue

International migration is an increasingly pressing issue in a globalized world. The movement of health professionals between developing and developed countries for work has called attention to its social

¹ ILO Decent Work Across Borders, *Mobility of health professionals between the Philippines and selected EU member states, Policy Dialogue*, Mandarin Oriental Hotel, Makati City, 23 July 2013.



and economic effects. In the case of Filipino nurses, the demand for them to work overseas and migrate has encouraged many to take up nursing. The Philippines, India and Vietnam began pursuing cooperative agreements on hiring health-care professionals to various destination countries, particularly in Europe.

While migrant health workers are observed to contribute to the health-care sector of developed nations, their countries of origin are negatively affected. This has been referred to as “brain drain”. The international migration of health professionals has raised concern over the achievement of the health-related Millennium Development Goals (MDGs), which relies on strong and sufficiently staffed national health systems. Given these observations, sending and receiving countries have become interested in developing voluntary policies to facilitate the return of health-care professionals to their source country, with the aim to support their resuming active participation in the health workforce of their home country.

In this context, ILO-DWAB commissioned the conduct of research projects to document the various dimensions of the mobility of health-care professionals, aimed at bringing together policy-makers and stakeholders to discuss the best options to ensure that migration of health professionals result in benefits for all concerned. Four of these researches pertain to the movement of health professionals from the Philippines to Europe. The first Policy Dialogue, scheduled in the Philippines, will focus on these four research papers.

Initiating Policy Dialogue in the Philippines

The ILO’s DWAB Project organized the Policy Dialogue on the theme “Mobility of health professionals between the Philippines and selected EU member states” on 23 July 2013, at the Mandarin Oriental Hotel, Makati City. In convening this Policy Dialogue, ILO-DWAB intended to bring together the researchers of four commissioned research projects and the Philippine stakeholders to validate the research findings, to learn lessons, and to generate policy implications and recommendations on how to address the migration of Filipino health professionals to Europe.

A total of 71 participants represented various organizations from the sectors of government, trade unions, employers, recruitment agencies, health professional organizations, non-government organizations, international donor and development organizations, United Nations agencies, and academe.²

Of the ILO-DWAB commissioned research projects, four studies relevant to the Philippines were presented and discussed in this Policy Dialogue, namely:

- *The Effects of the Philippines Bilateral Arrangements with Selected Countries;*

² Attendance, ILO Decent Work Across Borders, *Mobility of health professionals between the Philippines and selected EU member states, Policy Dialogue*, Mandarin Oriental Hotel, Makati City, 23 July 2013.

- Assessment of the *Impact of Migration of Health Professionals on the Labour Market and Health Sector Performance in Destination Countries*;
- Investigating the *Working Conditions of Filipino and Indian-born Nurses in the United Kingdom*; and
- Assessment of *Existing Services for Skilled Migrant Workers: Philippine Project Site*.

In this Policy Dialogue, each researcher of the ILO-DWAB commissioned study presented the research and the policy implications extracted from their findings. Two to three reactors provided the discussion, followed by participants in the open forum. The four researchers in a panel gave their recommendations for ILO-DWAB's constituencies -- for government, trade unions, and employers.

Overview of Documentation Report

This documentation report contains the following sections:

- **Background:** Discussed at the start of this documentation report, the background presents ILO's mandate, the ILO-DWAB Project and the objectives of the Policy Dialogue.
- **Opening Messages:** This section presents the organizers' opening messages.
- **Research Presentation and Discussion:** This section has two parts:
 - Research Presentation: The main section highlights the key points in each of the researchers' presentations -- contexts, research questions, objectives, methodology, findings and data analysis, policy implications and recommendations.
 - Discussion: Following each research presentation, the documentation presents the comments from the reactors and the participants in the open forum.
- **Recommendations:** The practical steps for action recommended by the panel of researchers are summarized in the last section.

The documentation team has taken note of the following terms used but not defined in the research presentations:

- Human resource for health (HRH), health professionals, health-care providers, doctors, nurses;
- Migrant, international health professionals, immigrants;
- Sending country, source country, country of origin, home country; and
- Receiving country, destination country, country of destination.

OPENING SESSION

The Policy Dialogue began with the registration of participants, the national anthem, and the invocation led by Father Graziano Battistella of the Scalabrini Migration Center. Ms Liberty Casco, Deputy Administrator of the Philippine Overseas Employment Administration (POEA) and Mr Lawrence Jeff Johnson, Director, ILO Country Office for the Philippines,



as representatives of the partner organizations, gave the opening remarks. Ms Catherine Vaillancourt-Lafamme, Chief Technical Advisor for the ILO-DWAB Project gave the Policy Dialogue's context and program. Ms Jennifer Frances dela Rosa, National Project Coordinator, ILO-DWAB, as moderator, guided the flow of the day's sessions.

Philippine Overseas Employment Administration



On behalf of Mr Hans Leo Cacdac (Administrator of POEA), Ms Casco greeted colleagues from the government sector, officials of the ILO, visiting experts, and friends from the EU and governments of Denmark, Finland, Germany, Norway, and the United Kingdom. Other guests included officials from the World Health Organization (WHO) and the International Organization for Migration (IOM), representatives from trade unions, employer and recruitment agencies, professional associations, civil society and non-government organizations, and researchers and experts from the academe.

Ms Casco congratulated the ILO for organizing this Policy Dialogue. She proceeded to say that “we are in the age of migration” and that advances in information technology, and cheaper and faster means of communication, has enabled mobility and faster exchanges of information.

“The concept of the global village that was difficult to imagine decades ago is now easily illustrated by integrated economies, common labour markets, and shared natural resources,” she said.

Ms Casco pointed out that the societies’ demographics, whether young or old, show the need and growing demand for professional services all over the world. The question is whether the supply responds to the need. The mobility of workers and enabling environments to allow them to practice their professions is an answer to this question.

In the recent Country Migration Profile, the Philippines’ Human Development Index from 1980 to 2012 improved from 0.561 to 0.654. Ms Casco pointed out that the Philippines fared well in education and health components, but not in the provision of decent income, which is “inextricably linked to employment”. Since the Philippines is a country of origin of migrant health professionals, the need for access to better health-care services is countered by the needs of health-care providers to grow professionally and have gainful employment abroad.

Sharing the results of the WHO Policy Dialogue on International Health Workforce Mobility and Recruitment Challenges, which she attended in Amsterdam in 2013, Ms Casco mentioned the six conclusions in this dialogue.

First, HRH is a complex but dynamic phenomenon that requires a multi-stakeholder approach. Second, the WHO Code is necessary but not sufficient and requires more advocacy and information exchange. Third, the HRH face core challenges in the areas of recruitment, retention, productivity, and skills mix. Fourth, HRH mobility patterns are changing and integration of mobile workers should be planned, as

circular migration is not well defined, understood and evaluated. Fifth, the types and reasons for bilateral agreements vary but the real problem should be clear if they are to be the solution. Sixth, regional Mutual Recognition Arrangements (MRAs) are growing in prominence and enable mobility, but faces tension with national regulation in some areas.

Ms Casco saw the experts' discussion as parallel to the objectives of making decent work away from the workers' homeland achievable. In this dialogue, "we will get to appreciate" the evidence from the research on countries of destination in need of health services, the situation at the workplace, policy environments, and views of professional health workers as actors in the global demand and supply of health services. Learning from the situation of our workers, "we can contribute toward constructing an agreeable framework" that can respond to ethical recruitment, talent replenishment, health needs, aspirations of achieving decent work among migrant workers, and that can harness their potential in contributing to development.

Ms Casco encouraged everyone present to absorb as much information being shared and evaluate such with the view of improving current mechanisms for the mobility of workers, their standards for employment, and their physical conditions for working and living. After all, in a global economy where universal health care is desired, it is imperative to ask "who will heal the healer".

In closing, she expressed hope that information would not only be shared, but that concrete actions are sowed, and that participants would engage themselves in discussion in a constructive manner.

ILO Country Office for the Philippines



Mr Johnson acknowledged the presence of Ms Casco, Congresswoman Leah S. Paquiz of the Ang NARS Party list, the partners from government, employers and workers organizations, the representatives of recruitment agencies, professional organizations, non-government organizations (NGOs), the members of academe, and colleagues from the ILO, the WHO, and the IOM.

According to Mr Johnson, the ILO is supported by the EU in implementing the project "Promoting Decent Work Across Borders", which seeks to better understand circular migration of health professionals to Europe. This is done using the ILO tripartite structure to engage government, employers' and workers' organizations, as well as professional organizations and recruitment agencies. Their participation is crucial "to prompt sound research and Policy Dialogues. It is essential for the process to ensure that "recommendations on different dimensions of the migration process are discussed in an inclusive way for the benefit of all."

Mr Johnson thanked those present for their continued engagement since the beginning of the project. He pointed out that the Philippines is one of the top three countries sending nurses and health professionals abroad, and that labour migration occurs and persists because of substantial economic benefits to migrant workers and their families, and to countries of origin and destination. ILO brings

“stakeholders together to design means by which migration can take place in a safe and productive manner”.

Mr Johnson expressed support for the President of the Philippines on the position that “migration should be an option and not a necessity”, articulated in the Philippine Development Plan and the Philippine Labor and Employment Plan, which aims to achieve sustainable and inclusive growth through decent and productive work. According to Mr Johnson, the ILO and social partners strongly believe that migrants are less vulnerable when they are moving out of choice, and not out of necessity. The ILO has established the earliest international standards on migration to ensure a fair deal for migrant workers and maximize gains for both sending and receiving countries and stakeholders. From the ILO’s perspective, unmanaged migration of health professionals can lead to inequities and losses of health-sector workforce. This can impact directly on the achievement of health-related Millennium Development Goals, considering that national health-care systems require sufficient, qualified and competent health professionals having access to decent work. In order to design the best policy responses to such challenges, it is critical to collect and to analyze data, as well as to carry out research to be able to design efficient policy interventions for the benefit of all.

According to Mr Johnson, circular migration has been promoted as a “triple win solution” to migration. In particular, the concept has been used by the EU as a possible solution to ethical migration. For some critical segment of the migration stakeholders, “circular migration could be a way of filling gaps in the labour market without having to fully integrate those who wish to only come for a limited period of time, or on a seasonal basis”.

Mr Johnson said a more detailed analysis of the opportunities and challenges of circular migration are needed in order to reap its potential benefits, especially for health professionals. DWAB’s goal is to strengthen Policy Dialogue through enhancement of the existing knowledge base on circular migration, which is the reason for today’s gathering. The DWAB team has been working with collaborators to look into different aspects of the migration of health professionals to Europe, which is an essential step from where to discuss, design, and agree on how to move forward in the interests of all parties.

Mr Johnson reminded those present to learn from the DWAB-commissioned policy research, and with their extensive experience in migration, explore means to ensure safe and decent migration. This is the first Policy Dialogue organized by the DWAB project. The team will also bring the research results to a wider European audience in the coming months. In the future, the team will again invite participants to look at nursing education in the Philippines and to discuss ethical recruitment practices.

To end his opening message, Mr Johnson expressed thanks to the organizations and the people that made this activity possible, namely the EU, the Department of Labor and Employment (DOLE), POEA and attached agencies, the Commission on Higher Education (CHED), the Professional Regulation Commission (PRC), and the Department of Health (DOH). He also expressed gratitude to the various employers and workers organizations in the health sector, the professional organizations and recruitment agencies for their constant support to DWAB.

Policy Dialogue: Context and Programme



Ms Vaillancourt-Laflamme gave a brief overview on the framework and methodology of the Policy Dialogue. She thanked those present for giving their time to attend and acknowledged the presence of representatives from the ILO tripartite constituency, as well as from other agencies, professional organizations, non-government organizations, and the academe. She stressed the importance of their presence, for the quality they give to the dialogue, and to their

participation, since this is an important condition for a very rich debate. She was happy over the presence of the EU member states and the EU Delegation. She stressed the importance of bringing in the perspective of sending and of receiving countries to have a balanced and adequate response to the challenges of migration.

