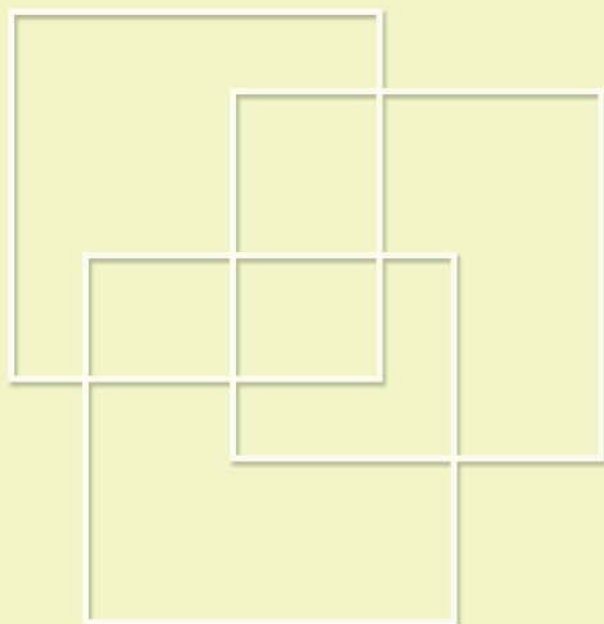


ILO Asia Pacific Working Paper Series

Philippines' Bilateral Labour Arrangements on Health-care Professional Migration: In Search of Meaning

Agnieszka Makulec
Centre of Migration Research
University of Warsaw
Poland



Promoting Decent Work Across Borders:
A Project for Migrant Health Professionals and Skilled Workers

Country Office for the Philippines

ILO Asia-Pacific Working Paper Series

Philippines' Bilateral Labour Arrangements on Health-care Professional Migration: In Search of Meaning

Agnieszka Makulec
Centre of Migration Research
University of Warsaw
Poland

A report prepared for the EU-ILO Project on
Decent Work Across Borders:
A Pilot project for Migrant Health Professionals and Skilled Workers,
Manila, Philippines

Country office for the Philippines

Copyright © International Labour Organization 2014

Publications of the International Labour Office enjoy copyright under Protocol 2 of the Universal Copyright Convention. Nevertheless, short excerpts from them may be reproduced without authorization, on condition that the source is indicated. For rights of reproduction or translation, application should be made to ILO Publications (Rights and Permissions), International Labour Office, CH-1211 Geneva 22, Switzerland, or by email: pubdroit@ilo.org. The International Labour Office welcomes such applications.

Libraries, institutions and other users registered with reproduction rights organizations may make copies in accordance with the licences issued to them for this purpose. Visit www.ifro.org to find the reproduction rights organization in your country.

ILO Cataloguing in Publication Data

Makulec, Agnieszka

Philippines' Bilateral Labour Arrangements on Health-care Professional Migration: In Search of Meaning. A report prepared for the EU-ILO project on "Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers", by Agnieszka Makulec; International Labour Organization, ILO Country Office for the Philippines. Makati City: ILO, 2014

ISSN: 2227-4391; 2227-4405 (web pdf).

International Labour Organization; ILO Country Office for the Philippines

(Key words to come)

14.09.2

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.

The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them.

Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.

ILO publications and electronic products can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above address, or by email: pubvente@ilo.org

Visit our website: www.ilo.org/publns

Printed in the Philippines

Foreword

Globalization, medical and demographic changes, uneven distribution of health professionals as well as newer technologies in service delivery, have encouraged health workers to cross borders, often in search for better opportunities. In turn, many developed countries rely on foreign health professionals to address shortfalls in their own supply and demand for healthcare workers. In the early 2000s, many observers of the international movement of health professionals used the term “brain drain” to describe the effect of such mobility on source countries. The importance of governing migration to address this deficit of talents in source countries became a priority for ethical recruitment conscious actors.

In 1949, the ILO, through its Recommendation No 86 – which contains a Model Arrangement on Temporary and Permanent Migration for Employment, including Migration of Refugees and Displaced Persons - paved the way for bilateral labour agreements as being the best mechanism to avoid many of the risks faced by migrant workers. This model agreement has since been used by a number of ILO member States in the design of bilateral labour migration arrangements. More recently, many destination countries – and international organizations including the World Health Organization – have developed codes of practice for the ethical and international recruitment of health professionals. All of these guidelines emphasized the need for governments to engage in bilateral arrangements to address the effects of migration on source and destination countries.

The Philippines started developing bilateral labour arrangements for the mobilization, training and employment of skilled and less-skilled workers in the 1970s. Since then, arrangements concluded by the Philippines with destination countries have improved in terms of scope and content.

To date, few studies focussing on bilateral labour arrangements have been conducted. There remain significant uncertainties with regards to the form, role, content, process of negotiation and the implementation needed for those bilateral arrangements to reach their stated objectives.

The ILO, through its European Union funded Decent Work Across Borders project is pleased to be part of the dialogue around bilateral labour arrangements and wishes to contribute to the reflection of policy makers in source and destination countries and other important stakeholders, on the best way forward in so far as migration of healthcare professionals is concerned.

The ILO would like to acknowledge the efforts of Ms Agnieszka Makulec in providing a historical account of bilateral labour agreements with selected countries and for engaging with many stakeholders in the Philippines and selected destination countries in order to shed some insights on the dynamics surrounding bilateral labour arrangements for the mobility of health professionals. It is hoped that the following analysis and reflections will contribute to improving the governance of migration between source and host countries and ultimately, benefit migrant workers and their families as well.

Lawrence Jeff Johnson
Director
ILO CO Manila

Table of contents

Foreword	.....	iii
Acknowledgement	.....	v
Executive Summary	.....	vi
1. Introduction	.....	1
1.1 Bilateral Labour Agreements: a policy tool to manage migration		3
1.2 To recruit or to restrict? On the debatable role of bilateral labour arrangements.....		5
1.3 Is something really better than nothing? On the Philippines' approach to Bilateral Labour Agreements.....		7
2. Background of the study		12
2.1 Study objectives and scope		12
2.2 Methods and sampling		13
2.3 Limitations of the study		13
3. Findings of the study		14
3.1 Limited effectiveness without implementation: the case of Norway and Spain.....		14
3.2 Better late than never? The case of United Kingdom		18
3.3 Importance of language, requirements and consultation process: the case of Japan		24
3.4 Why to bother with BLAs when recruitment goes well? The case of Bahrain and Saudi Arabia		30
3.5 Lessons learnt from Philippines' Bilateral Labour Agreements and policy implications		33
Bibliography	.....	37
Annex 1:		
List of respondents of interviews		42
List of participants of roundtable discussion.....		43
Annex 2:		
Research questions and methods		44
Annex 3:		
Frameworks and model agreements on content of Bilateral Labour Agreements		50
Annex 4:		
The content of Philippines Bilateral Labour Agreements on health-care professionals migration.....		53

Acknowledgements

This study could not have been completed without the valuable support and kind cooperation of a number of institutions and individuals, who spent time sharing their knowledge and discussing the key issues during the interviews. Although it is not possible to mention all engaged in this study, the author would like to specially thank:

- *ILO-EU funded project on Decent Work Across Borders (DWAB)*

Ms Catherine Vaillancourt-Laflamme, Chief Technical Advisor of the ILO DWAB project and Ms Jennifer dela Rosa, National Project Coordinator of DWAB, for believing in me and my study, valuable comments, constant encouragement, a lot of patience and on-site help during my field trips to Manila; Ms Desiree Joy Granil, ILO DWAB Project Assistant for on-site help during my field trips to Manila.

- *Philippine Overseas Employment Administration (POEA)*

Mrs Liberty Casco for an informative interview and sharing official POEA statistics on deployment of Filipino nurses within bilateral labour arrangements, as well as for her valuable participation in the roundtable discussion organized in Manila in February 2014.

- *Experts interviewed in-person and via telephone from the Philippines, United Kingdom, Norway and Japan*

All experts listed in Annex 1 from institutions who spent their valuable time to discuss the issues of Bilateral Labour Agreements (BLAs) and migration of health professionals from the Philippines during field trips to Manila (Dr Teresita Barcelo from the Philippines Nurses Association, Dr Kenneth Ronquillo from the Department of Health, respondents from the Overseas Worker Welfare Administration, Department of Foreign Affairs, PS-Link, the Alliance of Filipino Workers, the Federation of Filipino Workers, the Philippine Medical Association, the Philippines Physical Therapy Association and recruitment agencies, ABBA Personal Services, LBS Recruitment Solutions Corporation, IPAMS), to London (Mr Amos, former deputy Director of National Health Service, Mrs Cueva from UNISON and Workforce Division of Department of Health) and to Oslo (Philippines' Embassy in Norway, Directorate of Health, Fagforbundet). And via telephone (Dr Hirano from University of Nagasaki, Mr David Benton from the International Council of Nurses, the Japanese Embassy in the Philippines, Public Service International, the European Public Service Union, and the European Hospital and Health-care Federation).

- Experts who participated in the roundtable discussion
- All experts listed in Annex 1 who were kind enough to commit their time for discussion about the role of BLAs in managing migration of health professionals, and worked together for recommendations on BLAs improvements.

Executive Summary

Nowadays, there is a shortage as well as inequitable distribution of health professionals in many countries, which together with the increasing demand on health-care workers due to demographic changes intensifies the need for health-care workers globally. In 2006, the World Health Organization (WHO) estimated that there was a shortage of more than 4.3 million health personnel across the world and 57 countries (mainly sub-Saharan and South-East Asia) that suffered from critical shortages (WHO, 2006). On the other hand, the increasing demand on health-care professionals due to aging societies is identified in many developed countries and pushes them to international recruitment of health-care workers. Unmanaged international recruitment of health-care workers could have negative consequences for the sending countries, known as brain drain, and for the migrants themselves following the lack of sufficient protection of their human and employment rights. In the case of outflow of health-care professionals, brain drain means that the sending country is not only losing its “best and brightest”, which could have negative welfare implications (Bhagwati & Hamada, 1974), but also that the outflow of health-care professionals could endanger the “right to health” of the remaining population (Plotnikova, 2012).

Although the primary objective of BLAs is to facilitate recruitment of workers, it is currently recognized that they also have other objectives to achieve. Already, the ILO Migration for Employment Recommendation, 1949 (No. 86) indicated that government-to-government agreements should also aim at protection of the migrants’ rights. Similarly, the Philippines’ Republic Act 10022 claims that Filipino workers shall only be deployed in countries where their rights are protected, and sees the existence of BLAs with the receiving country as a guarantee of sufficient protection. The role of BLAs in mitigating the negative consequences of migration for sending countries either by setting the safe recruitment targets or introducing compensation measures is also well founded in national and international soft law documents. The United Kingdom Code of Practice for the international recruitment of health-care professionals (2004) says that “developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the United Kingdom to support recruitment activities”. The WHO Global Code of Practice on the International Recruitment of Health Personnel from 2010 -- despite discouraging active recruitment of health-care professionals from the countries with critical shortages of personnel -- also indicates that BLAs “should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate [compensation] measures”.

This report discusses the findings of the study entitled “The Philippines’ Bilateral Labour Arrangements on Health-care Professional Migration”, conducted between November 2012 and May 2013, with the EU funded ILO project “Decent Work Across Borders: A pilot Project for Migrant Health Professionals and Skilled Workers”¹. It aimed to study how the three roles of BLAs -- facilitation of recruitment, protection of migrants’ rights and mitigating of negative consequences of migration for sending countries -- are secured and implemented in the BLAs on health-care professionals’ migration between one of the major health professionals’ exporting countries, the Philippines, and five destination countries: the United Kingdom, Norway, Spain, Bahrain and Japan, all with whom the Philippines signed the government-to-government agreements dedicated to the migration of health-care professionals. Additionally, the recruitment of Filipino health professionals to the Kingdom of Saudi Arabia in the absence of the government-to-government agreements was studied. The study findings are based on the combination of different research methods, including both desk research (review of literature, legislation mapping and analysis of statistics) and field research (in-depth interviews with 32 stakeholders from government authorities, national and international professional organizations and trade unions, recruitment agencies,

¹ http://www.ilo.org/manila/whatwedo/projects/WCMS_173607/lang-en/index.htm

employers and academia in sending and receiving countries, as well as one focus group discussion, were conducted).

The findings of the study illustrate the numerous challenges in terms of the negotiation and implementations of BLAs (no matter if it is a recruitment agreement or memorandum of understanding) have to overcome in order to be effective in achieving any of its objectives. Due to various reasons, including particularly the asymmetry of powers during the negotiations of BLAs (reluctance of receiving country to enter into BLAs (Go, 2007) and “something is better than nothing” approach of the sending country, which will be explained further on in the report (Wickramasekara, 2012), it is very difficult in practice to negotiate the agreement equipped with all mechanisms to achieve its objectives.

Moreover, as BLAs with Norway (2001), Spain (2006) and Bahrain (2007) showed, it is even more difficult to have the negotiated agreements implemented, in particular if the receiving country is able to recruit the workers in the absence of the agreement -- thus having no incentive to make any binding commitments (this is also illustrated by the case of Saudi Arabia). Similarly, the example of BLAs with the United Kingdom shows that they could not have been fully effective if it is partial in its scope (e.g. does not cover both private and public sector), as its implementation is too bureaucratic and it misses the right timing. Finally, the importance of specifying the requirements and solving the language issue, as well as inclusion of non-state actors in the process of BLAs negotiation and implementation, is illustrated by the example of the Japan-Philippines Economic Partnership Agreement (JPEPA). The deficiency in a BLAs’ consultation, which includes active and effective participation of non-state actors in design, negotiation, implementation, monitoring and evaluation of BLAs, could be a key contributor to its failure.

The assessment of bilateral agreements is also made difficult by the frequently missing monitoring and evaluation mechanisms. This diminishes the possibility of both parties to react to the changing needs and political situation in both countries and globally. The important question nowadays is, are BLAs doomed to failure and no longer as effective as some of the BLAs were earlier on in Europe in the 1960s and 1970s. However, the role of BLAs in the recruitment of health professionals nowadays is still very important, due to its new objectives and changing political circumstances in countries involved, as well as the intricacies of health professional migration, their negotiation and implementation, which face new challenges. Therefore, several recommendations on international and national levels are proposed in order to enhance BLAs’ effectiveness in these new circumstances, including in particular those related to increased circularity of migration. The main policy recommendations resulting from the study could be summarized as follows:

1. Nowadays, the objectives of BLAs, in particular those concerning the migration of health-care professionals, can no longer be limited to recruitment and protection of migrants’ rights. Due to the severe negative consequences that the migration of health professionals could have on the sending country, the BLAs should also include measures to address the challenges of the sending country’s health-care system resulting from the outflow. These may include setting safe recruitment targets, the monitoring of the health-care system situation in the sending country during the whole duration of the agreement, and inclusion of compensation measures, e.g. scholarships and exchanges of experts, joint ventures and investments in health-care system facilities in sending countries, and support by return and reintegration.
2. Although the negotiation of BLAs with receiving countries is a very difficult and challenging process, the approach of “something is better than nothing” is not very effective in practice. Many agreements lack implementation and only exist on paper, and/or the recruitment is done through the alternative channels. In order to enhance the chances for BLAs to get implemented,

the negotiation and implementation of the agreement should be supported by other mechanisms, including engagement of non-governmental actors in both countries, engagement in multi-stakeholders' initiatives, promotion of international soft law and best practices, and the introduction of national regulations enhancing the BLAs' effectiveness. Agreements should be tailor-made for the sending and receiving countries and should be developed in a timely manner. Moreover, the design of recruitment and implementation processes must be interdependent; otherwise the receiving country may have few incentives to enter into any commitments, in particular those concerning the guarantee of protection of migrants' rights, and mitigation of negative effects of recruitment for the sending country.

3. Monitoring and evaluating of any BLA is very important and should not be neglected. These elements must be carefully thought through at the time of the BLAs negotiation and should be implemented on the regular basis. Without a clear idea about BLAs' specific objectives and indicators of its success, it will be very difficult to assess and improve it after. Any vagueness in the content of the BLAs and/or excessive complexity of its implementation decreases the BLAs' effectiveness. The regular monitoring and evaluation of BLAs' effectiveness helps to better adjust the implementation process according to sending and receiving countries' current needs, and increases its effectiveness in meeting the three main BLAs' objectives (e.g. helps to react on any negative consequences that the outflow could have for the sending country and on other problems resulting from the BLAs' implementation).
4. Due to the increasing circularity of migration flows and the popularity of circular migration as a concept in many receiving countries, the BLAs should pay special attention to addressing the challenges linked to circular migration in terms of the protection of migrants' rights, such as the issue of portability of social entitlements, integration support in the receiving country, access to skills and professional development, and costs and consequences of circular mobility processes -- particularly challenges linked to return and reintegration of migrants in their country of origin. Moreover, regular monitoring and evaluation of the circular migration agreements is even more important in order to secure the benefits to migrants and their families, and to receiving and sending countries.

About the author

Ms Agnieszka Makulec (Makulec.agnieszka@gmail.com) is a researcher in the Centre of Migration Research at the University of Warsaw in Poland. Her academic interests focus on highly skilled labour migration, and in particular migration of health-care professionals. Ms Makulec has taken part in several studies on migration, the most important of them being: the EU-funded international research project MoHProf (Mobility of Health Professionals), which covered migration of health professionals to/from 25 countries; a quantitative study on Polish HP migrants inflow and outflow to all health-care units in Poland; synthesis reports for the European Migration Network and studies on migrant integration for the European Commission (e.g. on human traffic victims' access to residence permits in EU Member States).

This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of Mr Davide Calenda, consultant to the International Labour Organization, and can in no way be taken to reflect the views of the European Union.

1. Introduction

The increasing global shortage and inequitable distribution of health professionals in many countries has intensified the need for health workers globally. In 2006, the World Health Organization (WHO) estimated that there was a shortage of more than 4.3 million health personnel across the world (WH, 2006). It is remarkable that these shortages were identified in 57 countries, mainly in sub-Saharan Africa and South-East Asia, and that they often coexist in a country with large numbers of unemployed health professionals. Many of the countries with critical shortages are important exporters of health-care professionals at the same time. On the other hand, many highly developed countries are claiming an increasing demand on foreign health-care professionals in their health-care sectors due to demographic processes of ageing of their societies and insufficient training of health professionals. Global shortage of health professionals, together with an increasing demand on health professionals in many developed countries, have accelerated international health-care professionals' recruitment, mobility and migration. Whereas the WHO studies in mid-1970s indicated that 6 per cent of physicians and 5 per cent of nurses were living outside their country of birth (Mejia, Pizurki, & Royston, 1979), more recent studies show that the past decade has witnessed rapid increases in migration of health personnel, notably in most OECD countries (OECD -- Organization for Economic Co-operation and Development, 2007b).

Active recruitment of health professionals from the developing to the developed countries could have negative consequences for the sustainability of the health systems in the former. The term “brain drain”, coined initially by the British Royal Society to refer to the exodus of scientists and technologists from the United Kingdom to the United States and Canada in the 1950s and 1960s (Gibson & McKenzie, 2011), is currently a synonym for negative consequences the sending country may experience due to the loss of highly skilled health professionals. Numerous studies have showed that skilled emigration tends to lower the source country employment level and thus has negative welfare implications for the source country (Bhagwati & Hamada, 1974), and that brain drain incurs not only the losses of high skilled labour, but due to asymmetric information the immigrants tend to be the best individuals within the skilled group (Kwok & Leland, 1982). Moreover, the source country is also losing in terms of lost taxes the skilled migrants would have paid (e.g. Desai, Kapur, & McHale, 2003; Kapur & McHale, 2005) and outflow could result in increased income disparities in the source countries. Migrants' remittances, notwithstanding its positive role in poverty alleviation and financing education needs of family members in the country of origin (Docquier & Rapoport, 2011), could result in appreciation of local currency and increased dependency of source country on this source of income (Wickramasekara, 2003).

The migration of health professionals is a specific case among the migration of highly skilled workers because their outflow could worsen the health situation in the sending countries (Gibson & McKenzie, 2011). Cross-border mobility in the health sector is portrayed as both an opportunity for health professionals immigrating to developed countries, and as a challenge for those remaining in low-income countries with restricted access to health-care provisions (conflict between “the right to freedom of movement” and “the right to health”) (Plotnikova, 2012). Although the existing empirical evidence on health externalities from health worker migration is inconclusive², some evidence claims that there is an association between emigration and adult deaths from AIDS in African countries with high HIV incidence (Bhargava & Docquier, 2008), and that there could be a relationship between the outflow of

² Clemens (2007) finds no evidence of a relationship between the rate of health professional emigration and health outcomes in Africa. Bhargava et al. (2011) find no significant effect of medical brain drain on cross-country infant and child mortality rates or child vaccination rates.

health professionals and the quality of health-care services in the sending countries (Wickramasekara, 2003) or effectiveness of health-care system in the sending countries (Bach, 2003). Many developing countries do not only have high vacancy rates in their health systems, but also high unemployment of health specialists, and their systems suffer from unequal distribution of health professionals. Some claim that active recruitment of health-care professionals means that developing countries are subsidizing the rich, as many countries contribute financially in the education of health professionals who are leaving (Kapur & McHale, 2005; Makulec, 2013), and consequently claim that receiving countries should compensate for the loss, e.g. in the form of the Bhagwati tax (Bhagwati, 1976; Brauner, 2010; Scalera, 2011; Wilson, 2008).

Conversely, the relationship between the outflow of health-care professionals and functioning of the health-care system could be seriously questioned. It is debatable what the cause and what the outcome is in this case. Is it that outflow results in poor functioning of the health-care system of the sending country, or is it the poor functioning of the health-care system which pushes the health specialists to migrate? (Makulec, 2013). Some authors (e.g. Clemens, 2007) claim that low numbers of health professionals (HP) per capita and poor functioning of the health-care sector in some African countries are not directly linked to health-care professionals' migration, but rather results from the labour market segmentation in these countries. There are so far no reliable studies, which could give a definite reply on the relationships between the HPs' outflow and functioning of the health-care systems in the sending countries due to the difficulties to define the direction of the causality between the two, and the difficulties in defining what the good functioning of the health-care system actually is.

Moreover, it must also be mentioned that there are numerous studies concerning the positive effects of out-migration of highly skilled workers to sending countries, and to migrants themselves. These consequences are first of all linked to the transfer of skills by the returning migrants (Dustmann & Weiss, 2007; Mayr & Peri, 2008). If the migration is not permanent, the returning migrants are supposed to bring new skills to their countries of origin. Several studies showed that returning highly skilled migrants are experiencing a wage premium from migration on the labour markets of their countries of origin (Barrett & Goggin, 2010; Barrett & O'Connell, 2001), are sources of innovations (Chellaraj, Maskus, & Mattoo, 2006) and entrepreneurship (Commander, Chanda, Kangasniemi, & Winters, 2004; Luo & Wang, 2002; McCormick & Wahba, 2003) for their countries of origin. Returning migrants are more economically active than the remaining population (Dustmann & Kirchkamp, 2002) and they are fewer burdens on the social security systems. Many studies also claimed (Beine, Docquier, & Rapoport, 2001; Mountford, 1997; Stark & Bloom, 1985; Stark & Wang, 2002; Vidal, 1998) that out-migration of highly skilled workers contributes to the augmentation of the total human capital of the sending country as the perspective of migration acts as an incentive for education for both those finally leaving abroad and those staying. Consequently, the outflow results in the salary and income equality increasing in sending countries (Mountford, 1997), as well as an increase of total society wellbeing (Vidal, 1998), in particular in the long term (Fan & Stark, 2007). These positive effects of outflow on human capital formation in the sending countries were proved empirically only for countries with migration rates of highly skilled workers not exceeding 20 per cent and with the highly skilled rate in total population not less than 5 per cent (Beine, Docquier, & Rapoport, 2002). It is important to notice that countries, where the outflow of highly skilled workers was above 20 per cent (and there were relatively few highly educated people in the total population), experienced negative consequences of outflow for their labour market.

1.1 BLAs: A Policy Tool to Manage Migration

Although the BLAs had their heyday in Europe in the 1950s and 1960s when public employment services played a significant part in the recruitment of migrant workers (Wickramasekara, 2012), the past two decades has seen a revival of bilateral agreements, with the OECD reporting 173 bilateral agreements in Europe by 2003 (OECD, 2004). Nevertheless, it is estimated that some 25 per cent of bilateral agreements in OECD countries are apparently not implemented (OECD, 2007a). The most operational seem to be those that obey the demand-supply imperative (thus serve mainly the recruitment objective), as opposed to pursuing political objectives including migrants' protection and mitigating negative consequences of migration for sending countries. The majority of the BLAs tend to be general and to avoid binding commitments (Pittman, 2013). Generally, the BLAs could take different legal forms, which affects their scope and implementation, as well as impacting on its effectiveness. Stella P. Go distinguishes between bilateral agreements (BAs), which are formal, legally binding treaties relating to cooperation in various aspects related to labour migration and memorandum of understanding (MOU), which are not legally binding on countries and its effectiveness very much dependent on how well they are implemented and enforced by the contracting countries (Go, 2007). According to the UN Treaty Collection Reference Guide, an MOU "often sets out operational arrangements under a framework international agreement. It is also used for the regulation of technical or detailed matters. It is typically in the form of a single instrument and does not require ratification. They are entered into either by States or International Organizations." (1999).

BAs are further divided into BLAs, bilateral maritime agreements (BMAs), bilateral social security agreements (SSAs) and anti-trafficking agreements (ATAs). Special forms of BAs are bilateral economic agreements, which although not being primarily labour agreements, could also include migration components (the Japan-Philippines Economic Partnership Agreement, JPEPA, is an example) (Go, 2007). In her previous work, Stella P. Go divides the BLAs between the Philippines and other countries into two broad categories: 1) the labour recruitment and special hiring agreements; and 2) the labour, employment and manpower development agreements. Whereas the former focus on the terms and conditions of employment and recruitment of Filipino workers or the exchange of trainees, the latter (mainly signed with Middle East countries) focus on the promotion and strengthening of areas of cooperation, and exchange of information and enhancement of the welfare and protection of the migrants' rights (Go, 2004).

Most of the government-to-government agreements have a form of MOUs, which have an unbinding legal character³. Many countries seem to opt out for MOUs rather than recruitment agreements, because of following reasons explained by Wickramasekara (2006):

- The looser form of MOUs make them easier to negotiate and implement than a BLA, which is legally a more complex instrument.
- An MOU provides more flexibility to modify in response to changing economic and labour market conditions. Many destination countries assume inflows of migrant labour to be less need-based, and labour market demand for such workers to be transient or temporary despite the observed longer-term dependence.

³ However, the Vienna Convention on Law of Treaties, as interpreted by the International Court of Justice in the case Qatar v. Bahrain, makes clear that the determination of whether an international agreement is legally binding depends fundamentally not on form, but rather on whether the two participants intended to be so obligated. The intention of the parties or participants can be inferred from a variety of factors, including the text and the surrounding context, such as the status of the signatories (Dhillon, Clark, & Kapp, 2010).

- Countries could also regard MOUs as the preferred choice for dealing with low skilled and semi-skilled admissions, as the hiring of these workers are particularly for temporary stays. The majority of BLAs in Asia concern the outflow of low skilled and semi-skilled workers.

Until recently, BLAs have been the exception rather than the rule in Asia and the Middle East (Wickramasekara, 2012). However, recently such agreements have become increasingly popular among destination and source countries in Asia and Europe, which are attempting to overcome the problem of enforcement outside their borders notwithstanding the problems with its negotiation and implementation (Dhillon, et al., 2010). Although the effectiveness of BLAs in pursuing its objectives could be questioned (as there is little research showing this impact), most authors suggest that they are “better than nothing” (Agunias, 2012; Go, 2007; Wickramasekara, 2012). It is claimed that in the absence of a global regime for international labour migration, BLAs are an important mechanism for inter-state cooperation in protection of migrant workers, matching labour demand and supply, managing irregular migration, and regulating recruitment (OECD, 2007a). The previous experiences with BLAs showed that they have especially worked as a mechanism for the temporary employment of foreign workers where:

- they targeted specific sectors with a severe labour shortage;
- there was a quota or ceiling;
- recruitment was organized;
- employers were engaged; and
- there was a circulation of labour (OECD, 2007a).

Moreover, the effectiveness of BLAs is also supported by the involvement of employers and their organizations in the implementation of BLAs and special administration to ensure smooth operation, including promotion of the programme in countries of origin, recruitment, testing and certification of applicants for the programme, timely data flow and information sharing between the two countries, migration and consular offices concerned and efficient travel logistics (OECD, 2007a). However, the above mentioned criteria of BLAs’ effectiveness are based on assessing and supporting its recruitment role rather than dealing with the effectiveness of BLAs in pursuing the objectives concerning the protection of migrants’ rights and mitigating negative consequences of migration. These two objectives are relatively new and as already said it is very difficult to assess the BLAs’ effectiveness in these terms. There are no studies that investigate the BLAs’ effectiveness in this sense. This study is trying to approach the problem of BLAs’ effectiveness by studying the content, the context in which they were developed and signed, and their outcomes. However, the lack of reliable data on migration “before” and “after” the agreements, as well as a lack of comparability among them, make it impossible to assess the true impact of the BLAs in terms of such parameters as the volume of migration, employment, the worker-paid costs of migration, and the economic costs and benefits of migration to the origin and destination countries.

1.2 To recruit or to restrict? On the debatable role of bilateral labour arrangements

Bilateral labour arrangements are one of the best known mechanisms for managing migration. BLAs formalize each side's commitment to ensure that migration takes place in accordance with agreed principles and procedures (OECD, 2007a). They ensure a predictable and transparent process of migration, could decrease the need for commercial recruitment agencies⁴, and shift the cost of migration from the individual migrant to employer/final client (Wickramasekara, 2006). Moreover, BLAs could help prevent or reduce irregular migration by offering alternative legal channels to migrate for employment, which, in turn, can provide a negotiation tool to secure the country of origin's willingness to cooperate on managing irregular migration (particularly on readmission of their nationals) (OECD, 2007a).

However, the role of BLAs are not only to enable the nationals of sending countries to gain access to the labour market of the receiving country (recruitment objective), but also to enable the receiving country to satisfy its labour market needs quickly and cheaply. This is in comparison to the long-term investments in education of needed professions and sending country to benefit from remittances and decreased pressure of its local labour market.

The role of BLAs in terms of protection of migrants' rights was recognized in early international law documents. ILO Recommendation 86 on Migration for Employment (1949) specifies the regulations concerning the process of recruitment and employment of migrants in the receiving country. It also proposes a Model Agreement to be used "in framing appropriate clauses for the organisation of migration for employment and the regulation of the conditions of transfer and employment of migrants". This is further discussed in the non-binding ILO Multilateral Framework on Labour Migration from 2005, which except from further elaborating on the recruitment and employment conditions of migrants, recognizes the nexus of migration and development and stresses that labour migration should contribute to employment, economic growth, development and the alleviation of poverty in both origin and destination countries (ILO, 2006).