Ms Vaillancourt-Laflamme proceeded to say that social innovation holds the key to progress for all and noted that knowledge and solutions flow across borders as freely as the problems. The science of public policy has long been recognized. When public policy is supported by scientifically sound evidence, it is for the benefit of the entire society.

Over the past months, there was time to engage in research, to look at migration experiences concerning the migration of health professionals, and to extract some lessons which, Ms Vaillancourt-Laflamme said, “can guide us in our respective mandate in promoting decent migration policy for the betterment of all”. They also worked with many excellent consultants in looking at different aspects of the issue of migration.

For this Policy Dialogue, Ms Vaillancourt-Laflamme briefly introduced the work of the four aforementioned consultants in the summary that examined different aspects of migration: Ms Makulec looked at the effects of the Philippine bilateral arrangements with selected countries; Dr Wickramasekara examined the effects of health professionals’ migration on the labour market and health sector performance in destination countries; Dr Calenda studied the working conditions of the Filipino and Indian-born nurses working in Europe, particularly in the United Kingdom; and Professor Lorenzo looked at services currently available to skilled migrant workers to see possible gaps and how these can be addressed.

The purpose of the Policy Dialogue, as Ms Vaillancourt-Laflamme pointed out, was to share experiences and enrich debates about migration. She encouraged the participants to contribute to the debate, not to be afraid to share, but to speak freely. She recognized the collective pool of understanding, and the participants’ years of experiences that could be shared.

On the dialogue process, each commissioned research will be presented, followed by reactions and discussion to raise inquiries, identify priorities, and extract lessons for guidance in migration management. Subsequently, the ILO constituents -- the trade unions, employers, and government -- will discuss in respective groups, while colleagues from the professional associations, non-government

organizations, recruitment agencies, and academe make select and join any group. The discussion is aimed at generating proposals relevant to the participating agencies. There will be a designated facilitator and documenter per cluster, after which, the groups will get back into plenary session to share the highlights of their discussions and draw out reactions.

RESEARCH PRESENTATIONS

The Effects of the Philippines Bilateral Arrangements with Selected Countries

Session Panel

In this session, Ms Makulec presented the study on the effects of the bilateral arrangements entered into by the Philippines with other selected countries. Dr Marla Asis, Director of Research and Publication at the Scalabrini Migration Center, facilitated the discussion. Reactors to the presentation were: Mr Mersole Mellejor, Director, Central Europe Division, Office of the European Affairs, Department of Foreign Affairs; Ms Rhodora Abano, Advocacy Officer, Center for Migrant Advocacy; and Dr Stella Go, Convener, Philippine Migration Research Network.

Research Presentation

Focus. Ms Makulec presented the study entitled *The Effects of the Philippines Bilateral Labour Arrangements with Selected Countries*. The research focused on the effects of bilateral arrangements entered into by the Philippines as the sending country of health professionals with countries of destination of Filipino health professionals.



Context. Citing WHO data (WHO 2006), there is a global shortage of 4.3 million health professionals. The shortage of health professionals is concentrated in 57 countries, mainly sub-Saharan states and those of East Asia. Such shortages could result in brain drain, such as loss of human capital, and the loss of investment in education could have some negative consequences on the sending countries. The migration of health professionals has consequences on the functioning of health systems of the sending countries. This creates conflict between the right to health and the right to freedom of movement. The consequences are to be considered in the management of migration.

Studies on brain gain effects in the sending countries argue that migration produces incentives for educating those left behind, such that the level of human capital increases. Studies also show that there is a safe level of health professional migration. If not more than 20 per cent of health professionals leave for work abroad, sending countries experience positive consequences. Nevertheless, Ms Makulec argued that despite the debate, the negative consequences on the sending country must be considered in the context of health professional migration.

She argued that results of previous studies are inconclusive in terms of determining whether health professional migration is the product or the consequence of poor health systems in developing countries. These consequences are usually considered in terms of the management of migration.

There are three roles for bilateral arrangements: recruitment, protection of migrants' rights, and mitigating brain drain. Recruitment pertains to access to the labour market, mechanisms of predictability and transparency, and prevention of irregular migration. The second role, protection of migrants' rights, entails protection against exploitation and deskilling, and recognition of qualifications in the receiving countries. The third role is mitigation of the negative consequences of migration in the sending countries, such as by recruitment only from countries with no shortage, by setting safe limits, and determining some sort of compensation to the sending countries for the outflow of their health professionals.

Ms Makulec also presented to the participants excerpts of key international documents that are important in managing the outflow of health professionals. She stated that three international frameworks govern the recruitment of health professionals, upon which the study framework was based. Migration for Employment Recommendation (Revised), 1949 (No. 86) states that “developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the UK to support recruitment activities.” In addition, the United Kingdom Code of Practice for the international recruitment of health-care professionals forged in 2004 provides that “international cooperation and coordination on international recruitment of health personnel” should be observed and that “such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures”. The WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010 stressed the role of bilateral agreements in mitigating the negative consequences of health professional migration. Specifically, it states that human resources should not be recruited from countries with critical shortages, and that health needs of developing countries be considered.

Objectives. In presenting the objectives of her study, Ms Makulec stated that her research is aimed at examining the effectiveness of bilateral agreements given the three aforementioned roles. Generally, her objective is to look at how Philippine bilateral agreements are faring in terms of how effective they are in recruiting and protecting health professionals, and in mitigating its negative consequences. She also pointed out that it was relatively easy to study the recruitment aspect, but determining the extent to which such bilateral agreements are effective in protecting migrants and in mitigating the negative effects of migration was challenging for a researcher.

Methods. In conducting the study, Ms Makulec used the following methods: triangulation of desk research (legislation mapping, review of literature and statistics); interviews and focus group discussions taking the perspectives of sending and receiving countries; consultation among 32 different stakeholders; and examination of bilateral agreements of the Philippines with countries of destination.

Findings. Ms Makulec argued that the “Philippines pays much attention to negotiating bilateral agreements, but did not manage to sign the agreements with the most important destination

countries". The top-10 destination countries for Filipino nurses are not among the countries that signed bilateral agreements with the Philippines on health professional migration. Currently, the Philippines has signed 22 bilateral agreements, of which six pertained to health professionals (three bilateral agreements and four Memoranda of Understanding), and include Norway (2001), United Kingdom (2002), Spain (2006), Bahrain (2007), Japan (2009), and Germany (2013). The study did not cover the German agreement as it was signed only recently in March 2013.

In general, Ms Makulec stated that negotiating for bilateral agreements is integral to the Philippine management of migration. Filipino bilateral agreements, she added, recognize the protection of migrants pursuant to Republic Act 10022, or the Migrant Workers' Act. Under this law, the Philippine government is mandated to send migrants to countries where there are policies in place to protect migrant workers. One mechanism for this is the forging of bilateral labour agreements. Generally, Philippine bilateral labour agreements prove how difficult it is to include brain gain objectives and to implement agreements. Those that had been implemented usually served recruitment objectives, which provided some protection for Filipino health professionals against exploitation, such as switching the costs of migration from the migrants to their employers.

In presenting her findings, Ms Makulec first emphasized that three bilateral arrangements were never implemented.

One is with Norway,³ which was terminated only six months after signing. Factors included financial (Norway had to invest), language training, changing political priorities, and recruitment from Eastern and Central European countries. Likewise, Norway began recruiting from Scandinavian countries.

In the case of Spain,⁴ it was very difficult to get information on the agreement. Only two nurses were recruited under the agreement. The pilot project was not developed nor was this evaluated or monitored in a special way by the Spanish government.

The bilateral agreement with Bahrain⁵ was a very interesting case. In Ms Makulec's view, this could have been regarded as best practice for including the aim of mitigating the negative consequences of migration of health professionals. Unfortunately, the agreement has not been implemented. Since recruitment to Bahrain has moved quite well, it made it unnecessary for Bahrain to make any investment and to pursue any form of compensation.

Ms Makulec also examined two other bilateral agreements involving recruitment, with the United Kingdom and Japan.

³ Agreement Between POEA and the Directorate of Labour Norway on Transnational Co-Operation for Recruiting Professionals from the Health Sector to Positions in Norway (June 26, 2001).

⁴ Memorandum of Understanding on Cooperation for the Management of the Migration Flows Between the Ministry of Labor and Social Affairs of the Kingdom of Spain and the Ministry of Labor and Employment of the Republic of the Philippines (June 29, 2006).

⁵ Memorandum of Agreement Between the Republic of the Philippines and the Kingdom of Bahrain on Health Services Cooperation (April 24, 2007).

She explained that there were actually two agreements with the United Kingdom. One was the recruitment agreement in 2002 and the other was the Memorandum of Agreement with the United Kingdom in 2003.⁶ These were done in response to the development of the health-care system in the country. Ms Makulec explained that the Philippines responded to the expansion of the National Health Service (NHS) in the United Kingdom and the urgent need for recruitment of overseas health professionals due to the shortage in the United Kingdom. However, when the media in the United Kingdom magnified the brain drain issue, the NHS Code of Practice was adopted. This required the signing of bilateral labour agreements with countries that have no critical shortage. The agreement was signed just after the peak of recruitment (in 2001, with 5,388 recruited) but terminated in 2006. One reason cited by Ms Makulec was that by 2006, the United Kingdom's demand for health professionals already subsided. Moreover, similar to Norway, changing political priorities in the United Kingdom focused on the retention and education of all nationals rather than recruitment from abroad. The agreement resulted in a very small percentage of recruitment for the public sector. She pointed out that the agreement focused on the need to meet the demands of the public sector in the United Kingdom, though there was demand from the private sector.

The other agreement examined by Ms Makulec was the Japan Philippines Economic Partnership Agreement (JPEPA)⁷, ratified by the Philippines in 2009. Under this trade treaty, a paragraph on the movement of natural persons was included. Compared to the UK agreement, the recruitment of nurses was much higher under the JPEPA. Hence, she argued that JPEPA was more effective in terms of recruitment compared to the UK accord. The reason is that in the UK agreement, there were more migrants (5,388 in 2001) recruited prior to the agreement than when it was already signed. In the case of Japan, Ms Makulec presented her slide, which illustrated that JPEPA was a market opener for Filipino nurses in Japan. Prior to the agreement, there was no marked presence of Filipino nurses in the said country. However, with JPEPA, Makulec pointed out that nurse recruitment to Japan reached its peak in 2009 (93 nurses) after the agreement was signed.

The critical issues in JPEPA were about the language requirements of six months and the difficult national examination in Japan written in Nihongo for Filipino nurses, while Japanese nurses took a different examination. She said the case of JPEPA highlights the importance of the consultation process, and that problems could have been settled and discussed had there been a thorough consultation process.

Conclusions. In closing her presentation, Ms Makulec noted that Philippine bilateral agreements are doomed to fail. They are not significant in terms of recruitment, but managed to include protection of

⁶ Recruitment Agreement Between the Government of the Republic of the Philippines and the Government of the United Kingdom of Great Britain and Northern Ireland (January 8, 2002); Memorandum of Understanding between the Government of the Philippines and the Government of the Kingdom of Great Britain and Northern Ireland on Health-care Cooperation (July 30, 2003).

⁷ Memorandum of Understanding Between the Philippine Overseas Employment Administration and the Japan Philippine Economic Partnership Agreement (JPEPA) (January 12, 2009); Memorandum of Understanding Between the Philippine Overseas Employment Administration and The Japan International Corporation of Welfare Services on the Deployment and Acceptance of Filipino nurses for "Kangoshi" and Filipino caregivers "Kaigofukushishi" (January 12, 2009).

migrant rights and compensation. Anti-brain drain provisions are seldom incorporated, except for the Bahrain agreement. But even with that accord, the implementation was very difficult.

Ms Makulec further argued that agreements should not only be about recruitment, but must also include provisions on protection and brain drain. With more circular migration occurring, this produces new challenges.