Bilateral agreements between origin and destination countries can be a significant means of providing minimum standards and rights for migrant workers (objective of protection of the migrants' rights) (ILO, 2010). Origin countries can negotiate for greater rights for migrant workers, which conform to international standards, with guarantees of compliance provided by the agreements. By providing access to regular migration and the formal labour market, such agreements can reduce exploitation (ILO, 2010) and mitigate the migrants' risks in particular in case of circular migration. As the agreements can contain provisions on the cooperative management of pre-departure and return, social security and pension portability, dispute settlement procedures, and remedies for violation of rights, they can be a significant means of providing minimum standards and rights for migrant workers. This role of BLAs is even more vital when taking into account that protection of migrants' rights is important for the sending country, which has no legal enforcement in the receiving country. Moreover, what is very important in the case of migration of highly skilled workers, in particular health professionals, is that governments can initiate bilateral agreements to recognize each other's qualifications, making it easier for health professionals to move from one place to another and continue working in the same field

⁴ Limitation of the role of private recruitment agencies in the process of recruitment could be a way to better control the migration process and protect the migrants against unfair recruitment and employment practices.

(Stilwell et al., 2004). By facilitating the recognition of qualifications, bilateral labour arrangements are also contributing to the prevention of migrants' deskilling. Migrants are usually forced to more or less temporarily work below their qualifications until or unless their qualifications are formally recognized by the receiving country. In case of health professionals this is particularly important, because even a short period of working below qualifications (e.g. not practising as nurse or physician during the stay abroad due to the problems with recognition of qualifications) could mean the loss of professional execution rights.

Finally, the brain drain discussion started in the 1960s has recently resulted in recognition of the role that BLAs have to play in mitigating the negative consequences of migration for sending countries (objective of mitigating brain drain). Brain drain, meaning a development gain for nations that are already resource-rich and a development loss for the countries and population from which these health professionals migrate, is caused or facilitated by unmanaged migration (Dhillon, et al., 2010). BLAs could in these terms be used to regulate the outflow -- by setting the amount of recruited health professionals at the level safe for the health system of the source country, by limiting the professional scope of recruitment (e.g. excluding certain occupations from recruitment or even defining its geographical scope. Moreover, they could further include some compensation measures for the loss of the highly skilled workers to the detriment of the sending country.

According to the WHO Global Code of Practice on the International Recruitment of Health Personnel, bilateral "arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures" (to compensate the source country for the loss). Such measures may include the provision of effective and appropriate support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent" (WHO, 2010). Moreover, paragraph 5.1 of the WHO Code claims that "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers" (WHO, 2010). Similarly, the UK Code of Practice for the international recruitment of health-care professionals (UK Department of Health, 2004) claims 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". The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) meeting made a recommendation for the need "... to promote transparent and effective bilateral agreements and memoranda of understanding" (UN ESCAP, 2011). It is also interesting to mention in this context the Health Worker Migration Initiative which proposes two models of BLAs, including the BLAs' objective to mitigate the negative consequences of migration (Dhillon, et al., 2010). The model agreement I includes such measures to combat brain drain by return and reintegration, exchange of students and visits of experts, scholarship programmes, joint venture and investments in health facilities, twinning of health facilities, support to initiatives to improve education and training facilities and technology transfers⁵.

According to literature, the effectiveness of BLAs in fulfilling the three above mentioned objectives is very difficult to measure due to several reasons, such as pursuing several objectives simultaneously while giving different weight to the various policy priorities (OECD, 2007a), lack of proper monitoring and evaluation of BLAs as well as clear criteria for them, and the lack of implementation of many BLAs

⁵ Annex 4 includes the table with comparison of the proposed content of BLAs, which are proposed in the most important international and national frameworks and model agreements on HPs' migration.

and its legally unbinding character. Moreover, it is debatable if BLAs could, in practice, be used to protect the labour conditions of migrants in the receiving countries and mitigate the brain drain, either by compensating or limiting the outflow, or used to promote or stimulate migration. Pittman suggests that the primary intent of BLAs is to increase, not restrict, international recruitment for the benefit of destination country employers and source countries' remittances (Pittman, 2013). These objectives may seem to be somehow contradictory to the objectives concerning the protection against exploitation and mitigating brain drain.

Moreover, it is important to notice that BLAs' objectives of political nature (e.g. those concerning the migration for development) are particularly difficult to be implemented (OECD, 2007a). The role of BLAs as protectors of migrants' rights and of the source country's health-care system is limited by the opposing interests of the two parties negotiating a BLA, and the asymmetry of powers between them, where the sending country is usually much more determined to sign any form of agreement to enable migration -- even at the cost of insufficient protection of their migrants and the interest of their health-care system as a whole. On the contrary, the receiving countries are very often reluctant to enter into any formal agreement due to several reasons. They claim that migrant workers are subject to the same laws and regulations as nationals and consequently they do not need any special attention. Some labour-receiving countries have also argued that since the terms of employment are negotiated by the overseas workers and private employers or agencies, they do not want to get involved. This is a heavy argument, as in recent years the role of private recruitment, contrary to the state-driven process, is increasing in the international migration process (Wickramasekara, 2012). Some countries go even further and regard labour recruitment as a private sector business in a market-oriented system requiring no government intervention. Moreover, receiving countries are concerned that entering into a formal agreement with one country could open the floodgates to proposals for similar agreements from other sending countries, which they are reluctant to entertain (Go, 2004).

1.3 Is something really better than nothing? On the Philippines' approach to BLAs

The Philippines is one of the Asian countries most actively seeking to conclude bilateral arrangements with destination countries. Being one of the largest supplier of nurses worldwide, it has a history of sending health-care professionals abroad dating back to the 1950s (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007). In 2012, the total number of nurses deployed overseas accounted for 15,941, according to the Philippines' Overseas Employment Agency (POEA). In an earlier analysis, Lorenzo (2007) claimed that numbers are most likely underreported, as many of those who seek work overseas are not officially documented by the POEA, because they leave as tourists or students and subsequently become overseas workers.

Both the domestic and foreign demand for nurses has generated a rapidly growing nursing education sector made up of about 460 nursing colleges that offer the Bachelor of Science in Nursing (BSN) programme and graduate approximately 20,000 nurses annually (CHED -- Commission on Higher Education, 2006). Although the Philippines is perceived as a country with no critical shortages of health-care professionals as defined by the WHO's "World Health Report 2006: working together for health" (WHO, 2006), paradoxically there are insufficient health workers in the Philippines to meet the needs of the population, particularly in rural and disadvantaged areas (Lorenzo, et al., 2007). It is estimated that over 200,000 Filipino nurses are unemployed or underemployed. Only 62,000 (about 22%) of the 273,373 nurses who were trained in 2009 are currently working in the Philippines (Pillinger, 2012).

The scale of migration, as well as the welfare and human rights issues confronting the overseas employment programme of the Philippines, have increasingly put pressure on the government to take concrete steps to ensure that overseas Filipino workers are adequately protected in their countries of destination (Go, 2004). Concluding bilateral arrangements (either in the form of BLAs or MOUs) is seen as one of the best mechanisms for protection of migrants' rights. According to the Republic Act No. 10022, the "State shall deploy overseas Filipino workers only in countries where the rights of Filipino workers are protected". The fact that the receiving country concluded a bilateral agreement with the government that is protecting the rights of overseas Filipino workers is regarded as one of the guarantees on the part of the receiving country to protect of the rights of overseas Filipino workers. The Philippines is therefore actively seeking to secure new agreements in order to better govern migration, limit the pressure on its own labour market, and to provide protection for their migrants working abroad. Although Filipino workers are found in about 180 countries worldwide since the overseas employment programme began in 1974, the Philippines has not, surprisingly, concluded BLAs with 22 countries⁶. It is important to note, however, that bilateral arrangements concluded by the Philippines have significantly increased in the recent years. About half of the countries (12 out of 22) that signed the BLAs with the Philippines did it in the last 10 years, and another four had their BLAs amended during this period. According to the Philippines government, although BLAs proved to be effective in addressing issues and concerns affecting the employment of workers, these take a long time to be developed and implemented. Thus, in recent years, the Philippines has steered away from the formulation of general or broad agreements and worked towards the adoption of more focused agreements which are easier to negotiate and make operational in host countries (OECD, 2007a).

For the purpose of this study, seven agreements (with five countries) on health professionals' mobility were studied. Those were concluded between the government of the Philippines and those of Bahrain, Japan (two agreements), Spain, Norway, and the United Kingdom (two agreements) (see box 1).⁷ These were chosen given the scope of the ILO Decent Work Across Borders project, covering Europe as a destination of health professionals. The case of Japan was added as, being referred to as a trade agreement, it provided a different look on the mobility of health professionals. The particular agreement with Bahrain was included as its comprehensiveness provided an interesting point in case for this study and also on the basis that a high number of Filipino health professionals migrate to this region of the world.

⁶ These are: Bahrain 2007, Canada (Alberta 2008, British Colombia 2008, Manitoba 2008, 2010, Saskatchewan 2006), Commonwealth of Northern Marianas Islands 1994, 2000, Germany, 2013, Indonesia 2003, Iraq 1982, Japan 2009, Jordan 1981, 1988, 2010, 2012, Korea 2004, 2005, 2006, 2009, Kuwait 1997, Lao PDR 2005, Libya 1979, 2006, New Zealand 2008, Norway 2001, Papua New Guinea 1979, Qatar 1997, 2008, Spain 2006, Switzerland 2002, Taiwan 1999, 2001, 2003, United Arab Emirates 2007, United Kingdom 2003, 2002, United States of America 1968.

⁷ It is important to note that the government of the Philippines has entered into agreements with other receiving countries, such as Canada, with what concerns the mobility of health professionals. The recent agreement on health-care professional migration was only concluded with Germany in June 2013 and could not be included in this present study.

Box 1. Selected Philippines' Bilateral Labour Arrangements on Health-care Professional Migration**Philippines-UK**

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)

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)

Philippines-Norway

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)

Philippines-Spain

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

Philippines-Bahrain

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

Philippines-Japan

Agreement between Japan and the Republic of the Philippines for an economic partnership (JPEPA) (September 9, 2006).

Memorandum of Understanding Between the Philippine Overseas Employment Administration and The Japan International Corporation of Welfare Services on the Deployment and Acceptance of Filipino Candidates for "Kangoshi", Filipino Candidates for "Kaigofukushishi", Filipino "Kangoshi", and Filipino "Kaigofukushishi" (January 12, 2009)

Moreover, the five countries that the Philippines signed the bilateral labour arrangements with are not necessarily the main countries of destination of Filipino health-care professionals. Out of these five countries, only the United Kingdom is constantly among the top-ten destinations of Filipino nurses from 2007 to 2011. Bahrain used to be on this list in 2010 (see table 1).

Table 1. Deployed Nurses by Top Ten Destinations. New hires and rehires 2007-2011.

Destination/Year (2010-2011)	2007	2008	2009	2010	2011*	% Change
All Destinations-Total	9,004	12,618	13,465	12,431	17,379	39.8%
1. KSA	6,633	8,848	9,965	8,771	12,922	47.3%
2. Singapore	276	667	745	723	775	7.2%
3. UAE	616	435	572	478	739	54.6
4. Kuwait	393	458	423	409	607	48.%
5. Oman	24	15	41	92	562	510.9%
6. Qatar	214	245	133	294	523	77.9%
7. Taiwan	174	231	202	252	294	16.7%
8. Jordan	27	51	66	112	154	37.5%
9. Sudan	7	26	2	18	139	672.2%
10. UK	602	1,614	1,151	533	529	-61.4%

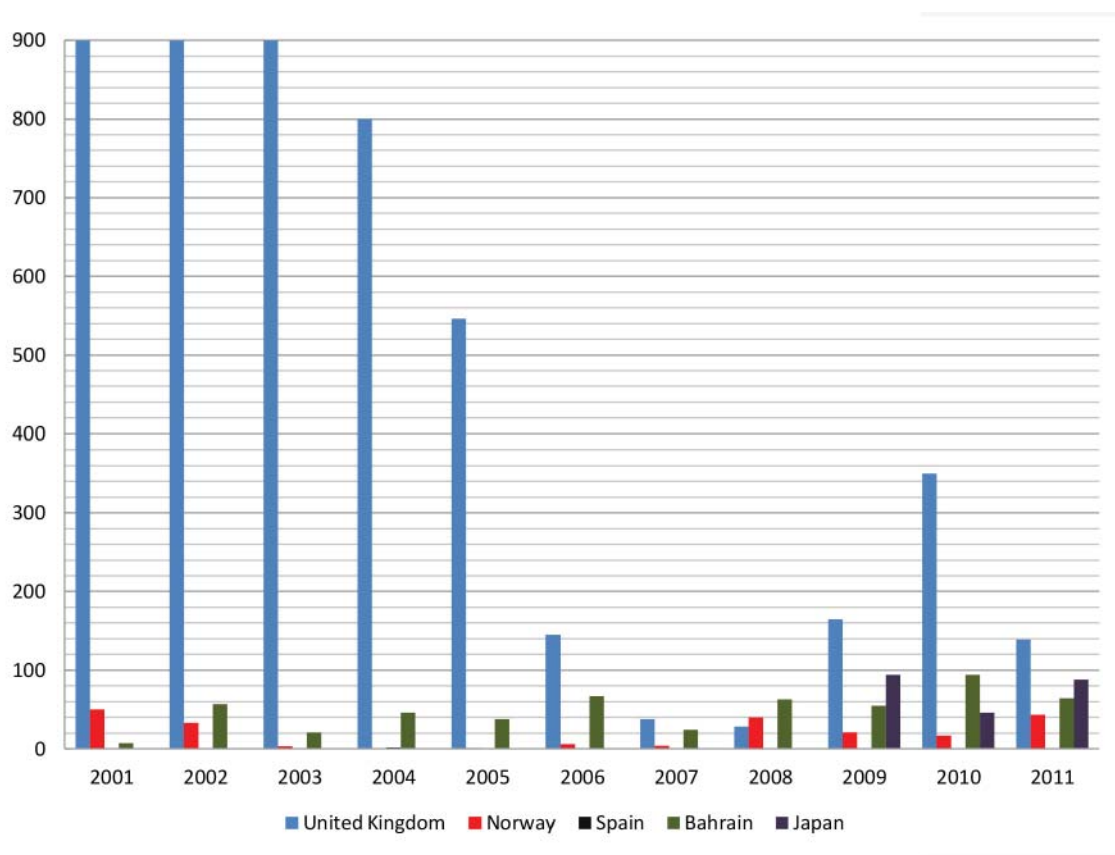
For 2012, the number of total deployed nurses is 15,941. Total deployed for all skills for same period is 458,000, which means deployment of nurses represents 3.5% of total deployed, all skills.
Source: POEA.

In 2011, among the top-ten destination countries of Filipino nurses, half of the countries are Gulf countries (including the Kingdom of Saudi Arabia), two other are Asian countries, and two are African countries. Out of 17,379 overseas deployed nurses in 2011, 12,922 were deployed to Saudi Arabia (about 74 per cent). Despite attempts, no agreement was signed with Saudi Arabia, although this option is being currently considered⁸. According to the statistics of the POEA, between 2001 and 2011 the total outflow of nurses to the United Kingdom was 12,232, whereas Norway accounted for 218, Spain two, Bahrain 536, Japan 228, and Germany five. Additionally, 396 caregivers were recruited at that time to Japan and 147 to Spain. When comparing the outflow of Filipino nurses to five countries, which have BLAs with the Philippines, only migration to the United Kingdom has ever been significant in numbers. However, only as small percentage of UK recruitment was attributed to BLAs (see figure 1.1).

Notwithstanding the limited outflow of Filipino nurses to the countries with which the Philippines signed a BLA, the total outflow of health professionals is not generally equal to the outflow within the BLAs as the practice shows than recruitment within BLAs is responsible only for a small part of the overall migration of Filipino nurses.

⁸ It is still not clear what such agreement could include and what will be covered by it -- only domestic workers, who are supposed to be more in need of protection, and also health professionals.

Figure 1.1 Total outflow of Filipino nurses to five destination countries (UK, Norway, Spain, Bahrain, Japan) 2001-2011.



*Deployment to UK in 2001 accounted for 5,388, in 2002 for 3,089 and in 2003 for 1,544.

Source: POEA .

The analysed agreements are all but similar in terms of content and legal form. Two agreements are recruitment or operational agreements for the recruitment of nurses (with Norway and the United Kingdom), one has a form of economic treaty (Japan), and four have legally non-binding forms of MOUs (with Spain, the United Kingdom, Bahrain and Japan), which supports the thesis that MOUs are easier to be negotiated and probably at the same time harder to be implemented.

Inclusion of two objectives concerning the protection of migrants' rights, and in particular those concerning mitigation of negative consequences of migration, is very challenging in these agreements. Moreover, the agreements faced several challenges in terms of their implementation, which was particularly true in the case of agreements that included other objectives than recruitment to satisfy temporary labour market needs in the receiving country. The Philippines agreements, which were effectively implemented, were usually only serving the recruitment objective, thus they provided for some protection against exploitation of workers e.g. by switching the costs of migration from the migrants to their employers (as seen in the Philippines-UK agreement). The inclusion of brain drain objectives was not only possible in the broader extent in only one agreement (with Bahrain), this agreement was not implemented at all (see Annex 5 for more details concerning the specific content of the five BLAs with regard to the three BLAs' objectives). Is the thesis that "something is better than nothing" still true given these findings? Are the agreements, which are far from reaching true success,

something that regardless could be effective in regulating migration of Filipino nurses to these five destination countries, and something that is worth the great effort of its negotiation? This report is trying to respond to these questions based on the findings from the qualitative study.

2. Background of the study

This report presents the findings of the study entitled “Philippines’ Bilateral Labour Arrangements on Health-care Professional Migration”, conducted for the ILO in Manila, the Philippines, as part of the project “Decent Work Across Borders: A Project for Migrant Health Professionals and Skilled Workers” (DWAB). The DWAB project is funded by the EU and seeks to better understand the schemes in line with circular migration of health professionals by engaging governments, trade unions and employer organisations, as well as professional organisations into policy dialogues; establishing networks of experts and trained practitioners; strengthening employment services for health-care professionals and skilled workers; facilitating skills recognition processes and enhancing labour market information systems.

2.1 Study objectives and scope

The study on “Philippines’ Bilateral Labour Arrangements on Health-care Professional Migration” was undertaken between December 2012 and June 2013 in order to achieve the following research aims:

1. Description of the context to the negotiation of bilateral arrangements between origin and destination countries.
2. Description and analysis of the process and actors involved throughout the process of negotiation of the bilateral arrangements.
3. Analysis of the effect and impact of the bilateral arrangements developed by the Philippines with regard to the migration of health-care professionals, in particular with regard to:
 - a) recruitment;
 - b) employment;
 - c) development effects of the arrangement, including return and reintegration provisions; and
 - d) administration of the arrangements.
4. Assessment whether or not the assessed bilateral arrangements have been instrumental in promoting decent work for migrant workers and offering suggestions as to how countries can best incorporate the concept of decent work into future migration labour arrangements.

The complex list of the research questions is attached in Annex 3.

The scope of the study was to cover the bilateral labour arrangements. The Philippines concluded with five countries (Norway, Spain, the United Kingdom, Bahrain and Japan) as well as the migration of Filipino health professionals to the Kingdom of Saudi Arabia, which is the main destination country of Filipino nurses. The complete list of BLAs analysed within this study is presented in Box 1.

On 19 March 2013, the Philippines signed a bilateral labour agreement on health-care professionals' recruitment with Germany (Agreement concerning the placement of Filipino Health Care Professionals in Employment positions in the Federal Republic Germany). This agreement is not included in the study, because of its late publication date.

2.2 Methods and sampling

The study results are based on the mixture of data collection methods such as desk and field research. The desk research included legislation mapping, review of secondary literature and statistics, whereas field research consisted of in-depth interviews and a focus group discussion. Interviews were conducted with different stakeholders in sending and receiving countries, including government officials (from ministries of foreign affairs, ministries of health, ministries of labour, and embassies), representatives of trade unions and professional organisations, of recruitment agencies, employers, as well as academics. In total, 32 respondents were interviewed during this study from four countries, as well as from international organisations. The majority of interviews were conducted face-to-face during three field trips (the Philippines, the United Kingdom and Norway). The focus group discussion, which took place in Manila on 11 February 2013, gathered 21 Filipino stakeholders. The sampling of respondents was purposeful selection; in particular its aim was to target the respondents and institutions, which were actively involved in the process of BLA negotiation and implementation, as well as to other selected organisations, which represents the interests of those touched by the BLAs' signature (employers, recruitment agencies, health workers). The total list of respondents is provided in Annex 2.

2.3 Limitations of the study

Although the study pays particular attention to provide the highest possible level of representativeness of the findings, it has some limitations that have to be recognized. First, there were some challenges in the identification of the right stakeholders per BLA. Some of the agreements, such as the 2001 agreement with Norway, are relatively old, and some personnel and structural changes have been implemented in relevant institutions since that time. An example was the change that happened with AETAT (Arbeidsdirektoratet, or Directorate of Labour), the agency responsible in 2001 for negotiation of the agreement. It was dismissed and its functions were assigned to a new institution called NAV (Arbeids-og velferdsforvaltningen, or the Norwegian Labour and Welfare Administration). Notwithstanding numerous attempts, it was also impossible to arrange interviews with the Gulf countries due to their unavailability to participate in the study. In the case of Spain, the researcher received a formal letter of non-participation in the study, because the agreement is currently being evaluated. In the case of other countries, the changing political priorities of the country (e.g. overseas recruitment is no longer on the political agenda, as in the cases of the United Kingdom or Norway) and issues around the agreements (on-going evaluation process as in the case of Japan) proved problematic. Limited knowledge and interest in BLAs in the receiving countries also contributed to the challenges linked to the process of identifying respondents for the interviews.

Moreover, comparing bilateral labour arrangements turned out to be a very challenging task because of differences between the form, character and content of the different agreements. In order to overcome these difficulties, the study was designed to form separate cases to introduce the unique characteristics of each of the agreements, such as identifying general factors responsible for a BLAs' success or failure, and drawing general conclusions for a BLAs' design and implementation.

Finally, the study is limited to qualitative means of data collection and analysis. In so being, the study cannot provide quantitative description of the BLAs' effectiveness. Due to the broad scope of the study, limited time and resources, it was also impossible to consult the migrants themselves. Such consultations could have brought some interesting insights into study.

3. Findings of the study

The findings of the study illustrate the numerous inputs in terms of the negotiation and implementation that BLAs have to overcome in order to be effective in achieving their objectives. The analysis covers not only the context and content of the BLA, but also and when possible, the description of the process of BLA negotiation, degree of implementation and problems encountered. The lessons learnt from these experiences are further presented in chapter 3.5 of the report.

3.1 Limited effectiveness without implementation: the case of Norway and Spain

The agreements with Norway and Spain are very different from the other. The agreement with Norway is an example of a typical recruitment agreement, which focuses on regulating the process of recruitment in a transparent and smooth way. It includes exchange of information between the two countries, pre-departure information for migrants, language and cultural orientation after arrival, fair contract of employment signed before departure, and recruitment fees being paid by a future employer. As for measures concerning mitigating negative consequences of migration, the Philippine-Norway agreement does not include any of them. However, discussion about brain drain in case of a health-care professional migration had already been espoused by WHO at the time the BLA was developed. Through the WHO Code of Practice on International Recruitment of Health-care Professionals, ideas about the role of BLAs in providing compensation for the outflow for the sending country was advocated. The agreement was negotiated by the POEA and AETAT, which was further restructured into NAV.

Conversely, the agreement with Spain is a prospect of future cooperation in the field of health-care professional migration. It has a loose form of MOU and a pilot project of recruitment, which may further be developed in proper recruitment of the Filipino nurses to Spain. Until now, the effects of this agreement were not evaluated and no decision about continuation of the recruitment process was taken⁹.

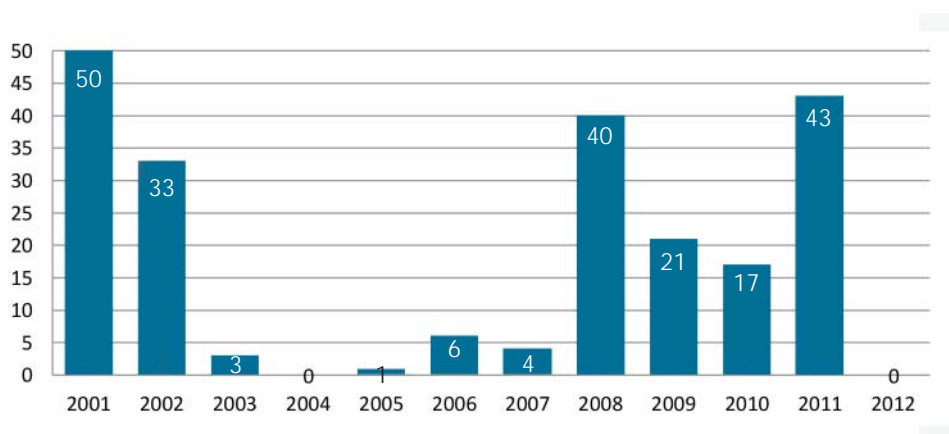
Though aptly developed, these two agreements were never properly implemented. The agreement with Norway was terminated six months after its signature due to political and financial reasons. The Spanish agreement was never properly implemented and only two nurses were recruited within this agreement in the year of its signature (2006). It is not clear what the rationale behind the signature of the agreement with Spain was, as Spain did not suffer from nurse shortages at the time of the MOU's negotiation¹⁰. Moreover, it is also important to note that two other MOUs, which are discussed in the next chapters, have not been implemented till now – an agreement with Bahrain and an MOU with the United Kingdom. It therefore becomes futile to discuss in terms of “effectiveness” of agreement,

⁹ Official reply from the Ministry of Foreign Affairs of Spain to the request for interview.

¹⁰ Interview with International Council for Nursing.

if those fail to be implemented. The main difference between the agreement with Norway and Spain was the fact that whereas since 2001 there has been almost no outflow of Filipino nurses to Spain, the deployment to Norway notwithstanding the lacking implementation of the agreement was pending, despite its low significance in numbers. According to the POEA, between 2001 and 2012 only two nurses were deployed to Spain in 2004. Figure 1.2 presents the situation for those who departed for Norway (see Figure 1.2). The entire outflow was beyond the recruitment agreement.

Figure 1.2 Total deployment of Filipino nurses to Norway between 2001 and 2012.

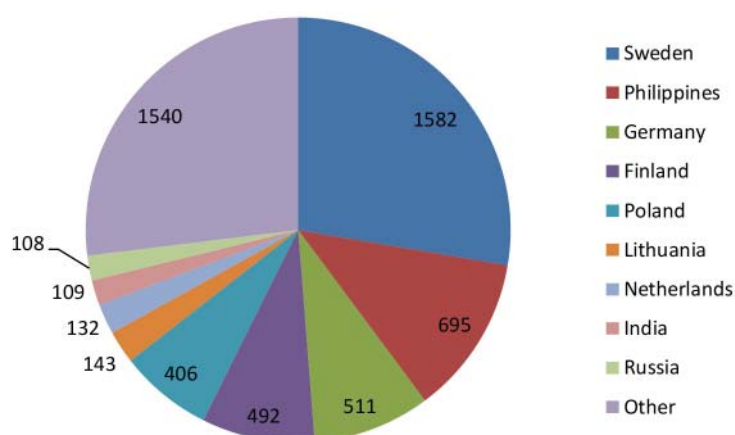


Source: POEA .

Despite the failure to implement the agreement between the Philippines and Norway, not only is the recruitment to Norway continuing over time (with the decrease of the number of the deployed Filipino nurses between 2003 and 2007, although it is not very significant in numbers), but the Philippines is the second country of origin among the foreign born nurses in Norway. As far as data are available on country of birth and country of qualification¹¹, 10,954 nurses and midwives (15 per cent of 75,276) of those working in the health sector in 2010 were not born in Norway. Out of 5,718 nurses and midwives working in the Norwegian health sector in 2010 who were born and qualified outside Norway, the largest group was born in Sweden (1,582), followed by the Philippines (695), Germany (511), Finland (492), Poland (406), Denmark (395), Lithuania (143), the Netherlands (132), India (109) and Russia (108) (Figure 1.3). Among nurses and midwives working in the health sector in 2010 and trained abroad, 12 per cent had Norway and 39 per cent another Nordic country as the country of birth. This shows that half of the foreign-trained nurses and midwives had a non-Nordic country of birth, with Filipinos being the most represented nationality.

¹¹ Missing data 80 persons; Data provided by the Norwegian Ministry of Health.

Figure 1.3 Foreign-born and foreign-trained nurses and midwives working in the Norwegian health sector in 2010.



Source: Norwegian Ministry of Health.

Similarly, the data on the granted applications for authorisation from foreign nurses confirm that Filipino nurses are among the most actively seeking authorisation in Norway among the foreign born non-Nordic nationals. During the period 2001-2008, a total of 13,482 persons of foreign nationality were granted authorisation to practice as nurses in Norway. Out of these, only 568 come from Africa, Asia, South America and the Middle East. The largest group of these are nationals of countries in Asia (493), mainly the Philippines (314), South Korea (52), India (42) and Iran (35). From 2002 to 2004, between 50 and 100 nurses from the Philippines were granted authorisation each year. Since 2005, this has stabilised at approximately 25 authorisations per year. For the same period (from 2005), we see a considerable increase in authorisations to auxiliary nurses from the Philippines (from 19 in 2005 to 270 in 2008)¹². Of the total number of granted applications for authorisation from foreign nurses in the period 2001-2008, the largest group is from Sweden, followed by Denmark, Finland and Germany. Since 2004, there has been a certain increase in the number of nurses from Poland, Estonia and Lithuania. These are countries that joined the EU in May 2004 and were granted automatic recognition of their qualifications across the EU (a simplified process in comparison the recognition of qualifications of non-EU nationals). It is claimed that in the case of Norway, as well as other European countries, intra-EU migration replaces to some extent the need for active recruitment of workers from third countries¹³. The need for personnel in the health sector in Norway is generally supplied within Norway and from areas geographically close to Norway (EEA countries)¹⁴. Use of personnel from countries outside the Nordic and EEA areas involves challenges in connection with language and authorisation.

Moreover, active recruitment of health personnel from developing countries raised serious ethical considerations for the Norwegian government. As a WHO member, Norway adopted the WHO Code of Practice on International Recruitment of Health-care Professionals and is particularly committed to its implementation. In 2012, the Health Worker Migration Initiative rewarded Norway for its great efforts in implementing the Code¹⁵. Norway puts special emphasis on refraining from recruiting health-care

¹² "A proposal for measures under Norwegian foreign and international development policy to address the global health workforce crisis," 2009.

¹³ Interviews with Philippines' embassy in Norway and Fagforbundet.

¹⁴ *ibid*.