In order to make the bilateral labour agreements more effective, Ms Makulec proposed numerous recommendations. First, she stated that notwithstanding the difficulty of implementation, bilateral labour agreements should not be limited to recruitment, but include provisions for protection and brain drain. Second, she argued that monitoring and evaluation are vital to assessing effectiveness and must be discussed during negotiations. This is especially important in terms of establishing indicators to assess protection and brain drain. Third, she raised the issue that for her, the “something is better than nothing” approach is ineffective, and that if bilateral agreements are just effective on paper, then the effort in negotiations will not be worth it.

To increase the effectiveness of bilateral labour agreements, Ms Makulec suggested that this must be supported by other mechanisms and must involve other stakeholders in the process, including the promotion of international soft laws and practices. Furthermore, tailor-made bilateral agreements are better. The right timing is also crucial, while recruitment and implementation must be interdependent and linked for agreements to be effective. Finally, Ms Makulec explained that circularity of migration creates new possibilities but also challenges in terms of migrants’ rights protection, portability, access to skills, consequences of circular mobility process, and support for return and reintegration.

Reactions

Dr Asis called on Mr Mellejor, Ms Abano, and Dr Go to give their comments on the research presentation.

Mr Mellejor

In responding to Ms Makulec’s presentation, Mr Mellejor mentioned that the observations of Ms Makulec are valid.

However, he pointed out that the Philippines has an advantage because of its long experience -- not just with deployment of health professionals, but with overseas workers in general. It has a good set of policies and a well-structured system of managing deployment of workers abroad. But he acknowledged that this is the case not just because of government, but also because of the contribution of civil society -- the NGOs, and the academe. He said the roles of these stakeholders are very important for the Philippines to arrive at the right policies in managing migration. Bilateral agreements evolve over time, and these usually respond to the changing context of international migration.

Mr Mellejor pointed out that conditions then are not the same as now and that approaches depend on conditions on the ground. For instance, the Department of Foreign Affairs (DFA) has a specific role, as a conduit, with agencies in partner countries and in the Philippines. It has a system of consultations, which



may be slow, but this is on account of seeking the needs and concerns of different stakeholders. In countries where the market is not open, the partners prefer government-to-government arrangements, and where the market evolves, they allow deployment processed by the private sector. In fact, the bulk of the current deployment trends are with the private sector.

Mr Mellejor agreed to Ms Makulec's recommendations, and said the latest agreement with Germany is unique as it has the inclusion of social security and the portability of social benefits, which is the way forward for labour arrangements. In his view, this agreement has responded to the points raised by Ms Makulec in her presentation.

Ms Abano

Ms Abano stressed the point that the migration of health professionals poses threats to the country's health delivery system, to the educational system, and to the future quality of health professionals. For this reason, the Philippines must address the need to hire personnel and pay decent salary, so that nurses will have the option to stay in the country or go abroad. Moreover, there is also an urgent need to raise the budget for health so that government can mitigate migration and develop human resources for health. It is lamentable that efforts, time and resources go into forging bilateral agreements, only to be told that it did not work out.

On the "something is better than nothing" approach, Ms Abano suggested that the negotiators should instead move to a position of strength and quality. Specifically, the situation of local government units must be considered for compensatory measures in the bilateral labour arrangement. For example, in the case of JPEPA, there were many consultations, but only a few recommendations passed. Monitoring and evaluation should have been present from the beginning. In addition, there is a great need for civil society organizations, such as NGOs, to be consulted on these issues as they are major stakeholders. Finally, pre-departure orientation and post-arrival programs should be included in the monitoring.

Dr Go

According to Dr Go, the study confirmed previous observations that bilateral labour arrangements are fraught with challenges and difficulties and that their potential as legal instruments have not been realized. The very few bilateral arrangements were forged with countries that do not have much recruitment of Filipinos, while none with countries with the bulk of overseas workers. This means that effectiveness and impact will be restricted. There should be focus on mitigating negative consequences, and there is also a need to look at alternatives.

Ms Go stressed that migration is still a biased market. The labour-sending countries are still at a disadvantage because the receiving countries can terminate the agreement when their needs are met. She suggested that there should be databases and data sharing mechanisms. Data sharing is needed to build labour market information and undertake labour market needs assessment. Furthermore, Ms Go suggested that since global shortages cannot be resolved, there must be efforts from both destination and origin countries to provide health services and protection for migrants, and for destination countries to fulfill their social responsibility in sharing in education and training. Countries of origin should give

priority to their own health needs, encourage Filipino health professionals to stay, and remove barriers that discourage the return of Filipino migrant health professionals.

Open Forum

Dr Asis facilitated the sharing of comments among the participants.

Dr Wickramasekara argued that the “something is better than nothing” perspective does not affect health workers so much, but more so low-skilled workers. He supports the need for tailor-made agreements and that in fact, some Memorandum of Understanding (MOUs) and Bilateral Labour Agreements (BLAs) can be considered good practice. He also pointed out that agreements can be made more effective if it is accompanied by other protocols, such as periodic meetings and joint monitoring between migrant-sending and receiving countries. In stating this, he noted that it is difficult to arrive at a perfect agreement because of the unequal bargaining power between the migrant-receiving and the migrant-sending countries. The basic point, according to him, is that there usually is no publicity after the signing of agreements, and nobody is informed. Last, he argued that the aims of bilateral labour agreements must not only be about recruitment, but about governance of migration flows as well. He noted, however, the agreements cannot tackle everything.

Congresswoman Paquiz said she agreed with the points raised by Ms Makulec, particularly regarding the Philippines’ “something is better than nothing” approach. She informed the participants that Filipino nurses currently accept forced trainings, contractualised work and job orders due to massive unemployment in their sector. According to her, the problem is the exploitation of nurses in some countries abroad, with some engaged in what is termed as “precarious” work. She said she believes that agreements must be tailor-made in that if migrant receiving countries do not ask for two years’ experience, the Philippine government must not volunteer that its nurses have two years’ experience to go abroad. She suggested that there be skills assessment, and that nurses take their training and examinations in the Philippines rather than in the receiving country, which she already raised during the consultations for JPEPA. Finally, she recommended that nurses get their language training in the Philippines and be accepted as regular nurses abroad, and made a call to protect Filipino nurses.

Professor Lorenzo pointed out that a bilateral labour agreement is intended to be an instrument to equalize the inequities between destination and source countries. Much has been achieved since destination countries now ask what they can give back to the Philippines in return. The agreements should include the benefits for the workers and the countries. Professor Lorenzo cautioned that multilateral agreements are more difficult to implement, while bilateral agreements require only two countries. However, it will take time to achieve equity of bargaining. Professor Lorenzo also suggested that other alternatives be explored to make migration better managed.

According to Mr Mellejor, there are other international instruments for the protection of rights of Filipino workers abroad, aside from bilateral labour agreements. There is a campaign for receiving countries to ratify the International Convention on Protection of the Rights of Workers, which can satisfy the non-recruitment objectives in agreements.

Ms Go argued that there are difficulties in forging bilateral agreements. Nonetheless, there are other alternatives. Countries of origin can push for migrant rights in various international fora. Other instruments such as international conventions can be used in the absence of bilateral labour agreements or in cases when they are ineffective. The Colombo Process, and other soft mechanisms, can be venues for advocacy without necessarily twisting the arms of destination countries to sign a bilateral agreement.

Ms Abano also expressed her view that agreements should involve more stakeholders.

Responding to the comments, Ms Makulec explained that the Philippines had made great progress in terms of the consultation process, compared to the early initiatives where there was limited discussion. Although JPEPA received much protest, there was protection of migrant's rights "on paper", which the effort worthwhile. She also agreed with the comments that other alternatives to bilateral agreements must be explored.

Assessment of the Impact of Migration of Health Professionals on the Labour Market and Health Sector Performance in Destination Countries

Session Panel

Dr Wickramasekara presented his study on the impact of the health professionals' migration on the labour market and health sector performance in destination countries. Mr Ricardo Casco, National Programme Office, International Organization for Migration, facilitated the discussion. Reactions were shared by Ms Kathleen Fritsch, Regional Adviser in Nursing, WHO Regional Office for the Western Pacific, and Professor Jorge Tigno, from the University of the Philippines Diliman.

Research Presentation



Dr Wickramasekara presented the research on "Assessment of the Impact of Migration of Health Professionals on the Labour Market and Health Sector Performance in Destination Countries".

Focus. Dr Wickramasekara started with the structure of his presentation, which were: the key messages of the study; the context and objectives of the study; the types of impact of the migration of health professionals; the labour market impact, health system performance, and quality of care; followed by policy implications and issues for discussion.

The first key message is that the impact of international health professionals (IHPs) on destination countries is much broader than just economic or labour market impacts only. This issue of health migration goes beyond economic assessment. Second, countries of destination need a range of policies to optimize the impact of health professional immigration; although they recruit migrant health workers, they do not have the right policies to optimize their contributions. Third, most

studies concurred that the formulation of long-run health worker immigration policies should take into account ethical dimensions of health work recruitment and brain drain. Fourth, IHPs face major induction and orientation problems in destination countries, which are often neglected by the countries' policies. Finally, this project covers circular migration and the two-way circulations consistent with migrant rights may be promoted for mutually beneficial migration.

Context. There is now a changing context of health professionals' migration. There has been a concern over the high outflow of health professionals; while in previous years, the concern was about brain drain, now there is less talk. This is partly the result of the agreement on the WHO Global Code of Practice. More UK medical schools have opened up and more nurses are being trained, hence more concern for jobs for local workers. There has been a free movement of health professionals within the EU and the European Economic Area (EEA), at the expense of workers from India, Asia and other countries. Recent changes in immigration policies have occurred, especially in the United Kingdom where the new government's policy shifted from the previous policy between 1997 and 2006, when there was proactive recruitment by the NHS. Also, there is now more training in countries of origin and less reliance on bilateral agreements by countries of destination.

Objectives. Given this context, the study conducted within the framework of DWAB, pursued the following objectives: to identify and analyze the impact and effects of the migration of health professionals on the destination countries (in terms of labour market impact, health system performance, and quality of care impact), and to propose recommendations.

Framework. The study employed the framework developed by the World Health Assembly on the relationship of the education, health and labour markets. This framework includes training, labour supply, labour demand, students and resources, and workers.

The study focused on two types of professionals -- doctors and nurses, and on three types of impact -- labour market impact, impact on the performance of the health system, and the quality of care impact. On employment impact, there are three kinds -- employment impact, wage impact and mobility impact.

Study questions. The questions are: (1) do IHPs displace native health worker professionals; (2) do they drive down wages of native health professionals; (3) do they cause native health professionals to move out of those areas where they are going or go out of the province.

Methods. The study employed desk review, consisting of the review of literature and online databases, and key informant interviews and feedback from project coordinators. The methods used were statistical, time series cross-section models to test whether wages have been affected or employment has been affected. Data sources included US current population surveys, and national survey of nurses. Controlling for factors, the analysis looked at the immigrant health workers increase in supply, and whether this affects employment and wage.

Findings. The findings show that skilled health workers inflow does not drive down wages because of the shortage of health professionals. On the delivery of services, immigrant health workers normally go to underserved areas, such as in rural areas in Australia and the United States. Asian doctors go to

disciplines like geriatrics, which deals with old age and elderly people -- an area unpopular with local doctors as it involves difficult shifts and night work.

On resource creation, foreign health workers relieve shortage. On the matter of financing, there are savings on training costs, £250,000 for each doctor from abroad, as shown by evidence from the British Medical Association to the House of Lords. The net gain of the United States for doctors from the Philippines and India is US\$1.7 billion dollars.