¹⁵ <http://www.aspeninstitute.org/policy-work/global-health-development/news/health-worker-migration-global-policy-council-announces> [accessed on 30th July 2013], interview with the Norwegian Directorate for Health.

professionals from countries with poor HRH. Moreover, despite not incorporating any compensation measures in 2001, BLAs with the Philippines and Norway currently recognizes that compensating sending countries for migrating health personnel is a global responsibility and could be provided by taking measures to protect and strengthen the sending country's health system.¹⁶ It is claimed that it would be difficult to develop an agreed set of rules for a compensation scheme calculated per individual, and would involve major administrative transaction costs. In cases where a bilateral agreement is being negotiated, it would be natural to include specified forms of compensation.¹⁷ However, in the case of Norway, which has few health workers from developing countries, it is claimed that there is no urgency to conclude BLAs. It is particularly advised that bilateral health personnel exchange agreements with developing countries should not be considered as relevant as long as Norway is not a destination country for health personnel from developing countries¹⁸. However, it is claimed that bilateral agreements on circular migration could be considered as part of development assistance activities.

Contrary to Spain, in Norway there were some shortages of health-care professionals at the time of the agreement¹⁹. There are shortages of some medical specialisations today, and current forecasts estimate substantial shortages of health-care workers and nurses in the future²⁰ due to the demographic processes of an ageing population. The reasons for concluding BLAs by the Norwegian side were then motivated economically by the demand on the labour market. Norway has little experience of large-scale and systematic recruitment from third countries²¹, although health professionals have chosen to migrate to Norway from a number of countries for several decades. In particular, there was an influx of Filipinos to Norway in 1970s, when Norwegian immigration policy was believed to be more relaxed²².

Despite the needs of the labour market and the effort put in the negotiation of the 2001 agreement between Norway and the Philippines, the Norwegian side terminated the agreement after six months²³ and it was never renewed. Official reasons behind the termination were the changing political priorities. The recruitment from overseas seems to compete with the recruitment from other European countries, in particular after the 2004 EU accession for ten new EU Eastern and Central European countries. Paradoxically, the brain drain discussion seems to have had a negative impact on the negotiation and implementation of BLAs on health-care professional migration. The considerations on the negative consequences of migration for sending countries, together with the WHO ban on recruitment of health-care professionals from the developing countries facing critical shortages of health professionals, could in effect lead receiving countries such as Norway, which pays a lot of attention to the WHO Code implementation, to refrain from overseas recruitment. This is to the advantage of promoting the medical education of their own nationals or recruitment from developed countries with lower salaries in health-care sectors. One of the important issues in case of recruitment of foreign health-care workers to Norway is language. The 2001 bilateral agreement included the language training of the Filipino nurses at the costs of the Norwegian government. On the contrary, these costs do not need to be carried out in case of recruitment from other Scandinavian countries, and due to salary differences in employment, Norway is still attractive for Swedish, Finnish and Danish health professionals. In case of recruitment from other European countries, language is still an issue, but there is no problem with the recognition of qualifications. There is no need to conclude BLAs and there is no problematic brain drain issue²⁴.

¹⁶ "A proposal for measures under Norwegian foreign and international development policy to address the global health workforce crisis," 2009.

¹⁷ *ibid.*

¹⁸ *ibid.*

¹⁹ Interview with Philippines embassy in Norway.

²⁰ Written interview filled by the Norwegian Ministry of Health.

²¹ Although it once signed the BLAs with Australia.

²² Interview with the Philippines embassy in Norway. Norway had not signed any other BLAs with the Philippines at that time.

²³ Interview with POEA.

²⁴ Brain drain issues are being discussed in some of EU countries such as Poland, but rather in the context of lost educational investments of the sending country.

3.2 Better late than never? The case of the United Kingdom

The only two bilateral agreements for health-care professionals, which managed to be implemented, were the agreements with the United Kingdom and Japan, although the motivations behind these agreements and their outcomes were different. The main motive behind the negotiation of agreement with the Philippines by the United Kingdom laid in the insufficient resources of nurses in the United Kingdom to meet the growing demand of the National Health Service (NHS), followed by the modernisation plans in the NHS announced after the new Labour government came into power in 1997 (Plotnikova, 2012). In 2000 the UK government announced its intention to radically overhaul health services and to increase investment in the NHS. In order to meet the workforce challenges set out in the NHS plan, a dedicated recruitment and retention strategy was developed, with a co-ordinated programme of activity at a domestic and international level. Apart from recruitment of internationally qualified staff, the programme also included promotion of medical professions internally (by national recruitment campaigns and national careers information services), encouraging health professionals who had left their profession to return to work in the NHS, improving pay settlements and working conditions in order to improve retention, and the introduction of flexible retirement (2007).

In 2000, the demand for additional NHS staff in the short term was such that international recruitment had to be a key contributor in helping to expand the workforce. The rapidly increased demand could not have been met by the internal labour market due to several reasons. First, it was a result of reduction in training places for nurses for the early 1990s (Buchan & Edwards, 2000), as well as overall trends of the “greying” of the UK nursing workforce (one in five nurses in the United Kingdom register is 50 years of age or older) (Buchan, 1999). Second, nurses’ preferences for more flexible working patterns resulted in growing number of registrations with agencies rather than NHS contracts (Deeming, 2002). The new Labour government announced a recruitment target of 20,000 extra nurses needed in the NHS in 2004. It was estimated that 115,000 nurses were needed to achieve a 20,000 net increase, since the service also had to cover losses to retirement and to non-NHS employment. Of the 115,000 nurses required to meet the 20,000 increase target, 20,000-27,000 were required from overseas (Deeming, 2004). The active recruitment by the NHS of foreign-trained nurses caused a series of accusations from source countries, international organisations and stakeholders in the United Kingdom with regard to “poaching” health professionals from “poor” countries (Plotnikova, 2012). In response to these concerns, the Department of Health introduced ethical recruitment policies, represented by the Code of Practice, and government-to-government agreements with a number of developing countries (Philippines, India and South Africa). These agreements enabled international recruitment to be directed to those countries where it was sustainable and away from developing countries with vulnerable health-care systems (2007). This is interesting in the context of the role of the BLAs in terms of mitigating brain drain through the content of the BLAs and the choice of countries with which the agreements were to be signed. Moreover, it is interesting to notice that the recruitment was directed to the English speaking countries which allowed the United Kingdom to benefit from lack of language problems in recruitment and employment of foreign specialists²⁵. Recruitment from developing countries could also be advantageous since recruited health professionals have higher competences compared to the natives. Whereas nursing education in the United Kingdom, until last year, was a vocational course and on-the-job training, nursing degree in the Philippines is attained by finishing a Bachelor of Science in Nursing degree (four years’ study and on-the-job training)²⁶.

²⁵ Interview with UNISON.

²⁶ Interviews with UNISON.

Complementarily, the UK Code of Practice on international recruitment was developed in order to govern the recruitment to NHS (thus it did not apply to the UK private health sector) and required NHS employers not to actively recruit from low-income countries unless there was a government-to-government agreement²⁷. The UK Department of Health, together with the Department for International Development (DFID) developed a list of developing countries, which should not be targeted for active recruitment of nurses. As of April 2013, there were 154 countries on the list, the Philippines included. Here, the Philippines was marked to indicate that there is an MOU between the Philippines and the United Kingdom, which would allow the recruitment of registered nurses and other health professionals including physiotherapists, radiographers, occupational therapists, biomedical scientists and other allied health professionals that are regulated by appropriate professional bodies in both countries.²⁸

The intention of the Philippines in concluding a BLA with the United Kingdom stemmed from the concerns of government on the level of protection of the migrants who came to the United Kingdom in 1990s, as well as its general interest to send the labour workforce abroad and benefit from remittances and decreased pressure on the labour market. In particular, there were serious concerns about the placement fees applied by some recruitment agencies, which were above the maximum amount stipulated by the POEA. Additionally, there were some other concerns about the level of protection of migrants in the United Kingdom, in particular concerning the way Filipino nurses were being treated in some nursing homes²⁹. The need to protect the Filipino nurses who came in great numbers to the United Kingdom in the late 1990s was one of the most important motivations of the Philippine government to negotiate the agreement.

The United Kingdom signed two agreements with the Philippines. The recruitment agreement was signed in 2002 by Mr David Amos, NHS-DH Deputy Director of Human Resources (UK) and Ambassador Cesar Bautista of the Philippine Embassy in London. It was enforced upon signing of the agreement and was stipulated to be valid for three years and renewable unless a party decides to terminate.³⁰ The key actors in the crafting of the BLA were the Philippine Department of Foreign Affairs (DFA), the Philippine Embassy in London, the Philippine Department of Labour (DOLE), the POEA and the National Health Service (NHS), and the Department of Health (DH). The DH served as the representative of the UK government and the Philippine Embassy, under the DFA, served as the representative party for the Philippines. The POEA, as part of DOLE, and the UK Department of Health took part in the drafting, revision and finalization of the agreement before it was signed.³¹ It is important to mention that although the process of negotiation of this agreement went rather smoothly³² and, since the BLA was an operational agreement, no public consultation was further required, nor was the recruitment industry involved.³³ With regard to the process of implementation, no problems were observed as well. The agreement was monitored through bilateral dialogue and regular conduct of meetings about three to four times a year at the Philippine Embassy in London to discuss any outstanding issues. Moreover, Filipinos were very active in the NHS workers' associations, whose engagement was supported by the Philippine Embassy³⁴.

²⁷ The Code was first developed in 2001 and updated in 2004. The 2004 update strengthened the scope of the Code in order to cover recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector health-care organisations providing services to NHS. It is important to note that the Code is not intended to restrict recruitment, and it is directed at NHS employers in England. A similar Code was developed by Scotland.

²⁸ <http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Code-of-Practice/Pages/developing-countries.aspx> [accessed on 30th July 2013].

²⁹ Interview with NHS-DH.

³⁰ Jennifer dela Rosa, A Retrospective Evaluation of the UK Philippines Bilateral Labour Agreement: A Policy Option for the Recruitment of Human Resources for Health (unpublished manuscript, London School of Economics and Political Science), 2007.

³¹ *ibid.*

³² Interview with NHS-DH.

³³ Jennifer dela Rosa, *op. cit.*

³⁴ Interview with NHS-DH.

The second agreement, signed a year after and ratified in 2004, was the MOU about the cooperation in the health-care field signed by Ms Sarah Mullaly, DH Chief Nursing Officer (UK) and Ambassador Bautista. Whereas the first agreement was a detailed description of the organisation of the recruitment process and included such elements as exchange of information between the countries, pre-departure orientation for migrants, organisation of transport, switching the costs of recruitment fees from migrants to their employers, fair contract of employment signed before departure, and protection of migrants by national law, this second MOU was much more encompassing. It included the continuation of recruitment project, intensification of bilateral exchanges of policy thinking with regard to nursing workforce development and best practice in the delivery of healthcare and the involvement of professionals staff and health-care managers in the project, particularly in relation to education and training of Filipino nurses and other health-care professionals, with a view for a Mutual Recognition Arrangement in nursing and other health-care professions between the parties. Contrary to the recruitment agreement, an MOU was not implemented. The recruitment agreement was terminated in 2006.

It is important to note that the Philippines' recruitment agreement signed in 2002 was only meant for recruitment to the public sector or the NHS. At the same time, the recruitment to the private sector was continuing and unbound neither by the agreement nor by the Code of Practice. The UK-Philippines agreement came a year after the peak of the Filipino nurse recruitment (2001) by the private recruitment agencies. Though the intentions and objectives of this BLA were exceptional (ethical, cheaper and more attractive means of recruitment, to meet the workforce target of NHS and to protect Filipino nurses), it was, however, developed and implemented when the demand for Filipino nurses was altogether declining and long after the NHS hospitals had started to fill their vacancies with international nurses.³⁵ It is claimed that by 2002, the NHS target was already reached with a significant contribution from international recruitment (Plotnikova, 2012). The agreement with the Philippines was terminated in 2006 and never renewed. According to the UK Department of Health, the emphasis on international recruitment has diminished followed by the stop of the international programmes by the Department of Health, because the short-term NHS needs were satisfied (2007). While there is no precise data on how many international nurses were recruited to, arrived in, and continued to work in the United Kingdom between 1998 and 2006, there were approximately 100,000 new non-UK nurse registrations with the Nursing and Midwifery Council (NMC) across that period (Buchan & Seccombe, 2012).³⁶ As the international recruitment was seen as a measure to satisfy the short-term acute workforce needs and this aim was achieved, the policy changed into increasing the role of other mechanisms of sustainable workforce planning in the United Kingdom.

In recent years, the United Kingdom restricted its immigration policy and did not plan to renew its overseas recruitment project, but rather opt for educating their own health-care professionals or, similarly to Norway, inflow of HPs from other European countries³⁷. While nurses from other EU countries continue to have free access to the United Kingdom, under EU directives, those from other countries have experienced increasing difficulty and costs in attempting to travel to work in the United Kingdom.

³⁵ Jennifer dela Rosa, *op. cit.*

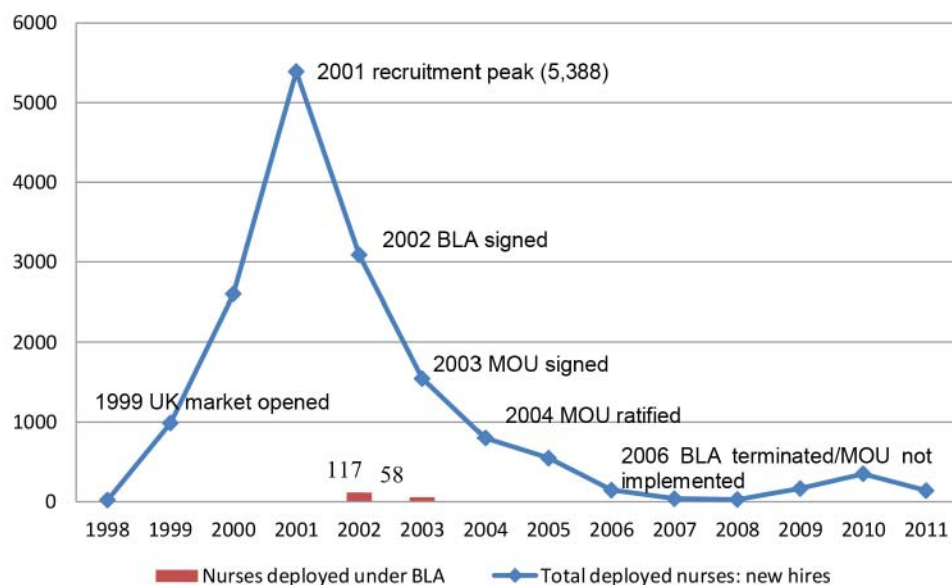
³⁶ The results of the research show that areas with the highest vacancy rates also had the highest representation of foreign recruits, with 24% of foreign-trained nurses in the UK residing in the London area and another 16% in the Southeast (comparable numbers for British-trained nurses are 11% and 13%, respectively). Without foreign recruitment, vacancy rates could be up to five times higher (three times higher if only Filipino recruits remained) (Batata, 2005).

³⁷ Interview with Workforce Division. However, the independent expert pointed out that it may be more a wish than a reality that due to the still insufficient resources of the nursing workforce in the United Kingdom and the rather pessimistic prognosis for future trends, the country may still face the need for international recruited nurses in the future.

Since 2005, a series of policy changes has made it much more difficult for non-EU nurses to enter the United Kingdom. First, in 2005 the NMC instigated a much tougher (and more costly) programme for overseas nurses intending to practise in the United Kingdom -- the Overseas Nurses Programme (ONP). Second, in 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list. Third, in 2007 the NMC then also raised the English language test requirements. Fourth, in 2008 the UK immigration policy changed, with the introduction of a points-based work permit system, making international recruitment a more difficult option for employers. More recently, there has been further toughening of immigration policy. In May 2010, the UK government announced their intention to review the immigration system to ensure that net migration reduced between 2010 and 2015 to the levels previously seen in the 1990s. New immigration rules were brought into force in April 2012 in relation to the approach to granting work permits to new entrants, and approving resident status for non-EU nurses currently working in the United Kingdom on time limited work permits (Buchan & Seccombe, 2012).

In total, between 2002 and 2006, only 175 nurses were recruited within the government-to-government agreement, whereas according to the POEA data, the total number of Filipino nurses deployed in the United Kingdom accounted for 6,124 (see Figure 1.4).

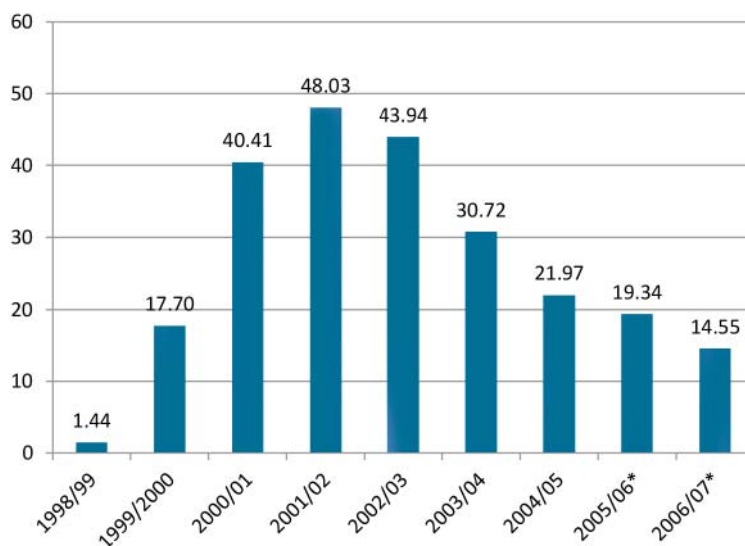
Figure 1.4 Recruitment of Filipino nurses to the UK 1998-2011.



Source: POEA. Taken in dela Rosa, Jennifer, 2007, op. cit.

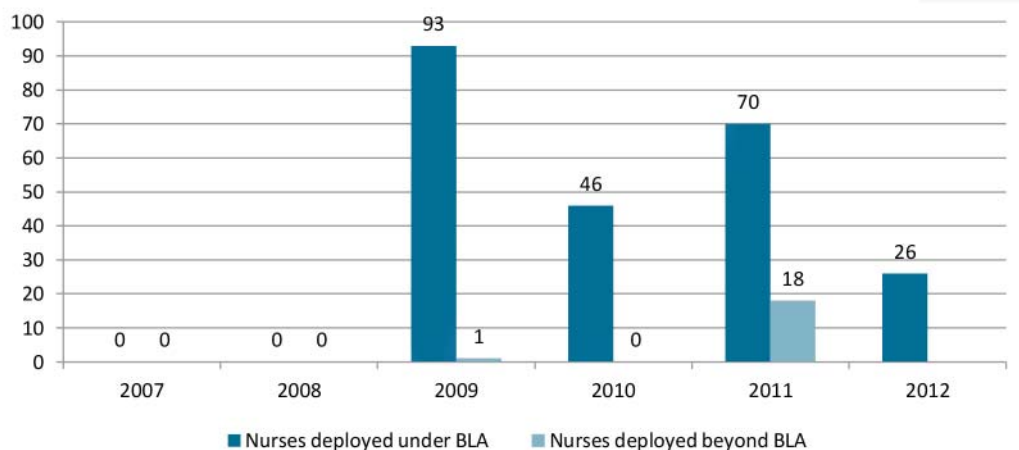
As some of the inflow of the Filipino nurses to the United Kingdom was done through the informal channels (with educational visas, as tourists, etc.), the UK NMC data on the initial overseas admissions to the register show even greater numbers: in 1998/99 -- 52 nurses of Filipino origin, 1999/2000 -- 1,052, 2001/01 -- 3,396, 2001/02 -- 7,235, 2002/03 -- 5,593, 2003/04 -- 4,338, 2004/05 -- 2,521, 2005/2006 -- 1,541 and 2006/07 -- 673 (UK Department of Health, 2007). Together, between 2002 and 2006, over 21,000 Filipino nurses were registered to practice in the United Kingdom (Figure 1.5 and 1.6).

Figure 1.5. Total number of Filipinos initial admissions to NMC Register.



Source: UK Department of Health, 2007.
 *Data available for only 20 TOP countries.

Figure 1.6.



Source: UK Department of Health, 2007.
 *Data available for only 20 TOP countries .

The limited significance of the UK BLA within the total flow of Filipino nurses could have several reasons, one of the most important being the satisfied demand and policy change, as well as the limited scope of the agreement, and bureaucracy and costs linked to its implementation. Generally, due to the meeting of the NHS demand, by 2002 the demand on internationally recruited nurses in the NHS was in decline. The inflow of internationally recruited nurses slowed considerably due to serious policy changes described above, including tougher NMC requirements and changes to the immigration system (Buchan & Seccombe, 2012). In recent years, the United Kingdom indeed moved from a situation of net inflow of nurses to a position of net outflow, meaning that more nurses are moving abroad to other countries, especially Australia, Canada, New Zealand and the USA, than are coming to the United Kingdom. Moreover, in 2004 the EU enlarged with ten new members from Central and Eastern Europe.

The United Kingdom decided not to introduce any transition period for access of nationals of these countries to its labour market. Contrary to the previous UK experiences with recruitment from EU 15, which was not successful (Deeming, 2004), the available data shows that the inflow of new EU nationals is replacing the need for overseas recruitment³⁸. However, in terms of recruitment of EU nationals to the UK health-care sector one problem is a language issue, as the EU nationals are not necessarily fluent in English, whereas due to the free movement of labour in the EU they are not obliged to pass any language tests (on the contrary to the overseas workers)³⁹.

The above discussed factors contributed, however, to the general decrease of international recruitment of nurses to the United Kingdom. More specifically, there are also other factors which are responsible in particular for the limited relevance and significance of BLAs in the total outflow of Filipino nurses to the United Kingdom. One of them, but not the only one, was that the agreement was only meant to be applied for recruitment to the UK public sector, whereas at the same time the UK private sector also had interests in recruiting Filipino nurses, and continued to do so. Moreover, contrary to other channels of recruitment of Filipino health-care workers, recruitment under BLAs was associated with bureaucratic procedure and costs described in the agreement. The procedure described in the agreement stipulated that the POEA would be responsible for inter alia advertising, pre-screening of the candidates, arranging the interviews with selected candidates, communication with candidates including support by providing necessary documentation, organization of pre-departure seminars, and arranging the transportation of successful candidates to the United Kingdom. The DOH and NHS employers were obliged to first of all pay POEA the sum of £140 per successful applicant as a processing fee, £17 per successful applicant as contribution to the Worker's Welfare Fund, and an additional £35 as standard contribution to the Employee's Guarantee Trust Fund to be administered by the POEA. Additionally, the procedure described in the agreement required the DOH and NHS Employers to cover the costs for advertising, costs of initial application to the UKCC (£70), costs of UK entry visa application (£70), costs of airfare tickets from the Philippines to the United Kingdom of selected candidates, repatriation costs (after at least 24 months of employment), conducting a pre-employment seminar prior to interview for applicants providing information about the post that they are applying for, the environment in which they may work and accommodation, making applications for Work Permits on behalf of successful candidates, and providing induction programme for successful candidates. Finally, it is also important to mention that in the implementation of the BLA, the DOH employed a response-handling company that utilized software designed to receive electronic applications and document queries to match the nurse applicant to possible NHS employers who would like to recruit Filipino nurses. The procedure had some advantages in terms of making the process transparent while guaranteeing the protection of the migrants' rights during the recruitment process (including particular proper information about the job offer, protection about the excessive fees and unexpected spending, induction programme, minimizing the risks with regard to further dissatisfaction with the salary, and working conditions). But its complicated nature, as well as the high costs of the recruitment procedure on the UK side, are the probable reasons for the lack of significance of the number of recruited nurses within the BLA in comparison to those recruited by other channels.

³⁸ Interview with NHS. The expert mentioned in this context the not very successful recruitment of Spanish HPs to the United Kingdom before 2004 EU enlargement, which is opposite to the current high inflow to the United Kingdom of HPs from new EU nationals.

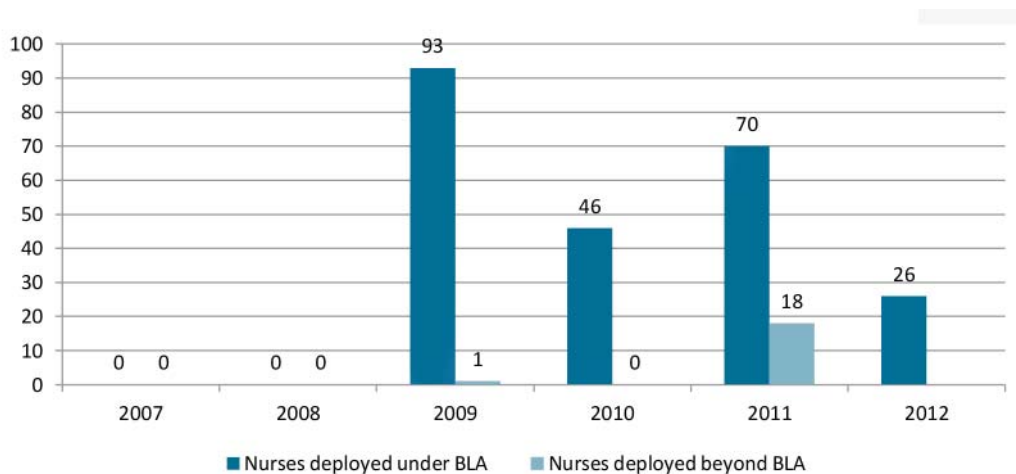
³⁹ Interview with UNISON.

Additionally, the late timing of the agreement could also be an important factor contributing to its lack of significance. As the recruitment of Filipino nurses to the United Kingdom had already been very well established (the market was opened in 1999), there were already established networks between UK-based hospitals with direct arrangements with Philippine-licensed agencies and UK intermediaries who acted on behalf of UK-based hospitals, and who were tied up with Philippine licensed agencies. These networks were a second, apart from the recruitment-to-private sector, channel of recruitment that existed independently from the signature of the UK-Philippines recruitment agreement in 2002. Apart from this, the three-year experience of recruitment of Filipino nurses to the United Kingdom certainly resulted in the establishment of informal networks, which are very important in the migration process. The already-established Filipino migrants in the United Kingdom could act as a source of information and support for other migrants interested in finding employment in the UK public and private health sectors on their own. Although there is no data on the number of Filipino nurses who were not actively recruited to the United Kingdom, but contacted the UK employers by themselves, the discrepancy between the POEA data on the number of nurses deployed in the United Kingdom, and UK NMC data on the number of overseas admissions to the Nursing Register, show that many Filipino nurses were recruited by channels other than the official one.

3.3 Importance of language, requirements and the consultation process: the case of Japan

The Philippines bilateral labour agreement with Japan is another case of an implemented agreement concerning migration of health-care professionals. Contrary to the UK case, the deployment of Filipino nurses under JPEPA is almost predominately responsible for the whole outflow to that country (Figure 1.7). Between 2009 and the first half of 2012, about 247 nurses and 396 caregivers were accepted to work in Japan. As there were almost no migration of Filipino nurses to Japan before the agreement, the bilateral labour arrangements between the Philippines and Japan played the role of “door-opener” to the new overseas labour market for Filipino health professionals. It is, however, important to note that the pattern of deployed nurses in Japan within the agreement has decreased since 2009. The possible reasons for this include Japan’s worsening economic and employment situation, and the increase in Japanese who wanted to enter the care and medical professions. The hospitals and care facilities that employed foreign candidates chose to concentrate their training capacity on those candidates, which might otherwise overburden their capacity to train in the case of employment of additional candidates (Ohno, 2012).

Figure 1.7 Total deployed nurses to Japan: new hires 2001-2011.



Source: POEA .

The bilateral labour agreement between Japan and the Philippines is a trade agreement in the form of an Economic Partnership Agreement (EPA). This treaty consists of 16 Chapters, 165 Articles and eight Annexes, and rests on three key pillars: liberalization⁴⁰ facilitation (i.e. simplification and harmonization of customs procedures, use of ICT and paperless trading, measures to improve the business environment, and competition policy framework to address anticompetitive business practices); and cooperation (i.e. cooperation initiatives on HRD, financial services, ICT, energy and environment, S&T, trade and investment promotion, SMEs, tourism, and transportation and road development) (Yap, Medalla, & Aldaba, 2006).

The article for migration of nurses and care workers is derived from WTO's General Agreement on Trade and Services (GATS) Mode 4, which became a separate article of Movement of Natural Persons under the agreement (Reiko, 2012). This article stipulates⁴¹ that the Japanese side will allow entry of Filipino candidates for qualified nurses and certified care workers that satisfy certain requirements and will allow them to work after completing training for Japanese language and other specialized trainings. It is further explained that Filipino nurses are required to speak fluent Japanese and pass Japanese national examinations to ensure they are able to provide adequate patient care in Japan. Filipino candidates applying as nurse (kangoshi) are required to obtain a nurse license in the Philippines, and have three or more years of experience working as a nurse. Those willing to enter the programme as certified care workers (kaigofukushishi) are required to having graduated with a bachelors' degree from a higher educational institutions, from which the minimum period required for graduation is four years, and be certified as caregivers in the Philippines or having graduated from a nursing school. It is not only controversial to include the movement of natural persons in a trade treaty, but also results in the lack of provisions concerning recruitment and employment of migrants. The inclusion of recruitment of Filipino nurses and care workers into a trade treaty allowed the Japan side to present this as part of

⁴⁰ Japan is obliged to immediately remove tariffs on products like shrimps and prawns, asparagus, leguminous vegetables, dried bananas, mangoes, mangosteens, fresh papayas and manufactured goods like knitted and crocheted fabrics. Gradual tariff elimination is to be implemented for several other products. The Philippines' immediate tariff elimination concerns products such as fresh apples, pears and quinces. The gradual tariff elimination is foreseen for several other products, while elimination of tariffs for automobile industry is subject to further negotiation.

⁴¹ Apart from the acceptance of Filipino nurses and care workers, this paragraph also includes specific commitments concerning short-term business visitors, intra-corporate transferees, investors, natural persons who engage in professional services and natural persons who engage in supplying services, which require technology or knowledge at an advanced level or which require specialized skills belonging to particular fields of industry, on the basis of a contract with a public or private organisation.

the negotiation concessions to the advantage of the free trade with the Philippines, rather than a typical recruitment project accompanied with fears of the locals against the inflow of foreigners and its labour market effects. In fact however, the agreement faced criticism from both sides, in Japan - it raises fears against the deterioration of quality of care and working conditions in healthcare. And in the Philippines - it is seen as unfair treatment of fully-qualified nurses by the Japanese side.”