In terms of quality of health-care impact, three approaches were used: complaints from the public, peer group, and others. The United Kingdom uses fitness to practice procedures, success or failure in competitive examinations. There are few studies on the comparison of outcomes of patients in terms of international medical graduates and native medical personnel, though there is one study. Generally, in the United Kingdom, foreign medical graduates have a much higher incidence of complaints and higher impact decisions. This means that foreign medical graduates are subjected to more disciplinary procedures, including cancellation of their licenses, compared to local counterparts. These procedures have not been very transparent, as some studies showed, and the UK's General Medical Council has stated the need for a review of these procedures.

There are issues of bias and discrimination established in a number of studies. Quality issues in the United Kingdom are not related to IHPs. There were patient surveys, but no results involving IHPs.

Furthermore, Dr Wickramasekara's study identified the constraints faced by foreign health professionals. There is no proper induction on expected standards of ethical and regulatory conduct in the United Kingdom, referred to as clinical practice; though there is one study that clearly found that migrant nurses and doctors were provided with information on standards. They have limited career prospects. They are confined to general practice (GP) and unpopular disciplines. In the United Kingdom, local graduates move to the next level of consultant, while migrant health professionals will be confined to non-career positions. There is also limited access to further training.

In the literature, there is focus on circular migration as a triple-way situation. In the United Kingdom there is promotion of the Medical Training Initiative as a circulatory migration initiative, but there are limitations and problems, such as immigration and the maximum limit of two years.

There is emphasis on volunteerism as UK doctors go to other countries and have partnerships. But there are problems when they are employed and volunteerism becomes an issue.

Furthermore, the presentation mentioned that in Canada, Australia, and the United States, there are no considerations on brain drain and ethical impact, whereas the UK's Department for International Development is available for such concerns. The UK Medical Training Initiative provides for two years for people from developing countries to receive training. This operates under Tier 5 of the points based immigration system of the UK Border Agency, with a cap at 750.

Policy Implications. From the discussion, there is need for credible immigration policies in destination countries, greater transparency and avoidance of retrospective legislation, and respect for international

instruments and the WHO Code. On the contribution of these international health workers to destination countries, there is a need for more documents and data -- whether they work below qualifications, how many are employed, and if there is respect for rights.

There is a need for proper induction and orientation, more effective collaboration between countries of origin and countries of destination -- not just confined to bilateral agreements on paper, but a need to go beyond this. The WHO Global Code of Practice is clear on bilateral agreements, but there is a need to move further into technical assistance, and support for medical training. Promote training and social dialogue and give more opportunities for circulation. Not just migration control, not just how to stop migration, but also see how to promote mutual, beneficial forms of migration with respect for migrants' rights. Finally, the main issue is the generation of better health work-force data at origin and destination. Though there is much concern, there is no data on how many health workers are leaving.

Reactions



Mr Casco called on the reactors to give their comments, respectively Ms Fritsch and Professor Tigno.

Ms Fritsch

Ms Fritsch thanked Dr Wickramasekara for the presentation of an expansive literature review. She said it was a timely discussion and dialogue “as we look at the global context of human resources for health in a changing world”. She noted the rapidly aging populations, growing non-communicable diseases including cardiovascular disease, self-induced and other injuries, continued emerging diseases and disasters, worldwide shortages of health workers, and imbalances and inequitable distribution, as seen in the Philippine experience.

Given the conceptual framework, Ms Fritsch highlighted the five components of human resource for health: finance, policy, leadership, partnerships and education. From the presentation, there is need for more data on migration, and more evidence. Looking at the continuum presented, there is also limited data on the students who then become workforce participants or resources and then workers exiting from the workforce.

According to Ms Fritsch, they just finished an analysis of the health system strategies, including human resources for health in the region. They are meeting with ILO and member states. The data they are able to obtain translates into density but does not tell where people are and their competencies. They experienced difficulty in getting data on the actual number of graduates in countries, where the graduates are in the workforce, and losses in workforce due to movement to other sectors, retirement, and migration. These data are important, as well as the segregation of data by world urban areas and by the public-private sector. For Ms Fritsch, there is much work to do from the labour market economic standpoint -- not just plain data sets, but to have the data needed to plan properly.



She added that from the labour market standpoint, there are continued imbalances between servicing and population needs and education outcomes. In the context of increasing self-sufficiency of destination countries, policy coherence and enforcement of policies are needed. In the world of migration, graduates should be educated around some common core sets of competencies. There is growing work in the Association of Southeast Asian Nations (ASEAN) and other networks. However, there are still some difficulties because countries have education in different languages, different modes of learning, and different curricula. Ms Fritsch said that this requires control in the quality of educational institutions, and that “we upscale education so that graduates passing national examinations are hired”.

Ms Fritsch suggested that aside from knowledge examinations, other measures for long-term evaluation of competencies should be explored. She asked, are we safe to practice within our own country and in other countries? This brings to mind the linkages with cultural safety and linguistic language safety, not only clinical practice safety.

It was also pointed out that immigrant health workers face difficult situations, but that there is less information about their actual experiences and stigmatization. They often work in much harsher conditions or they may be deployed in more rural and areas. These areas have more language and cultural challenges, and more professional isolation. Thus, quite a bit more qualitative data are needed in the experiences of patients, as well as immigrant workers.

There is a need to address the needs of the workers, for rights, for equal treatment and respect, and to deal with stigmatization and discrimination. On the other hand, the protection of the public is also important.

Ms Fritsch noted the need for more qualitative data and for an annex to explain the economic analysis. It might be helpful to link the studies on the effect of health systems and wages and the labour market to where the immigrant workers are working. Where are they working? What are the effects? Is there more demand for health services or less demand? Not only wages, but what are the long term effects on patient outcomes and service utilization?

Finally, Ms Fritsch thought it beneficial for readers and policy-makers to look at the data bases, references, and literature. Much of these have come from the northern hemisphere, from the United Kingdom, but less from the other parts of the region.

Professor Tigno

Professor Tigno referred to the effects of migration on wage and labour migration, and labour factor differentials. Empirical evidence, whatever has been available, shows that immigrants do not significantly affect wage differences in destination countries, nor do immigrants displace native workers in a significant way. In health-care professional studies, there is not enough evidence to suggest that health worker migration led to the movement of native health workers away from the areas of high concentration of immigrant workers.



On the analytic framework and econometric analysis, Professor Tigno noted that these mention the impact relation between migration and labour market in such a way that one is looked upon as the stimulus. The usual approach is to treat immigration as a kind of stimulus likely to cause something, such as depressed wages or displacing native workers. Migrants fill a vacuum or need in destination areas, especially in underserved places. Professor Tigno said he would turn the usual analysis around, so that instead of looking at the immigration of health-care professionals as a stimulus, it would be treated as a response, as an effect caused by a vacuum or need in developed areas. How did the shortage of such a type of workforce occur in these countries? Why is there a need for health-care professionals in developed areas, and why is there a need to examine what appears to be an oversupply in developing areas?

In his view, the two concerns are strong related to one another. He would be interested in knowing the wage differentials across sectors of the same labour market in these destination countries, especially comparing sectors within the health-care industry itself. He “suspects that the wage differentials for the nurses and caregivers would be much wider compared to doctors and other medical specialists”. Moreover, shortage of health-care professionals in developed areas could be due to the fact that such workers in the health sector are not paid well enough to attract qualified native applicants relative to other trained professions (such as in the case of Japan).

According to Professor Tigno, the policy options mentioned in the presentation are fundamental to the policy process -- referring to data gathering, data generation, documentation, review of existing mechanisms. Also, it is important to ask what to look for in a guiding framework. What would be the framework to inform the EU and its member states in the way it deals with the health sector and the immigration of health-care professionals? To respond to this question, the first point is to examine why there has been a vacuum in the first place. Increasing the number of medical schools and nursing schools in either destination or sending areas would be the solution. There would be more medical and nursing graduates who are unable to find effective employment in the labour market as they were trained for, as doctors and nurses.

Professor Tigno expressed support for all the speaker’s recommendations, especially the fifth. In addition, there is need to strengthen the collective bargaining power of health-care professionals in destinations, as well as sending areas -- especially among nurses and to some extent other health professionals, including caregivers where the vacuum is more likely to occur and which immigrants are more likely to fill up.

Finally, Professor Tigno cautioned that politics cannot be ignored. In discussing the migration of health-care professionals, one should also take into account the political dimension, not just the policy dimension. This is because migration policy is very much a political economy decision.

Open Forum

Father Battistella inquired if the study considered the demographic factor in examining the increasing demand for health workers in the developed countries and the supply from the developing countries. Developed countries are aging or have aged already. Most of the health needs come from money spent to live six months longer. The demographics in developing countries are changing; they are not necessarily always remaining young populations.



Mr Ashley William Gois, Executive Director of the Migrant Forum in Asia (MFA), raised the issue about health as a common good, yet this is treated today as a comfort good, in the sense that there is privatization of industry and migration flows. There is a diverse market for health professionals. There is a model in Europe and there is a model in the gulf countries where health is subsidized by the state, at least for the nationals. Another is the model of Doctors Without Borders. Is there a possibility of looking at health in that sense as a common good that can come post 2015?



Dr Asis thanked Dr Wickramasekara, and inquired from him about the IHPs' concentration on certain disciplines. She also asked whether in the area of high incidence of migration of health professionals, there is differentiation of the labour market -- one for local professionals and another for IHPs. The question is whether increasing wages would resolve the situation. In the first Asian crisis of 1998, the increase in the wages of workers, in sectors no longer wanted by the local population, did not increase the number of local workers going into those particular sectors.



Facilitator Ms Christiane Wiskow, Health Sector Specialist, ILO Geneva, also thanked the speaker for the excellent presentation and for his broad and inspiring reactions. She said "we have to look at the labour market as a driving force for migration. In the presentation, the demand in the United Kingdom for IHPs is driven by national workforce policies."

Ms Wiskow supported Professor Tigno and Dr Asis on their suggestion that conditions of work be examined. Why do health workers choose to work in a certain environment? She called attention to the so-called care economy, on the blurring of domestic work and nursing, where qualified nurses work in nursing homes. Deskilling occurs when migrants enter a country to a professional working field lower than one's position. In her view, globalization has as interdependent consequence for the destination and source countries.

In response to the reactions and comments, Dr Wickramasekara clarified that the presentation did not include details, which are in the research report. For Ms Fritsch, he did not find much information, and

that he'd mostly obtained micro data. He agreed with Professor Tigno on the need to go beyond econometric evidence, to strengthen collective bargaining mechanisms, and to consider the political dimension in migration policy, which is very much a political economy decision. In the UK migration policy for instance, the current objective is to bring down the numbers of migration nurses to the 1990s level, below 100,000, and are targeting students also as immigrants, as part of migration control. There is need for an account of the way policy mechanisms are dealt with and for a review of policy mechanisms in place.

Dr Wickramasekara said his study did not cover caregivers and doctors that have become nurses. He agreed to the comments, such as the need to strengthen collective bargaining power and to consider the political dimension in making political economy decisions.

Mr Casco clarified Mr Gois question. He asked: since health care is global, since it is a common good that flows into diverse settings, in different countries with different laws, is there a way to level the field such that there is some standard, some reference in governance and in the handling of gaps and challenges?

The speaker replied that health is a public good, a global public good, and that this is a foundation in the Global Code of Practice. Countries have different policies in getting health workers. There is a difference between European countries and destination countries like Australia and Canada and the United States, which do not think about the public good aspect. So how can they come to a common platform, since the code is non-binding? This difficulty has been recognized. There is also the difficult issue of compensation for the brain drain impact.

Clarifying the points raised by Dr Asis, the facilitator emphasized the concern about the health professionals getting into a different market and deskilling into the care economy, as the lines get blurred, such as when a nurse becomes a caregiver.

Dr Wickramasekara replied that he did not obtain figures but there are anecdotes where health professionals cannot get work commensurate to their qualifications. In his view, there are opportunities and the health professionals migrate to other countries where they face different conditions.

Ms Fritsch contributed further to the discussion, saying that migration is not due to choice but to demands in sectors of the market. There are increasing demands in care-giving because of aging and associated functional impairments in people that are getting older, in terms of cognitive deficits and functional loss in hearing. From a migration point of view, there is deskilling, as when one moves from a professional field of work, registered and licensed, to work as a caregiver.