The process of the JPEPA negotiation started formally in early 2004 and resulted in the signature of the agreement on 9 September 2006, at the sidelines of the Summit of the Asia-Europe Meeting (ASEM) in Helsinki. However, the beginnings of the agreement are dated from 2002. Former Japanese Prime Minister Junichiro Koizumi, during his visit to the Philippines and other ASEAN countries in January 2002, proposed the “Initiative for Japan-ASEAN Comprehensive Economic Partnership”, to which then Philippines President Gloria Macapagal-Arroyo gave her full support. At the Japan-ASEAN Forum in April 2002, it was decided that bilateral economic partnerships under such an initiative could be explored. Hence, when President Arroyo visited Japan in May 2002, she proposed that a working group study the possibility of forging a Japan-Philippines Economic Partnership Agreement, which may include the elements of a free trade agreement (FTA). Executive Order 213 created the Philippine Coordinating Committee (PCC) to study the feasibility of the proposed JPEPA. The PCC was an inter-agency body composed of concerned government agencies co-chaired by the Department of Foreign Affairs and Trade and Industry. The PCC also served as the Philippine negotiating team for the JPEPA. In December 2003, at the fringes of the ASEAN-Japan Summit, President Arroyo and Prime Minister Koizumi made a joint announcement that Manila and Tokyo shall launch formal negotiations for the establishment of the JPEPA in early 2004. The agreement was signed in 2006 by Prime Minister Koizumi and President Arroyo. On the part of the Philippines, the final step for ratification was the Senate’s approval, which finally took place in 2008. The process of ratification in the Senate was delayed -- some NGOs and other organizations opposed the agreement, as they questioned the possibility that tariff-free toxic wastes could be imported from Japan, and that Filipino nurses and caregivers did not have a fair deal, and the Senate held extensive hearings which delayed consent (Ohno, 2012).

The implementation of the agreement in terms of movement of nurses is implemented by the Japan International Corporation of Welfare Services (JICWELS) and by the POEA. In order to foster the implementation of the agreement the JPEPA was accompanied by the MOU between the POEA and the Japan International Corporation of Welfare Services on the Deployment and Acceptance of Filipino Candidates for “Kangoshi”, Filipino Candidates for “Kaigofukushishi”, Filipino “Kangoshi”, and Filipino “Kaigofukushishi”. The MOU was signed on 12 January 2009 by Jennifer Jardin-Manalili, Administrator of the POEA and by Takashi Tsunoda, Managing Director of the Japan International Corporation of Welfare Services. The document describes the process of deployment of Filipino nurses to Japan and cooperation between the POEA and JICWELS in recruitment. According to it, JICWELS is responsible for recruiting Japanese institutions willing to employ Filipino workers, matching the employers with employees, transportation expenses of prospective employees from the airport in the Philippines to Japan, a meeting service at the airport and orientation after entry into Japan, and ensuring that employment contracts become effective between employers and employees when they start to work. On the other side, POEA is responsible for recruitment of Filipinos who would like to work as nurses or care workers in Japan, including proper information (pre-departure seminars) and taking part in matching employers with employees. The costs of recruitment, which are to be paid by the Japanese employers to POEA, account for US\$435 as a processing fee, inclusive of contract guarantee, and \$25 as contribution to the Worker’s Welfare Fund per selected Filipinos.

The Philippines-Japan agreement is not the only one that Japan concluded concerning the migration of health professionals. In 2007, Japan became a “super-aging society”, one in which the percentage of elderly people is more than 21 per cent of the total population (Ohno, 2012). According to Japan’s

National Forum on Social Security, between 2007 and 2025, the demand for elderly care workers will double, and that for nurses will increase by 20 per cent to 60 per cent. A Cabinet decision by the Democratic Party of Japan set a goal of turning the occupations of elderly care and nursing into a ¥50 trillion market and creating an additional 2,840,000 jobs by 2020 (Asato, 2012). It is doubtful if Japan will be able to satisfy this demand with its own resources, as the qualified working-population (aged between 15 and 64) is forecast to decrease by eight million over the next ten years (2010-20), thus causing a severe shortage in the workforce, and there are little possibilities of raising the salaries in the elderly care sector in Japan as they depend strongly on the insurance system (Asato, 2012). Although the Ministry of Health, Labour and Welfare (MHLW) in 2000 estimated that the gap of 35,400 in the nurse workforce in 2001 would be solved by 2005 by the mobilization of potential nurses not yet in the labour market⁴², it does not seem to be feasible. According to the newest information, this gap has been widening -- until by 2011 it is estimated at more than 56,000 (Asato, 2012). The ministry does not address the fundamental issue of why the number of potential Japanese nurses who choose not to work in the nursing field is increasing, nor does it offer any decisive policies to utilize the potential workforce (Hirano, et al., 2012).

Even before the recognition of a serious elderly care crisis in Japan, the project for accepting nursing and care-giving workers based on EPAs between Japan and Southeast Asian countries had begun. In 2008, the very similar EPA with Indonesia was signed, which also included a paragraph on nurses, and caregivers' migration⁴³. Japan's acceptance of foreign workers from the Philippines and Indonesia is not officially intended to solve the shortage of the labour force in the medical and social welfare fields (Ohno, 2012). Rather, this acceptance was agreed as an "exception" in order not to jeopardize Japan's EPA negotiations (Reiko, 2012). The government set up maximum numbers of foreign workers by considering the effects on the domestic labour market rather than a measure for labour shortage in nursing and care-giving fields. There were less than 400 nurse candidates and 600 certified care-worker candidates by country for the first two years (Ohno, 2012).

The agreement with Japan, JPEPA, is criticized by the Philippines Nurses Association⁴⁴ and Philippine trade unions for resulting in the deskilling of Filipino nurses. The agreement requires not only full nursing qualifications, but also three years of experience from Filipino nurses. The accepted nurses work at the beginning as nurses' assistants, as they formally come to Japan for training. They are required to follow six-month language training and only after passing the national exam are they fully certified to work as professional nurses in Japan. Although many of the Filipino nurses coming to Japan within the agreement may have valuable experience working as registered nurses in the Philippines, they are not allowed to perform any medical interventions for the patients until they have a national nursing license in Japan. The research show that Filipino nurses may indeed perceive their status as nurses' assistants after arrival to Japan as contradictory to their pre-departure expectations of "developing their professional career" and "learning about advanced Japanese technology" (Ohno, 2012). For some of the respondents in the cited study it was shocking and demeaning to their status as professionals to perform basic care works such as changing diapers and collecting urine or other garbage, and assisting in taking meals and tea to the patients, which are usually performed by family members or nurse aides in their home country, but by nurses and other care workers in Japan. Only one Filipino nurse from the first batch of candidates deployed to Japan successfully passed the exam in the front of National Board in 2010. This is exactly the same national exam the Japanese nurse candidates are obliged to pass, which is in the

⁴² It's estimated that the potential nursing force to be at more than 900,000 (Hirano, Reiko, & Shun, 2012).

⁴³ Japan's EPAs with Singapore and Malaysia are already in place, the EPA with Thailand is yet to be signed, while talks with Indonesia, Brunei and Vietnam are still on-going. However, these agreements do not specifically address the issue of movement of HPs between the countries. Apart from Filipinos and Indonesian, Japan is also going to accept Vietnamese nurses and caregivers according to the MOU signed in 2011, and there are some prospects for agreement with India (Ohno, 2012).

⁴⁴ Interview with the Philippines Nurses Association.

Japanese language *Nihongo*, and is considered to be a very difficult language for foreigners⁴⁵. These hard language requirements contributed to much criticism of JPEPA from Filipino nurse associations. The most recent information concerning the number of Filipino nurses who succeeded in the national exam up to date are the following: from 93 Filipino nurses coming to Japan within the first batch (2009) up to May 2012, 11 passed the exam; from the second batch (2010) -- 4, from the third (2011) and fourth batches (2012) -- 0. In total, within four years, out of 237 Filipino nurses deployed to Japan, 15 manage to pass the national exam and 36 have already left Japan⁴⁶ (Carlos, 2013). The nurse candidates may take the exam three times within three years, whereas the certified care worker candidates may take it only once over four years because a pre-condition for taking the certified care-worker exam even for Japanese examinees includes working three years at a care facility (Ohno, 2012). On the contrary, candidates who pass the national exam become formally registered nurses or certified care workers, qualified to remain in Japan and work under a “designated activity (*tokutei katsudo*) visa” that can be extended indefinitely.

The reasons for difficulties with meeting the language requirements by Filipino nurses is not only caused by the overall difficulty of the Japanese language, its lack of similarity to Tagalog (Filipino) or English, and the limited time of language training, but it is also an issue of the quality of language training organized by the accepting institutions. As these are the accepting organizations which are supposed to provide the language training and exam preparation for the foreign recruited nurses, there is a conflict between the numbers of hours worked and studied between employers’ and candidates. Several studies showed the bipolarization among institutions in terms of the provided learning hours -- whereas some of the institutions provide more than 8.8 learning hours a week, others limit the training to 4.4 hours (Asato, 2012). The average of weekly training hours has remained comparable at 13.3 hours. However, recently the ratio of institutions that provide less than five hours of training rose to approximately 30 per cent, while those allotting 20-25 hours per week, four to five hours per day, equals 30 per cent. Many accepting institutions have also had problems with the organization of training, because of the lack of educational infrastructure. Asato cited the MHLW study on Japanese staff in charge of training that found that 14 of the 24 institutions requested educational guidelines and teaching materials for their candidates⁴⁷ (Asato, 2012). The problems lie in the fact that almost all foreign candidates’ education is entrusted to the institution where they work -- they do not only have no previous experience in employing foreign workers, but also have limited experience in education (hospitals are generally not educational institutions in Japan). Even so, they are obliged to provide education in the Japanese-language as well as exam preparation. This situation results in the fact that even though the Japanese government has spent ¥1.5 billion over the last two years to improve the training infrastructure (Asato, 2012), it didn’t manage to solve the problems with the quality of training.

It is also important to note that not only have the accepting institutions little experience with education of foreign workers, but are also reluctant to carry the high costs of it. Until the time when candidates begin working after six-month language training, the initial cost of accepting one candidate, including mediation fees, Japanese language training and commission paid to the National Board, is approximately ¥600,000. Furthermore, if presumed that an accepting organisation has two candidates and provides 13.2 hours of training per week for each of them, in addition to providing a tutor, then nearly 40 additional man-hours of work is dedicated to training each week. If administration and other costs are

⁴⁵ The success rate for Indonesian candidates is better -- 15 from the first batch passed the exam in 2010. The pass rate of first-batch nurse candidates from Indonesia remains at 14% out of a total of 104 entrants; from the Philippines it is only 1%. It is important to notice that the pass rate for foreign non-EPA candidates is much higher (individuals, not a government-to-government scheme). The ratio for non-EPA applicants was 50% in 2006 and rose to nearly 100% in 2011 (the number of applicants increased as well) (Asato, 2012). The passing rate of the exam among Japanese candidates fluctuates at around 90%.

⁴⁶ According to the data of the Japanese Ministry of Health, Labour and Welfare.

⁴⁷ Educational guidance was only developed in 2010.

included, the total is much higher, which is considered to be a burden by the employers (Asato, 2012). Some accepting institutions are trying to avoid this burden by not paying their workers for training time. In consequence, the workers are not paid for a full 40-hour working week, as they expected from their contracts signed before departure.

The obligation to pass the national nursing exam by foreign qualified nurses is explained by the claim that nursing is a special profession, which includes a high degree of emotional skills, and not only technical. The good understanding of language and culture is thus necessary to perform the nursing work⁴⁸ (Ohno, 2012). Therefore, the work the nursing assistants are performing is not deskilling, but learning the necessary context and emotional skills necessary to fully perform the nursing duties. The other argument in favour of the language requirements for foreign workers is that ensuring equal remuneration for Japanese and migrant workers and providing sustainable Japanese language skills and adequate exam preparation might prevent the worsening of wage and working condition in the labour market (Asato, 2012), as well serving the unchanged quality of the provided medical service (Hirano, et al., 2012). The fear of worsening wages and working conditions of Japanese nurses or formation of a dual labour market in Japan is raised by the MHLW and Japanese Nursing Association (JNA) (Asato, 2012). Paradoxically, the research show that this is what is actually happening due to the organization of the language training.

Other requirements the Filipino nurses have to fulfil are highly criticised by the Filipino nursing associations. Filipino nurses are required to have three years' experience, whereas the Indonesian ones, only two. Although the minimum two years' experience, one year shorter than Filipino candidates, is due to the similarity of Indonesia's educational system to Japan's (Ohno, 2012), this contributes to the JPEPA criticism of the agreement and the feeling of unfair treatment of Filipino nurses by the Japanese side (despite its well-known, world-wide good reputation as qualified nurses) and the failure of the Filipino government in the negotiation process. The requirement of three years' experience from fully qualified Filipino nurses is also considered to be against the interest of the sending country -- it does not contribute to mitigate negative consequences of outflow for the sending country, on the contrary, it could further increase its negative effects. In order to mitigate brain drain, the receiving country should recruit new graduates rather than experienced nurses -- in particular in cases of such training projects as is in place in the case of the JPEPA⁴⁹. The situation when the receiving country requires experience from the nurses result in the situation when the newly graduated nurses are forced to volunteer in their country of origin -- they cannot find employment in the Philippines and urgently need professional experience to look for the job abroad. Currently, the agreement is being reviewed, and the changes concerning the language preparation, including the introduction of additional pre-departure six-month training⁵⁰ and/or introduction of knowledge of Japanese as pre-condition for entry into the programme (Ohno, 2012), are being negotiated. However, such changes may not be enough to radically change the situation with the trainings, as more deep-founded changes in the organisation of the training in Japan may be necessary.

⁴⁸ Interview with Japanese academic.

⁴⁹ Interview with the Philippine Nurses Association.

⁵⁰ Interview with the Philippine Department of Health.

Despite its role as market-opener for Filipino nurses and care workers and good prospects for continuation of the programme as the shortage of healthcare and care-giving workers in Japan is predicted to gradually increase over the next years, the effectiveness of the JPEPA agreement, even in terms of satisfying its recruitment objective, could not be assessed as definitely positive. The amount of Filipino nurses being recruited to Japan within four years of the existing of this agreement is not significant in comparison to the outflow to other countries. Moreover, it is decreasing. The language problem (perceived as generally difficult, as well as no guarantee or even probability for long-term employment in Japan due to the problems of passing language training) and the demanded three years' experience from Filipino nurses are definitely the important factors limiting the numbers of those interested in migration to Japan. However, these are not the only ones -- the labour market situation in Japan, its policy of encouraging natives to return into nursing professions, and the reluctance of the Japanese employers to carry the costs and the difficulties for training foreign candidates are also contributing to this situation.

Moreover, as some research shows, even those Filipino nurses who were finally accepted to the programme treat migration to Japan as a first step in the migration experience, and expect to further migrate to the United States, Australia or European countries (Carlos, 2013). This observation could have several implications for JPEPA effectiveness. First of all, this may be somehow against the intention of the agreement, as the Filipino nurses and the Japanese employers are expected to invest a lot in the language and professional training of Filipino nurses after their arrival to Japan. Treating the migration to Japan as only the initial step to migrating to other countries is a loss of this investment. Moreover, the reason for the low-passing rate of the Japanese licensure exam by Filipino nurses could also be found in the low motivation of the candidates. If the migrants do not treat Japan as their final destination for migration, they are also less motivated to pass the exam. In case of further migration, both the successful exam records and knowledge of the Japanese language are not a necessity or neither an advantage in finding employment in the third country.

3.4 Why to bother with BLAs when recruitment goes well? The case of Bahrain and Saudi Arabia

As already discussed in the chapter 1.2, the most important destination countries for Filipino nurses are Gulf countries. Among the top-ten destinations for Filipino nurses, Saudi Arabia is the most important destination, being responsible for above 70 per cent of the total number of overseas deployed Filipino nurses. Other Gulf countries in the top-ten in the 2011 list were the United Arab Emirates, Kuwait, Oman and Qatar. Migration of Filipino nurses to Bahrain is also significant in terms of its magnitude -- Bahrain was one of the top-ten destination countries for Filipino nurses in 2010.