Professor Tigno added further that he agreed with Mr Gois that health is a common and social good, but it is treated as a private good. In dealing with health as a social good, there is also the obstacle that governments look at health as a political tool, a political good. This poses as an obstacle to reaching a harmonized view in the way health is treated or seen or addressed across different countries. In the Philippines, there is an enigma, in a sense that there is a surplus of health professionals: doctors and nurses are sent overseas, but there's a shortage of health professionals within the country. This may be

due to the fact that health-care professionals are trained primarily on tertiary care, when in fact the main need in the Philippines is on primary health care.

Thus, the emphasis on tertiary care also acts as a kind of driver for people to leave the Philippines, where there are better equipped hospitals. Started some years ago, some doctors have downgraded their skills to become nurses, and nurses to become caregivers, and migrated to the United Kingdom and other countries. This is a sign of the breaking down of the value chain of care-giving and a blurring of distinctions between what is a doctor, a nurse, and a caregiver.

Investigating the Working Conditions of Filipino and Indian-born Nurses in the United Kingdom

Session Panel



Dr Calenda presented his study on the working conditions of Filipino and Indian-born nurses in the United Kingdom. Ms dela Rosa facilitated the discussion on his presentation. Reactors were Ms Annie Geron, Vice-President, Public Services International (PSI), and Ms Sheila Siar, Director, Philippine Institute for Development Studies.

Research Presentation

Focus and Rationale. Dr Calenda examined the working conditions of internationally recruited Filipinos and Indian nurses in the United Kingdom, because the Philippines and India are the biggest sources of internationally recruited nurses (IRNs) for countries of the Organization for Economic Cooperation and Development (OECD), of which the United Kingdom is a member. Issues of ethics and impact have emerged in the last ten years, particularly on recruitment practices and working conditions -- not only on working experiences but the social integration of workers and their immigration trajectory; retention policies, considering many IRNs plan to move from the United Kingdom to other countries; and quality in the provision of health care.



Context. The initial review of literature has provided the background for selection of the United Kingdom. In the case of the United Kingdom, state policy shaped the way employers utilized and provided working conditions for IRNs. The market has social players like trade unions, professional associations, and recruitment agencies. There are international regulations, soft regulations like bilateral agreements and the Code of Practice of international recruitment. Eastern European nurses started to move to the United Kingdom, which changed the situation of non-European nurses there.

Issues emerged, such as downgrading and deskilling, segregation, barriers to professional development and uncertainty. Changes in migration management and admission requirements occurred in the United Kingdom: from massive recruitment between 1998 and 2006 (openness to mobility), to progressive



restrictions in 2006 onwards. In 1998, the Labour government funded the expansion of the health system and relaxed immigration rules, resulting in the recruitment of nurses, including Filipinos and Indians.

From 2006 onwards, there has been a progressive restriction, not only in migration management, but also in the rules of admission into the nursing profession in the United Kingdom. Since 2011, the economic crises, cuts in health funding, and social cohesion problems have changed the situation there.

Research Questions. The study raised questions on the lessons that can be learned from the case of the United Kingdom and the policy directions and recommendations that can be drawn. Specifically: (1) What are the working conditions of Filipino and Indian IRNs in the United Kingdom? (2) What factors shape their working conditions? And (3), how do working conditions shape IRNs' orientation towards the UK labour market?

Objectives. The study was directed at the following objectives pertaining to Filipino and Indian IRNs in the United Kingdom, namely to know their experiences in the United Kingdom, and to describe their settlement conditions, recruitment process, working conditions, effectiveness and future plans.

Methods. The methods used for the study included desk research, the review of scientific and policy literature, fieldwork research -- including interviews with key informants in the United Kingdom, and an online survey. The survey was conducted from April to June 2013 and had 433 respondents. Of these, 80 per cent were female, 36 were Filipinos, and 397 were Indians (of which 384 came from the state of Kerala). Interviews with key informants in the United Kingdom, conducted between May and June, 2013, had a total of 13 interviews among migration associations, government entities, and Filipino activists and representatives from UK-based Filipino communities.

Dr Calenda said the online survey used channels like Facebook, while other methods included posters in the embassy and interviews on radio. As noted, most respondents came from Kerala in India. It was difficult to reach Filipinos for the survey, so to compensate, key informants were interviewed with representatives from the Filipino communities in the United Kingdom.

He said the Filipino and Indian nurses have commonalities in culture, including a Catholic background, English language, UK-based national communities, and good reputations as nurses. In terms of institutional background, they have a long history of nurses/migration and state-led migration management. He noted the historical linkages with the United Kingdom, bilateral agreements and memorandum of understanding, and similar migration pathways motivated by economic and professional reasons. The significant presence of private reputable industries in both countries was also observed.

Findings. The key themes in Dr Calenda's presentation were migration trajectory, social participation, recruitment experience, and working conditions.

Secure Migration Status. Data showed that almost two-thirds (60.3 per cent) of the respondents lived in large urban areas and a quarter (25.3 per cent) in medium cities, while the rest (14.2 per cent) settled in



small cities. Almost all of them live in the United Kingdom with their family. There are more Filipinos that are single than the Indians from Kerala. Very few respondents received external support from public authorities, employee associations, social organizations and trade unions for settling or moving in the United Kingdom. But that was not an issue for them.

About nine of ten respondents changed their legal status while in the United Kingdom. Most of them (67.3 per cent) became UK citizens, while around a quarter (25.9 per cent) obtained permanent residence. Only 6.5 per cent extended their work permit. There is only a small minority among them (less than 1 per cent) whose migration status is not secured. Dr Calenda pointed out that he did not check the hypothesis that change in migration policies affect the conditions directly, but that changing the migration rules cause great insecurity.

Social Participation. Most of the social life and participation is within a diaspora community. Almost three-fourths (73.7 per cent) of respondents reported having often or very often social contact with people from their country of origin, compared to just slightly above a third (35 per cent) reporting often or very often having contact with people from the United Kingdom. Only slightly above a fifth (22 per cent) reported often or very often having contacts with those from other countries.

On their participation in formal institutions, almost all are not members of migrant or political organizations (92.1 per cent and 97.7 per cent, respectively). Around seven out of ten are not members of trade unions and charity/not-for-profit organizations (69.5 per cent and 77.8 per cent, respectively). A third (29.4 per cent) became active members of religious organizations, but more than half (52.1 per cent) are not members, while the rest (18.5 per cent) are inactive members.

While they are not as active in formal institutions, they keep themselves informed on what is going on. About a third of respondents keep themselves often or very often informed on news in the city (36 per cent) and the United Kingdom (41.3 per cent). The majority (52.9 per cent) of them, however, still keep themselves updated on their home countries.

Key informants do not have time for participation in political activities, political parties or associations other than their own community associations. But religious organizations, such as the church, are very important.

Recruitment Process. Most respondents among the IRNs heard about job openings from advertisements in newspapers, social networks and the Internet in general. Few of them heard from staffing agencies and very few from hospitals. A third of respondents mentioned that they did not have the United Kingdom as their first country of immigration; most of them came from other nations, like the Gulf countries.

More than half of the respondents who were recruited through recruitment agencies reported problems on misleading information fed to them and high fees collected from them. Almost a quarter of the respondents recruited directly by the employer reported the same problems. Direct recruitment from public health agencies in the United Kingdom is a bit more ethical than recruitment from private agencies. Problems with recruitment still exist even after the publication in 2004 in the United Kingdom

of the *Code of Practice for the International Recruitment of Healthcare Professionals*. The code bans the charging of work permits, but most of the IRNs paid for their work permit. One key informant shared that: “Although the NHS should pay the cost of the trip and other things to overseas nurses, we found that many nurses had to pay the agencies everything.” On the other hand, a key informant from an NHS employer said: “It is not easy to implement a strict monitoring, [as they] are not involved in operational aspects.” They do not have the means to strictly monitor the compliance of recruitment agencies.

Working Conditions. What is clear is that the sense of job security has decreased for almost half of the persons interviewed, despite being permanently employed. The security of the workplace and career prospect also decreased. Changes in the system due to economic considerations and cuts in funding have affected the nurses.

Many experienced ethnic discrimination at the workplace. Cross analyzing data on discrimination (discriminated/non-discriminated) with data on aspects of the working conditions, the results showed that discrimination is correlated to a decrease in working conditions, especially job security, career progression and security at the workplace.

A majority of the respondents consider their working conditions worse compared to the working conditions of their colleagues working as a nurse in the same team or department. The proportion is highest among IRNs working in teams predominated by colleagues with UK origins. A majority of the respondents have personally experienced practices of harassment, bullying or abuse at the workplace, including from patients and service users, colleagues, managers and team leaders.

On the quality of the work environment, those who suffered discrimination felt that their professional identity is less recognized; they feel worse at work in terms of work shifts and workloads, less able to cooperate with colleagues, and less satisfied with the quality of care they can provide.

Policy Implications. For policy implications, the study identified the following patterns: (1) De-motivation and detachment; and (2) re-emigration or return.

De-motivation and Detachment. The more the IRNs suffered from bad working conditions, the less they identify themselves with the organization they work for, and the less they feel satisfied with the quality of care they give to patients. This is a subject to be debated.

Re-emigration or Return. Many of the IRNs reported their plans to return. Most of them especially wish to go to Australia, and to Canada and the United States. Few of them would like to go back to the Philippines. A third of respondents have considered the possibility of returning to the home country. Half of those discriminated at work plan to re-emigrate, while 30 per cent of those not discriminated at work plan to re-emigrate.

Dr Calenda said there are respondents that feel frustrated and they do not see their future in the United Kingdom. These respondents mentioned working conditions, life in the United Kingdom and its changing climate as problems they faced. He also noted that people are starting to retire.

For final remarks, Dr Calenda said there is no evidence that recruitment and recruitment problems shape all the experiences of the IRNs. But it is a proxy indicator and a predictor. Bilateral agreements should include clear measures to monitor the implementation of codes of ethical recruitment, and to assess the impact of recruitment practices on the working conditions of IRNs after arrival in their destination country.

Trade unions and professional associations are not engaged in the recruitment process, but the IRNs should be because they went through the recruitment process. Recruitment agencies, ethical or not, are gatekeepers of key information. Online informal exchanges should be acknowledged by public institutions. There are actors that can play a role in monitoring the working conditions after bilateral labour agreements are signed. There are backdoor recruitment processes and mechanisms that can bypass bilateral labour agreements.

IRNs do not have time to participate. They work so hard and have little time left for their family. They go to church because it is the best way to meet the family and the community, and because it is tradition. Most of them are members of trade unions and professional associations.

UNISON, one of the largest trade unions in the United Kingdom, is tackling their low active participation through developing a network of Filipino-born IRNs activists within the organization, across the United Kingdom.

Dr Calenda suggested that working conditions be addressed at both the national level and health facility level on the quality of management and the culture of labour relations. As the NHS has been reformed, the health facilities have become autonomous.

Reactions

The discussants for this study were Ms Geron and Ms Siar, respectively.

Ms Geron

Ms Geron remarked that the findings in this study confirm the feedback data that the Public Services Labour Independent Confederation (PSLink) obtained from the ground, from their participatory research and mapping of migration in the health and social sectors. The similar findings include charging of exorbitant fees, misleading information from recruitment agencies, unfair treatment and discrimination at work.

PSI is greatly concerned that such illegal and unethical recruitment practices exist and are diffused across health facilities, nationalities, and geographical areas in the United Kingdom, even when the United Kingdom is already considered one of the best destination countries.

As presented by Dr Calenda, the United Kingdom does not charge any placement fee, but Ms Geron noted the research finding that many recruited nurses were charged excessive fees, including fees to acquire work permits. For Ms Geron, the government should seriously address this issue. She asked “how such a blatant violation of a policy can go without consequences on the recruitment agencies”.

The trade union position takes the position of complete ban on the collection of placement fees for migrant workers, because this puts the burden of migration on the workers and disregards the contribution they make to the economy of the destination countries. In principle, workers in general and migrant workers, in particular, should not pay in order to work.

She said they are not surprised that the study found the recruitment done by the NHS as more ethical than the recruitment done by the private recruitment agencies. They agree the Code of Practice is not enough. This code is voluntary in nature. Unless translated into concrete provisions in bilateral labour agreements and monitored, this will not be useful. More than securing comprehensive provision on labour rights protection, she thinks that the Philippine government should ensure strict enforcement and regular monitoring of the bilateral labour agreements. There has to be a stronger regulation of private recruitment agencies. POEA is doing a tough job in monitoring recruitment agencies, and additional effort is needed.

For their part, they urge the states to ratify ILO Convention No. 181, concerning private employment agencies not to contradict the position that migration be by choice, not by necessity. There is a need to pursue government-to-government recruitment schemes to avoid reliance on brokers, which often leads to abuse and exploitation of migrant workers.

The study findings on greater job insecurity experienced by Filipino and Indian migrant nurses in the United Kingdom, resulting from cuts in the NHS funding and economic crises, “serve as testament that migration cannot replace decent job creation in home countries”. On the State of the Nation Address, they [PSI] waited [to see] tangible direction on how jobs will be created in the Philippines. Promoting labour migration is not always fair. Ms Geron continued to say that “it is unsustainable to place migrant workers at the mercy of the economy and shifts in macroeconomic conditions in destination countries”. The trade union movement consistently calls on government to prioritize creating decent jobs rather than exporting or actively marketing workers abroad. While workers have the right to migrate, they also have the right not to migrate.

Ms Geron pointed to the study findings about the deteriorating working conditions and uncertainty about the future that led many respondents to consider leaving the United Kingdom for work elsewhere, while as much as 31 per cent were thinking of going back to their home countries. She said this should serve as a wake-up call for government to address the factors that push workers to migrate or work abroad. For a start, Ms Geron called attention to exploring the guaranteed portability of social security benefits and implementation of an effective reintegration program.

Ms Geron observed that UNISON, a sister organization, was one of the resource organizations in the study. According to her, it would be interesting and useful if there was information about the role of the trade unions in securing good working conditions. The questions to ask are: how many of those working as nurses in the United Kingdom are members of unions, and were they provided with information on the right to join the trade union and their collective bargaining rights.

In thanking Dr Calenda for highlighting the link between working conditions and quality of health-care services, Ms Geron stressed the PSI position that there can be no quality health services without decent work. Health workers are really the backbone of the health system. The aspiration is for migration to become a choice, and not a necessity.

Ms Siar

At the outset, Ms Siar qualified her comments as based on Dr Calenda's executive summary for his research. She assumed this to be as close as possible to the full report, particularly for the key findings and recommendations. She remarked that the topic had important academic and policy implications in the migration development discourse, with findings highlighting the deskilling of migrant labour, the gendered nature of migration of health professionals, ethnic discrimination, and the different motivations of skilled workers -- not just economic incentives, but also professional and career development.

Ms Siar's first comment described Dr Calenda's methodology as appropriate, having used quantitative data substantiated by qualitative data. However, it was somewhat short-sighted in approach in the sense that the research participants were mostly located in the destination country of the United Kingdom. The paper was about working conditions of nurses in the United Kingdom, but the reality is, as revealed in other studies, their difficulties started in the home country, in the hands of unscrupulous immigration brokers who fed them with misleading or false information and even charged them with high fees.

According to her, future studies on similar or related topics would benefit from a more comprehensive approach, which treats the migration experiences as a set of factors and actors in the home and host countries interacting with, and impinging on, each other. This study should have included key informants from a governmental body, such as the POEA, as well as the Commission on Filipinos Overseas (CFO), and legal recruitment agencies.

Furthermore, in bilateral agreements, it is important to address the issue of ethical recruitment and the evaluation of impact of recruitment practices on the working conditions of IRNs. This should be done by the governments of host and home countries, not only for the nurses, but for all other migrant professionals as well.

For her third point, Ms Siar called attention to Dr Calenda's statements on page 3 of the executive summary: "There were not major differences between the experiences of Indian-born and Philippine-born nurses"; "All of them, half of them, experienced ethnic discrimination at work"; "Working conditions were worse off compared to their colleagues working on the same team/department; and, "Working conditions worsened through the years". Ms Siar inquired, what does the author mean by colleagues? Are they from English speaking backgrounds? What are their geographical origins? Where did they obtain their tertiary education? Furthermore, Ms Siar argued that several studies on the deskilling of migrant workers have already shown that those from English speaking countries or English speaking backgrounds have obtained their qualifications from the host country or from developed

countries such as the United Kingdom, the United States and Australia, which have better employment outcomes. For example, the study of Paul Miller (2008) revealed the downward professional mobility experienced by overseas trained teachers in England.

Stressing her fourth point, Ms Siar called attention to page 6 of the executive summary, stating that “job insecurity seems to depend more on macroeconomic factors, particularly the cuts in the NHS funding than other factors.” Ms Siar commented that the author has taken these economic factors as the principal reasons for the job insecurity. She further raised the questions: if racial or ethnic discrimination is also a factor, then it would be inaccurate to say that one factor takes prominence over the other as far as effect is concerned; and, if there are racial and ethnic groups that are directly affected, then job insecurity is not just an economic, fiscal, ethnic, and social issue. From her point of view, this seems to depend more on macroeconomic factors than other factors. Ms Siar further said, “since the majority of the participants were women, did gender have an effect”? She considered it interesting to know the relationship between the participant’s race/ethnicity and gender, and between gender and discrimination.

Ms Siar also disagreed with Dr Calenda’s statement about the commonalities between IRNs from India and the Philippines, and particularly on the historical linkages with the United Kingdom, as it is with the United States that the Philippines has historical linkages.⁸

Ms Siar called attention to the coping mechanism of IRNs and to Dr Calenda’s statement that improvements at the workplace were actions taken by the managers and from collaboration and dialogue among the members of the team or department. She would like to know the actions taken by the participants themselves to improve their conditions. She mentioned that migrants are [pictured as] passive actors in the migration process, and that their adaptable and flexible nature to address the unpleasant realities of migration is what partly makes migration a continuing phenomenon.⁹

On her last point, Ms Siar highlighted the data on the plan of 31 per cent of respondents to return to their home country. She noticed that there were only 36 Filipino workers who participated in the survey, such that the percentage clearly reflects the responses of Indian nurses. For her, this finding has an important implication for home countries on the reintegration of migrant workers, which is an important stage in the migration process. This poses a challenge to home countries to absorb the returning migrants, both the highly and lowly skilled, ensuring that they have a positive experience when reintegrating into their home country economically, professionally, and socially.¹⁰

⁸ “Indeed there were Filipinos who migrated to the UK in the 1800s such as sailors and, of course, the educated elites such as our very own national hero, Dr Jose Rizal. But it was only at the beginning of the 1970s that there was a sustained movement of Filipinos to the UK.” Gene Alcantara: “Permission to Work: Filipino Migrant Workers in the UK”, in Filomena Mongaya Hogsholm: *Views of Filipino Migrants in Europe* (2007), pp. 235-261.

⁹ This statement was later clarified by Ms Sheila Siar in response to the comments from Dr Stella Go.

¹⁰ A research by Yvonne Riaño and Nadia Baghdadi in 2007 looked into the strategies taken by skilled Latin American, Middle Eastern and Southeastern European women immigrants in Switzerland, who experienced deskilling and the specific activities they have undertaken to improve their labour market participation. These strategies include reskilling, working below their skills, creating their own employment, and doing volunteer work.

Dr Calenda

Dr Calenda thanked the reactors and agreed with their comments and critique. His response will go into the final report, but for now he picked some points to discuss.

Portability is one big issue when citizens move to other countries and for the United Kingdom as well. On the migrant's contribution, there is literature [British] to be read and there are ongoing contentions such as on the matter of paying taxes.

On the comment about the migrants' plan to return, this was a multiple response question, to which respondents expressed the possibility of returning home, together with other options. It is not that 31 per cent are going home, but that this is a choice along with other options. On historical linkages the reactors were absolutely right, according to Dr Calenda. Furthermore, the Filipinos in the United Kingdom are the best, considering that in United Kingdom, there is no need for a university degree to become a nurse. The Filipinos in the United Kingdom do not have a bad image, even from employers, and are not problematic in terms of integration.

Lastly, on the respondents' feeling of having better or worse working conditions than colleagues working as nurses in the department, the data was cross analyzed with a previous question on whether they work in a team, and another on how the team was composed. This came out as significant in the regression model.

Open Forum



Dr Stella Go wanted to clarify the methodology used, noting that sampling is skewed, considering that this covered only 36 Filipino nurses compared to 397 Indian nurses, which will affect data analysis and the appreciation for the data. Also, the online survey has to be clarified in terms of how this was done -- were respondents from large-sized hospitals, the number of years spent in the United Kingdom, and other factors that could have an impact on their working conditions. Since the research focused on working conditions, what questions were asked? The questions are perceptual, whether conditions

have become worse than before. But it might be better to ask for actual indicators, like working conditions, wages, and the like.

Dr Calenda's statement about foreign nurses not making a contribution to the UK economy has to be clarified, though he referred to "not paying taxes". According to Dr Go, this may not be accurate because foreign nurses make their contribution by keeping the health system alive. Without them, who will take care of the health needs of UK citizens?

Dr Go also asked for clarification on the statement that "migrant workers are passive", mentioned by Ms Siar. From her viewpoint, migrant workers have a lot of "agency", to use a sociological term, because they make a choice.

Responding to Dr Go, Dr Calenda clarified that his research report had detailed data regarding the questions raised, but which he did not include in his presentation. There is data on their actual working conditions, particularly on their hours of work, where they work, and what kind of structure of work. Furthermore, he was not interested in comparing the Indian and the Filipino nurses, but in looking into the worker as a human being in the United Kingdom, with specific characteristics coming from another culture. It was difficult to reach the Filipinos for the questionnaire. The main issue is racial discrimination in the United Kingdom. He emphasized that he cannot generalize the results, not for the Filipino or for the Kerala Indians. The efforts in the qualitative interviews were intended to compensate, and he is aware that this is far from a perfect triangulation model of research. Nonetheless, he is happy to be told that other sources of data confirm what he has found. Finally, on the migrants' contribution, that is the mainstream position in the United Kingdom, considering politics and the manipulation of public concern.

Also pertinent to Dr Go's comments, Ms Siar clarified that there was a mistake in the statement. It was meant to say: "...migrants are pictured as passive victims; but I like to think of them as active participants in the migration process, their adaptable and flexible nature to address the unpleasant realities of migration is what partly makes migration a continuing phenomenon".

Ms Casco asked Dr Calenda to clarify his recommendation for clear measures to monitor the implementation of the code on ethical recruitment. She wanted to know how this can be monitored, considering the voluntary nature of the code. On placement fees, both skilled workers and professionals, even low skilled workers have experiences and this has been a challenge for countries of origin, and which would need the cooperation of the countries of destination. Ms Casco raised her view that more than voluntary codes, there should be regulations for countries of destination to impose and to regulate the malpractices of recruiters. Even when the country of origin, like the Philippines, has rules and regulations, it will need complementary action from the other side.

Ms Wiskow inquired if Dr Calenda's research took account of the terms of employment, not only of the migrant workers, but also of the national workers in the facilities, since the terms of employment might be a determining factor.

Dr Calenda immediately replied that the study considered the kinds of employer and types of contracts, for which there were questions in the survey. Most of the respondents had full-time jobs. This background information was not significant in the regression model.



Director Rustico de la Fuente of the National Reintegration Center for overseas Filipino workers (OFWs) observed the need to revalidate the study to check on whether there is a failure on the part of Filipino nurses to cope with the situation in the United Kingdom, or if it had problems with its structure, such as with the retention system. It seems unusual, he said, for 31 per cent to want to return home, because the tendency of nurses migrating to Europe is to remain there and even bring their families in the succeeding years, such as happens in Belgium and other parts of Western Europe. In his observation, if there is a high level of dissatisfaction, this must be indicated by some form of

formal complaint. But there are no significant complaints received by the Overseas Workers Welfare Administration from Filipino nurses in the United Kingdom. Regarding the availability of a reintegration programme for Filipino nurses, Director de la Fuente gave the good news that migrants have options when they return, and this return programme is currently being improved. Definitely, migrants can be referred to re-employment opportunities or they can take the option to go entrepreneurial.

Dr Calenda replied that the sample is not representative. But take for example a person who went to the United Kingdom ten or 12 years ago and who brought their family after a few years. Now, the migrants have to decide whether to let their children go through the UK education system or to return home. There is some kind of a life cycle. Their situation now is different from their situation before.

On the evidence of complaints, Dr Calenda's key informant interviews showed that the Filipinos in the United Kingdom solved their problems within the Filipino community, not through trade unions or institutions. This is a less publicly visible way to solve problems. But from the institutional point of view, this is not very good, because the problems remain to be invisible, which cannot lead to change in the system.

Assessment of Existing Services for Skilled Migrant Workers: Philippine Project Site

Session Panel

Professor Lorenzo presented her study that assessed the existing services for skilled migrant workers in the Philippines. The Philippines is one of the project sites of the ILO Decent Work Across Borders (DWAB) Project. Ms Wiskow took the role of facilitator. Reactions were provided by Ms Casco and Dr Yolanda Robles, Executive Vice-President, Philippine Pharmacists Association.



Focus. Professor Lorenzo examined the services available to skilled migrant workers in the Philippines. When the study began, the multi-disciplinary team was cognizant of ILO's aim to foster a "mutually beneficial" approach to migration that benefits the migrant workers, and source and destination countries, within a rights-based framework for labour migration management.

Research Objectives. On the goals of this commissioned research, the team "sought to better understand schemes related to circular migration of health professionals (more specifically nurses), and through this, "map-out, assess, and recommend enhancement of existing services for both prospective migrants, and returned/returning migrants, with a special focus on health-care professionals." Specific objectives were to:

1. Review and confirm mapping of existing pre-orientation, pre-departure, and return services in the Philippines that are available for skilled migrants, especially for health-care professional migrants, based on recent literature;
2. Describe services utilized by health professional migrants;
3. Assess the effectiveness of existing services to health professional migrants from their point of view;
4. Identify gaps and needs for new services;
5. Arrive at consensus among stakeholders and draft recommendations based on the discussion; and
6. Develop relevant final recommendations to address identified needs and gaps to be given to national government agencies and non-government organizations working on migration services in the Philippines.

Framework. The conceptual framework showed the process of scoping and mapping of national organizational policies and programs on migration services, the assessment of agencies providing services, and the analysis of gaps and needs for new services leading to recommendations for improvement. Stakeholders' perceptions were obtained in the assessment of the policies and the services.

Research Questions. The review of related literature showed the deployment of Filipinos overseas, of which 1.4 million were deployed in 2010. Nurses were the most number of deployed among health workers, in different destination countries topped by Saudi Arabia. From 2007-2011, the reports show the deployment abroad of 60,909 nurses; 5,539 physical and occupational therapists; 1,075 medical doctors; and 530 pharmacists. The Philippines has been cited as Best Practice Model for Migrant Services. In this context, the research questions were posed, specifically: how effective are current policies and services offered by national government agencies and non-government organizations, and what policy directions can be undertaken to improve migrant services?

Methods. The methodology for this research employed a descriptive-analytic design. The first level assessment covered policy scoping and mapping of international and domestic policies, and extensive literature and records review. For the second level assessment, inquiry/interviews and focus group discussions were conducted. A total of 14 government institutions were interviewed and nine non-government organizations. Content analysis was used on the interview data and organized these into matrices. Data triangulation was conducted to ensure reliability and validity of information.

Subsequent to the desk review and interview, the research team conducted a round-table discussion, for consultation and consensus among stakeholders, and drafting of recommendations to submit to government and non-government organizations working on migration in the Philippines.

Findings. In summary, the key findings showed the evolution of policies and services, and the types of services rendered by various stakeholders such as government, and private sector recruitment agencies.

Evolution of policies. The timeline of policies was constructed to show the enactment of policies through the decades, since the Martial Law era in the 1970s up to 2010. This shows the complexity of policy development concerning migrant workers services in the Philippines.

The evolution of policies and services started with the Social Security Act in 1954. From the 1970s to 1980s, government agencies were established to actively manage overseas employment, train workers, ensure their welfare, manage recruitment, and later on, included reintegration.

In 1995, the landmark Migrant Workers and Overseas Filipinos Act was passed. It still largely covers the services and regulatory bodies that protect migrant workers. The law has provisions on overseas employment, multi-agency involvement, and services for migrant workers.

Between the 1990s and 2000s, many policies came about, but mainly to strengthen these agencies and expand their services. In 2010, amendments to the Migrant Workers and Overseas Filipinos Act were approved, including the creation of more agencies and expansion of services.

Migration Services. A matrix was developed showing the analysis of services and programs for Filipino migrants and corresponding agencies providing such services. Registration is the most predominant migrant service provided by these agencies, with medical services, savings and remittance services the least provided.

Different types of stakeholders were found to be involved in the provision of migration services, specifically: (1) national government agencies; (2) a sample of private sector agencies; and (3) prospective migrants and “circular” migrants.

Services for migrant workers were then listed and classified as (a) compulsory and non-compulsory; and (b) mandated vis-à-vis non-mandated. Services across the different migration cycle phases could be classified into different service foci: (1) overseas employment information; (2) personal financial security; (3) social security and welfare; (4) competency/skills enhancement; and (5) reintegration services.

Analyzing migration services, the government agencies with critical involvement are the Overseas Workers Welfare Administration (OWWA), CFO and POEA. Private sector recruitment agencies are involved. There is multi-agency involvement in the following services: (1) reintegration; (2) social security and welfare; (3) financial security; and (4) provision of overseas employment information. The data shows that there are no dedicated specific functions for each agency. One agency, government or private, can have multiple functions and multiple services.

The study noted the differences in the perception of the service providers about the service they provide compared to the perception of the recipients on the service they received. The study also

looked at information-based strategies. The research team saw the need for the evaluation of the services and for further understanding of cooperative strategies across the different providers.

Undertaking “gaps analysis”, the research noted the most prominent actors in migrant services provision, namely three government agencies:

- CFO was identified as the “premier institution promoting policies, programs and projects with migration and development as a framework”. They were mostly in the business of advocating programs and projects but did not give specific services.
- OWWA is the one responsible for the “delivery of welfare services and benefits and ensuring capital build-up”.
- POEA, on the other hand, “regulates overseas employment through tripartism, full disclosure, deregulation, selective deployment, dynamism in systems and information technology”.

Most agencies provided services that they were mandated to do, e.g. POEA, the Central Bank of the Philippines (BSP), Land Bank of the Philippines, Technical Education Skills Development Authority (TESDA), and Philippine Health Insurance (PhilHealth). The services vary -- from migration verification to financial services and education, and even social health insurance.

Some agencies’ services evolved over time (e.g. CFO, OWWA, and DFA-Office of the Undersecretary for Migrant Workers Affairs), but some agencies marginally provide direct migrant services as they only provide support services such as the DOH, PRC and Social Security System (SSS). DOH, for example, has this new concern in providing health services for migrants, but thus far they have not provided for any specific programs to protect migrants’ health whether here or abroad.

Most non-government agencies only complement or extend the services of government agencies. Most of these are involved in providing information services such as pre-departure orientation seminars (PDOS), pre-decision kits and the like, e.g. recruitment agencies (EDI Staffbuilders, LBS Recruitment Solutions) and the Philippine Nurses Association (PNA). Surprisingly, many migrants identified recruitment agencies to be one of those that provided comprehensive recruitment services from information provision to processing of employment, and on site. They even provided post deployment assistance and, when needed, repatriation assistance.

There were also agencies that provided advocacy services. Trade Unions-PSLink, the Philippine Government Employers Association (PGEA), and Ang NARS are examples of these service organizations. Most professional organizations just provided document certification and verification and continuing education certification, e.g. Continuing Professional Education-Philippine Physical Therapy Association (CPE-PPTA), Philippine Pharmacy Association (PPhA), and the PNA.

In terms of feedback from the migrants, their affirmation of services, as well as negative comments, the PDOS and Pre Employment Orientation Seminars (PEOS) were the most visible and experienced services. PDOS was recognized as necessary, but implementation issues abound. For example, PDOS will only be

given a few hours before the migrant's departure, consequently making it difficult for migrants to absorb the discussions.

The findings also showed that migrants did not appreciate the compulsory services of the Pag-IBIG and PhilHealth, as these were viewed as unnecessary deductions from migrants' earnings. The embassy, DFA, and reintegration services were most invisible, according to the respondents. Web-based information and services were appreciated the most.

Recommendations and Policy Implications. The recommendations based on the findings include the following:

Recommendations for stakeholders:

- Streamline services. Most services overlap or sometimes, even compete, with each other;
- Establish linkages with Philippine Overseas Labor Office (POLOs) and other on-site offices and establish connectivity with other government offices. The DFA needs to work more closely with the Department of Labor and Employment (DOLE) and they need to work more closely with SSS;
- Decentralize services to regional levels, recommended to the POEA. Instead of the migrants going to the POEA office and queue for hours, the services may be decentralized to POEA regional offices;
- Reach more people through technology;
- Review of partnerships to improve partnership;
- Improve data and information sharing and collaboration; and
- Segregate health professional migrant workers from other migrant workers and distinguish the services provided.

The policy recommendations generated from the findings are as follows:

- Conduct policy scan to determine the need for updates on the mandates to reflect services that they actually provide or plan to provide. With so many agencies right now going into migrant services and even coming up with newer offices, there is a need to rationalize;
- Harmonize organizational policies to minimize policy and programme gaps and overlaps;
- Clarify organizational focus; and
- Clarify roles of migrants, their families and providers of services, and provide incentives.

Furthermore, the study elicited recommendations for organizational development, which are:

- Improve coordination and inter-linkages between government, non-government organizations and migrants; and
- Explore a network organization in the field of migrant services provision (Proposed Organization for Migrant Service Providers in the Philippines), and determine who would be the key coordinator of all these services.

Reactions

Ms Casco



Ms Casco underscored the fact that the migration of OFWs has been managed through a strong legal and policy framework that regulate recruitment for employment in destination countries, and ensures their welfare and protection through the different phases of the migration cycle. She cited the passage of the Migrant Workers and Overseas Filipinos Act of 1995 as Amended by Republic Act 10022, which provided stronger mechanisms for the protection of OFWs. The implementation of the laws is done by several government agencies, with social partners from the private sector, workers' groups, civil society, academe, and media that participate in policy and programme development.

Ms Casco agreed with the recommendation on the streamlining and decentralization of services. According to her, government has done continuous streamlining and rationalization of services to address identified gaps and overlapping of functions. The OWWA Medicare programme was transferred to PhilHealth and the PDOS from POEA to OWWA. In this sense, certain agencies focused on certain services.

She emphasized the limitation of resources that hamper efficiency and full effectiveness of the delivery of services. The convergence of programmes and services is the approach now pursued to optimize efforts, i.e. inter-agency coordination in the delivery of services to OFWs at national and regional level, and partnership with the local government unit as mandated by law.

Still to be developed are skills-specific policies, programmes and services customised to the needs of the skill sectors. Standard employment contracts have not been prescribed for the health professionals.

In her view, the active migration of health professionals has given rise to the concerns for brain drain effects on the local health sector. Explaining further, this has resulted in the inclusion of human resources development (HRD) provisions in bilateral labour agreements. The objective is to get the cooperation of the country of destination and promote ethical recruitment practices.

Furthermore, the pursuit of social security agreements for OFWs can be expanded for better protection of our workers. Improvement of data and information sharing is also an important concern. At the POEA level, efforts are being made to pursue some online systems for the delivery of frontline services. A recent initiative is a Memorandum of Agreement signed with the Bureau of Immigration to monitor the movement of migrant workers.

Ms Casco suggested a stronger information campaign, to be undertaken on mandatory membership in government programs, like PhilHealth and Pag-IBIG, for all departing OFWs. This should promote better awareness and appreciation of the benefits afforded by these social protection mechanisms to the migrant workers.

She emphasised the importance of the policy scan to address programme gaps and improve services for OFWs. Also, programmes to strengthen the capacity of migrants to understand their rights and responsibilities in the migration experience, and maximizing their contributions to development should be strengthened. In this regard, the cooperation of the health sector is most welcome.

Dr Robles



From the perspective of a professional organization, Dr Robles said the study gave a very good glimpse of the existing services available to migrant workers, which are provided by both government and non-government groups at various stages of the migration process. She expressed appreciation for the speaker's discussion of policy development and the evolution of services.

The recommendation on creating a central coordinating body composed of the providers of migrant services, whether government or non-government, is significant. This will consolidate the efforts for services to migrant workers. However, which government agency or group will be able to fill up the function of coordinating? In making the selection, Dr Robles suggested the following criteria for the agency to take the lead in this central coordinating body: a good grasp of the migrant policies of sending and receiving countries; be accessible to migrants anywhere they are; have the facility for interaction with the migrant workers; and render an online inter-agency service.

The description of the nature of existing services and the classification of these services from pre-departure to departure are quite helpful in prioritizing areas where service gaps exist. An "incentive approach" would be helpful to encourage participation in, or utilization of, the services for migrant workers. People tend to participate in activities that they think are favourable to them.

Dr Robles is in favour of data and information sharing, collaboration, and performance evaluation, which are useful for the rights and welfare of the workers to be addressed. However, which office will validate the accuracy of the data provided or shared?

There are different kinds of services for migrant health workers, but there are gaps to be addressed. In Dr Robles' observation, services are still inadequate for the needs of various health professionals and there is inequality in the provision of information services to health professionals. There is a need to improve transparency on actual work conditions. Problems arise when there is conflict between expected and actual work conditions.

Open Forum

Mr Casco commented that very useful and practical information can be derived from the study. He explained that with centralised structures, functions, and homogeneous procedures, it would be difficult to set up a special door or counter just to address the specific needs of health professionals. What can be done is to make information occupation --



specific, client-specific, and to use available technologies, such as posting the information on websites.



Ms Siar inquired if the study included student-visa migrants? This is a “problematic” group, she said, because professionals who want to work overseas would have to pay a huge amount of money to enter countries of destination using a student-visa. She asked which agency should look after the needs and welfare of this group. In the framework of the study, are diaspora organizations considered as providers or sources of services, especially support services in the destination countries?



Mr Cesar Averia, Jr, from the recruiters’ group, brought up the issue of the placement fee. There are more than 1,000 recruitment companies in the Philippines. The placement fee is equivalent to one month’s salary. How about selective charging? According to Mr Averia, some of the recruiters’ clients prefer their workers to pay, which will lessen the charges to their companies, but others do not want to charge the workers. The EDI-Staffbuilders has followed this principle of not charging the candidate -- the best candidate need not pay anything. They study the markets to where they send Filipino workers. They visit

the countries where they deploy their candidates to assess the working conditions of the potential Filipino workers in these destination countries. They view the partnership of government, the private sector and the employers as necessary. This system has worked for their company in their recruitment of Filipinos to Finland.

Professor Lorenzo responded to the questions and comments raised by the participants. Regarding the difficulty of providing special lanes for health professionals, it is important to be creative in providing services, considering limited government resources. Migration service transactions are much easier in areas of destination than in the Philippines. Why? It is not just the queuing with other migrant workers, but the health workers’ concept of service, which is, that they are provided with the specific information relevant to their needs. On student visa holders, the study had interviews with some prospective migrants. They are “in-between” because they are not really workers. For now, there are no services for such special cases. In response to the representative of the recruitment agency, Professor Lorenzo agreed that public-private partnerships, plus the employers, are essential in safeguarding the welfare of the workers.

In addition, one reactor acknowledged that the issue of student visa is a grey area and a new policy is needed to take up the welfare of student visa holders. The other reactor highlighted the importance of information from the returning migrants in designing services given their personal experiences, and the potential of government agencies and non-government organizations working on migrant concerns to be the employers for returning migrant workers.

As additional comments, the reactors noted, respectively, that a new policy is needed to take care of student visa holders that returning migrants’ information and personal experiences can contribute to the design of services.

PLENARY SESSION

Highlights of the Presentations

In the plenary session, Ms Vaillancourt-Laflamme summarized the key points presented by the researchers of the ILO-DWAB commissioned research projects.

From Ms Makulec's presentation, Ms Vaillancourt-Laflamme highlighted the point raised about the scope of bilateral agreements, which should not be limited to recruitment but also include protection and brain drain damage. Also, monitoring and evaluation are essential, as without these, bilateral agreements often fail. On Ms Makulec's discussion on the Philippines' "something is better than nothing" approach, Ms Vaillancourt-Laflamme called attention to the debate, whether to uphold this or take another approach. In terms of circularity, Ms Vaillancourt-Laflamme emphasised Ms Makulec's view that if there are possibilities, there are also questions and challenges that need to be addressed, particularly social protection, access to training, and costs of circularity.

On Dr Wickramasekara's presentation, Ms Vaillancourt-Laflamme stressed three main points. There is a need to go beyond impact assessment in looking at the effects of migration in the health labour market in receiving countries. The critical migration policies in the host country were quite important. More transparency in the fitness of practice is needed. Also important are: proper induction programs for migrant workers when they go and when they arrive; collaboration between country of destination and country of origin; and social dialogue -- as well as many more in the list of Dr Wickramasekara's list of recommendations.

From Dr Calenda's presentation, the important observations emphasised by Ms Vaillancourt-Laflamme pertain to the motivations and detachment among Filipino and Indian-born nurses in the United Kingdom, as well as their desire to immigrate or to return to their home country. These are, perhaps, related to the downgrading of global working conditions in Europe, particularly in the United Kingdom. Also important are the bilateral agreements, and the monitoring and implementation of the code of ethics to help migrant workers cope with their working conditions.

As for Dr Lorenzo's presentation, the streamlining of many services that Philippine authorities have put in place for migrants is important. On the issue of the placement fee, the representative from the recruiters' group gave very good comments. Also important, according to Ms Vaillancourt-Laflamme, are social protection and bilateral agreements.

Steps Forward for ILO

Ms Vaillancourt-Laflamme proceeded to address the panel of speakers for their ideas and insights on what to do, and what to focus on for the ILO constituents -- the trade unions, government, and employers.



According to Dr Wickramasekara, trade unions have an advocacy role, a support role, and an organizing role. He expects trade unions to do advocacy for migrants' rights, and to take up the cause of migrant rights. In his analysis of migrant workers, they have serious problems with conditions at the workplace, and they need organization. The unions are there [to help them] to recognize their rights. Induction programmes are also helpful. They can act on governments for compliance and they can do promotion of the codes of practice.

Regarding governments, it is clear that they have migration policies, in the United Kingdom and the United States. But Dr Wickramasekara said that they should try to distinguish migration control and proper migration policies. Governments have a responsibility for policy, legislation, and implementation, and should help in the ratification of conventions, and promotion of guidelines. He thinks that collaboration between countries of destination and countries of origin is necessary. Governments should be asked to give technical assistance programs. When they talk about circular migration programs, of bilateral programs, governments have a major role, particularly in brain drain damage.

For employers, Dr Wickramasekara expects them to hire and ensure decent work for health workers.

Dr Lorenzo expressed the view that trade unions are much underappreciated in the Philippines and most people see trade unions as trouble-makers, but she knows positive experiences from the case of the Philippine General Hospital where employees and faculty formed their organization. She suggested the formation of an extensive information system on the rights of workers, and what trade unions can provide. Trade unions can draft frameworks on working conditions. She cited the case of a health professional contracting an infectious disease due to poor working conditions.

For government, Dr Lorenzo acknowledged the services they are doing, but government should concentrate on providing policies, regulations, and doing pilot services. Once some mechanisms work well, government should turn these over to the non-government organizations and to the private sector. Even with meagre resources, the public expects services from government.

The employer hospitals should provide skills upgrading and improved working conditions. There are many hazardous conditions in the health sector. If work conditions and training of staff are not up to date, there are "horror stories" that can come out, particularly in terms of the worker's health and not being cared for.

Dr Calenda focused on the need for information among the community. Protection should shift from the community to something much more organized and structured. He suggested organizational change in the trade unions, since the problem is that trade unions have become too technical and too professionalized, and have lost touch.

From government, Dr Calenda expected clear policy. It is very important for government [of sending country] to cooperate with the destination country, and to deal with segregation and segmentation. He thinks that many people have become alienated.

For the hospital employer, Dr Calenda, taking himself to be the manager, asked “why recruit [migrant health workers]? Would it make a difference?”

Being the last to speak, Ms Makulec thought it difficult after everything had been said, and it was challenging to give recommendations for all three groups. She said, perhaps, there should be country-to-country or government-to-government agreements. While government is a major actor in negotiating bilateral labour arrangements, there is little said about employers' role. Government is active in discussions about content, consequences of forming the agreement and its implementation. They also take the role of promoting the mechanisms of bilateral labour agreements.

The effectiveness of the bilateral labour arrangements is not as high as it should be. According to Ms Makulec, it would be good to find other channels and involve other actors to support the development of bilateral labour agreements. Evidences and best practices are also needed to enhance implementation of bilateral labour agreements and other tools such as the WHO Code of Practice for the International Recruitment of Health Professionals, and their monitoring.

CLOSING

In closing the Policy Dialogue, Ms Vaillancourt-Laflamme remarked that the migration of health professionals is not a simple issue. While she has worked on this for a few years, those present have done so for many more years. For her, health is a very complex issue; health is a human right, and there is a need to look at health professionals in this framework.

In international circles, health is quickly turning into a “normal commodity”, which calls attention to revisiting the political agenda. Because health is what it is, the private sector may not be the best to take the lead in policy-making. The drivers behind the importance of health command the government for a public health approach. It is a difficult issue to handle, she said, because if health is a human right, the migration of health professionals is also touching upon the right of mobility, and on the right to decent work. The migration of health professionals is never a “one solution” deal. It is always a compromise between these fundamental rights. In taking one direction to solve some component, some sectors and actors become unhappy and pull to the other direction. That health is a complex issue might be an apt explanation about the difficulty in looking at this issue.

Ms Vaillancourt-Laflamme thanked the resource persons, reactors and facilitators in providing guidance on this complex issue. She added that because of the nature of health as a public good, there is a role for government as a custodian of this good to actually act on this; and, in that framework, there is a role for employers and trade unions to intervene in the debate as well.





In closing, she said that the discussion had provided the way for how ILO constituents could intervene in making the migration of health professionals benefit all the workers and employers, and for access to health care in sending and receiving countries.

Ms Vaillancourt-Laflamme thanked the documentation team and the staff. She thanked the EU for allowing them to work with competent people and all the participants.

For the next step, she announced that the report on the proceedings will be made available to the participants. Invitations will be given on future topics, one of which will be on the ethical business model for recruitment agencies, noting that there are many good recruitment agencies. The IOM is looking at this issue along with some recruitment agencies. In the following months, a business model on recruitment agencies might be readily available. Furthermore, the research results will be shared with the destination countries in Europe. Ms Vaillancourt-Laflamme finally closed the day's Policy Dialogue with an expression of sincere thanks to all.