Generally, the Gulf countries are particularly reluctant to enter into any bilateral agreements with the third country, including those concerning labour migration. Moreover, they do not have to enter into BLAs in order to recruit Filipino nurses, as the recruitment process is anyway on-going. The positive examples of BLAs effectiveness in the regulating outflow show that the interdependency of the process of recruitment and the existence of BLAs (meaning that no other channels of recruitment are possible) is one of the key success factors (compared to, e.g., the effectiveness of Poland's agreement with Germany) (Okólski, 2004). In such a situation, what motivations could the Gulf countries have to take any obligations concerning the protection of the migrants' rights, or providing compensation measures for the sending country for this outflow? The recruitment process organized at the governmental level is not seen as an advantage by Gulf countries, as the recruitment is effective due to the existence of the

well-established cooperation between Filipino recruitment agencies and employers in Gulf countries such as Saudi Arabia and Bahrain⁵¹.

Bahrain is the only country that has already signed a bilateral labour agreement with the Philippines concerning the migration of health-care professionals. The agreement, entitled “Memorandum of Agreement between the Government of the Republic of the Philippines and the government of the Kingdom of Bahrain on Health Services Cooperation”, was signed on 4 April 2007, and is exceptional. It is considered to be one of the best practices in terms of the BLAs, including compensating measures for the sending country for the outflow of health professionals (Dhillon, et al., 2010). The objectives of the agreement, stated in its first paragraph, make it clear that this agreement is different from the typical recruitment agreements. It aims to: A) Provide an ethical framework that will guide the recruitment policies and procedures of the contracting parties; B) Create alliances between the Philippines and Bahrain’s recognized health-care and educational institutions to produce sustainable international education, training, and professional/technical development programmes that will increase the supply and improve the quality of competent human resources for health; C) Provide reintegration for the human resources for health, who shall return to their home country; D) Develop mechanisms for sustainability of the development of human resources for health; and E) Promote the development of health-related research institutions.

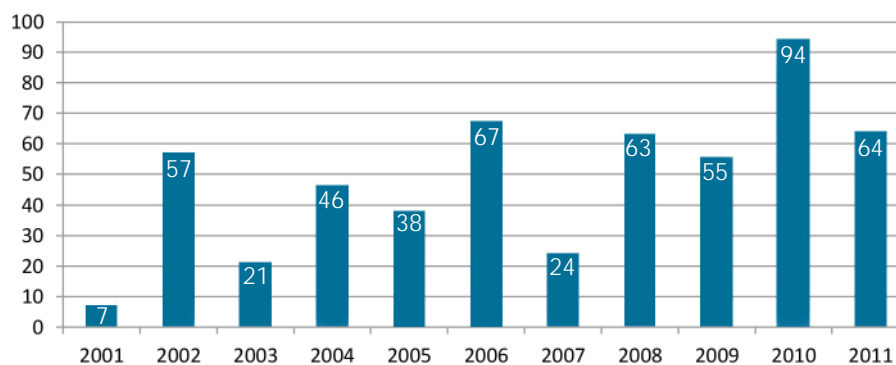
Not only are the objectives of the agreement far more reaching than those in other recruitment agreements, but they also include such compensation measures for the sending country as supporting initiatives to promote human resource development -- e.g. upgrading health facilities, strengthening training institutions, facilitating transfer of technology and skills, development assistance including reintegration programme, mutual recognition agreement, and scholarships (the Bahraini government is supposed to provide graduate and post-graduate scholarship programmes that may be administrated by providing scholarships to Filipino human resource for health to leading Bahrain universities. Upon completion of the programme scholars will be required to return to the Philippines). Other initiatives include internships and exchange of experts, joint ventures and investments in health facilities including training hospitals, research institutions, IT-enabled health services operations, and supporting transfer of technology by joint research and projects or sharing of best practices. Moreover, the agreement also contains statements concerning the protection of migrants’ rights. It says that candidates for recruitment should be provided with an internationally accepted contract, and the candidates should receive information about their local community, including access to public services, established social networks, and available cultural support. Human resources for health shall moreover provide equal employment opportunities in terms of pay and other employment conditions, access to training, education and other career development opportunities and resources, as well as the right to due process in cases of violation of the employment contract. The recruitment finally takes into consideration the socio-economic impact of migration of the human resources for health. All these provisions are exceptional not only among the other BLAs, and in particular for Gulf countries, but also are very innovative with regard to addressing the negative consequences of migration of health professionals for sending countries, particularly as the WHO Code of Practice was only developed three years later -- in 2010 and the best practices for including such provisions in BLAs were only developed afterwards. It is important to note that the Philippine Department of Health⁵², contrary to negotiation of other agreements, was strongly involved in the process of the negotiation of the MOA with Bahrain, which could result in more emphasis on the recruitment consequences for the functioning of the health-care sector in the sending country.

⁵¹ Interview with Filipino recruitment agencies.

⁵² Interviews with the POEA and Department of Health.

The main problem with this agreement is, however, that it was not implemented until now⁵³. Officially, the implementation process is pending, but as this implementation requires commitments and costs on the Bahraini side without any clear benefits for this effort (as the recruitment of Filipino nurses is not dependent on the process of MOA implementation), it is not very probable that implementation will be feasible in the near future. Figure 1.8 illustrates the numbers of total deployed nurses to Bahrain, and we can observe that the tendency is rather stable with a slightly increasing trend, notwithstanding the lack of MOA implementation.

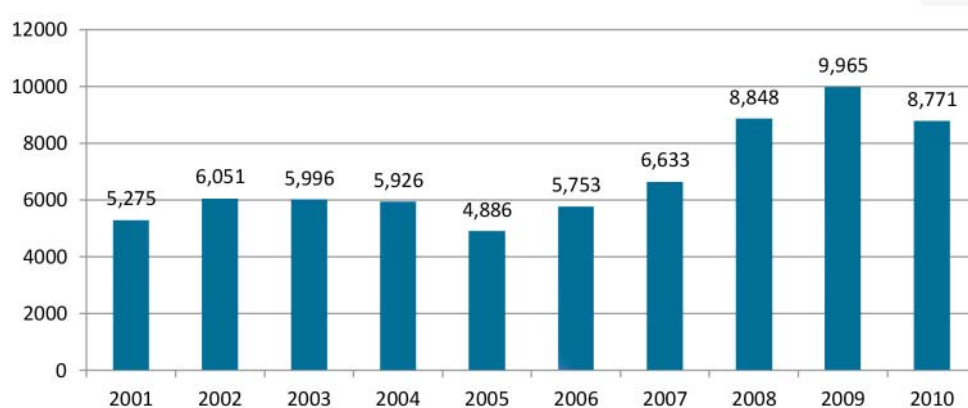
Figure 1.8 Total deployed nurses to Bahrain: new hires 2001-2011.



Source: POEA.

The success of the recruitment project without any formal agreement is also illustrated by the case of Saudi Arabia, which has faced an acute shortage of native nurses primarily due to lack of enthusiasm among young Saudi Arabians for vocational training, and religious barriers that restrict female access to education and employment (Ohno, 2012). As shown in Figure 1.9, the outflow of Filipino nurses to Saudi Arabia is very significant in numbers, and it fluctuates at around 6,000 new hires yearly, with the substantial increase up to 8,000 to 9,000 from 2008.

Figure 1.9 Total deployed nurses to Saudi Arabia: new hires 2001-2010.



Source: POEA.

⁵³ Interview with the Department of Health.

However, numerous authors claim that Saudi Arabia has a reputation as a difficult destination due to the anecdotal stories of abuses and discrimination against Filipino women in Saudi in the mass media⁵⁴ (Ohno, 2012). Taking into account that the salary scale in Saudi Arabia is lower than in the United States and other Western countries, the increase in the number of recruited to Saudi Arabia is rather seen as a result of the shrunken labour market for foreign nurses in the other countries. It is moreover claimed that migration to Gulf countries is generally a first step to migration to other destinations (e.g. the United Kingdom, the United States or Australia) (Alonso-Garbayo & Maben, 2009). This is true due to the fact that access to employment in these destinations from the Philippines is easy due to the minimal requirements needed, it's quick and relatively cheap, and with the facilitation by local recruitment agencies in cooperation with employers and recruitment agencies from the destination countries (Carlos, 2013).

At the same time, the Gulf countries very often implement temporary labour migration policies, where foreigners have little chance to be granted permanent residency or citizenship. They are required to have an employer or a sponsor in order to be allowed to stay and work in the country, and are usually not allowed family reunification. There are also some racial discrimination issues in the workplace, such as locals and Westerners being given priority in hiring and promotion, and paid more and granted more benefits for the same kind of job or position (Carlos, 2013). On the contrary, in Western countries salary, working conditions and protection of the migrants' rights is considered to be better. It is also worth noting that experience with working abroad may not only be perceived as an asset for employment in the next country, but also the possibility to find an employer in a European and other Western country could be easier in the third country than in the Philippines.

However, despite the apparent, first glance success of recruitment of Filipino nurses to Saudi Arabia and the lack of a formal agreement, the experience of Filipino nurses show that such agreements could have advantages in order to protect the migrants' rights when abroad, and mitigate the negative consequences of the outflow for the sending country's health sector. The Bahrain experience, however, shows that investing in negotiation of such agreements may be very challenging as there is little possibility to encourage the Saudi side to enter into agreements by making dependent the process of recruitment and implementation of the agreement. Without this mechanism the agreement, even if negotiated, could share the fate of Bahraini agreement -- being only a good practice on paper. As there are current considerations on Philippine and Saudi Arabia side about such an agreement, the Philippines would need to find another incentive if such an agreement is to be negotiated, moreover, implemented by Saudi Arabia in order to protect the Filipino migrants' rights.

3.5 Lessons learnt from Philippines' BLAs and policy implications

The general lessons learnt from the study of the Philippines' bilateral labour arrangements are not optimistic. From the three functions of BLAs nowadays in regulating the recruitment process, providing mechanisms for the protection of migrants' rights, and compensating for negative consequences for the outflow, even the first one is very difficult to be satisfied by the bilateral agreements. The Filipino experience shows that, the thorough negotiation of the agreement does not necessarily result in its implementation. These are two separate processes and due to dynamism of the policy priorities' changes in the receiving countries, many agreements only end up as paper documents (e.g. Spain, Norway, Bahrain).

⁵⁴ The leading Philippine newspaper published an article that Saudi religious police arrested a Filipino nurse on charges of immorality for sitting in a restaurant with a male colleague, while another story reports on Filipino Catholic nurses who were forced to convert to Islam.

It was also seen that the agreements that are implemented are not necessarily successful. There are several factors, which are contributing to the lack of significance of the Filipino BLAs. First of all, the Philippines did not manage to sign the agreements with the main countries of its nurses' destination, and instead signed the agreements with countries where the outflow is generally not so substantial in numbers (with the exception of the United Kingdom). The significance and implementation of the agreements is highly depended on the political situation of the receiving country, which the sending country has little influence on.

The other important factors are the scope of the agreement and the existence of the alternative channels for recruitment. The experiences show that the government-regulated process of recruitment is complicated by the bureaucracy and costs of recruitment, which need to be carried out by the employers rather than the migrants themselves. This contributes to the employers' preference to choose alternative channels of recruitment if those exist (as shown from the experience with BLAs with the United Kingdom and JPEPA). If the agreement does not play a role of a new market opener for Filipino nurses, the formal and informal networks of recruitment could already be very effective in satisfying the labour market's needs of the receiving country leaving little free space to be taken by the government-to-government recruitment. This is particularly reinforced in the situation when the high demand for foreign nurses very much precedes the signature of the agreement, as in the case of the United Kingdom when the agreement was signed when the needs were on the short way to be satisfied. The UK agreement also proves that the limited scope of the agreement (if it does not cover recruitment for the whole health sector in the receiving country) is also a limitation to the BLA's effectiveness.⁵⁵

The next factors contributing to the limited significance of the BLAs could also be seen in the language and other issues. The language issue is very important for the effectiveness of BLAs, as it is a cost for employers and a risk for migrants. Migration to the destination country, which requires the learning of another language (in particular as in the case of JPEPA - in a very limited time and with little prospects for success) is perceived by migrants as a kind of migration risk, and discourages them to take part in the agreement. At the same time, if employers (as in JPEPA) or the receiving country's government (as it was expected in the Norwegian agreement) are responsible for the costs of the training, this decreases their motivation to participate in the recruitment. Organization of the language training could also be a factor that contributes to the violation of migrants' rights, as the JPEPA experience show.

Even more difficult is the issue of the BLAs' effectiveness in protecting migrants' rights. The analysed agreements mainly focused on freeing the migrants from paying the placement fee, as they could have a negative consequence for migrants in terms of their strong commitment to their new employer. It is important to note that in the case of United Kingdom, the high placement fee used to be a problem in the recruitment of Filipino nurses to the United Kingdom before the agreement was signed in 2002. These fees were more than the maximum amount stipulated by the POEA, which is equal to a month's placement fee. In 2000, the POEA issued Memorandum Circular no 5, which stipulates the guidelines on the deployment of Filipino nurses to the United Kingdom, and this governed the recruitment undertaken by Filipino-licensed agencies that have agreements with UK employers or recruitment agencies. With the signature of the agreement, the placement fees were shouldered by the employers. This however is only partially true, because even in the case of public sector employment in the United Kingdom, these costs were partially passed to migrants. The respondents in the interviews claimed that the recruitment

⁵⁵ The increased demand for nurses to the United Kingdom came in 1999. Many nurses had been deployed before the agreements. The UK -RP BLA was triggered by a complaint related to poor work conditions of nurses already recruited to elderly facilities in the United Kingdom.

fees, which were applied to migrants who were recruited to the UK private sector, were not as high and troublesome for the migrants. Taking into account the slightly higher salaries in the UK private sector, paying the recruitment fees to work in the private sector could still be more cost-efficient for migrants than being recruited to the NHS⁵⁶. Also in the case of JPEPA, the research showed that the lack of a placement fee is not considered by the migrants to be an important factor for choosing their migration destination. None of the Filipino and Indonesian nurses and care workers pointed to a lack of placement fees to be an important factor in their decision to migrate to Japan within JPEPA and IJEPA (Hirano, et al., 2012).

Moreover, the agreements seem not to prevent some form of migrants' rights violation in the receiving countries. In the case of the United Kingdom, the respondents mentioned problems with the working conditions of Filipino nurses in some elderly houses as well as problems with migrants' access to professional trainings depending on their official status in the United Kingdom⁵⁷. For Japan, discussed problems like some institutions not paying for training, as well as the issue of migrants' potential deskilling, were important. Moreover, as the issues with migrants' rights possibly being more fragile in Gulf countries than in European countries, it is important to note the Philippines' failure to engage the former in any guarantees in this regard.

In terms of BLAs' effectiveness in terms of mitigating negative consequences of the outflow for the sending country or compensating for them, the analysis shows that it is extremely difficult to provide and implement such provisions of BLAs. Not only were such provisions only present in one BLA with Bahrain, they failed to be implemented due to the lack of incentives for the receiving country to comply with them. Moreover, the JPEPA case shows that the BLA may somehow contribute to the problems on the labour market in the sending country by specifying the target group for recruitment -- in this case, by accepting only experienced Filipino nurses as nursing candidates.

Finally, it is important to notice that the process of negotiation of the agreements, and in particular the engagement of non-governmental stakeholders in the consultation process, could play an important role in increasing the BLAs' effectiveness and mitigating the future problems with its implementation. The results of the study show that in the case of many agreements (particularly the older ones), the process of consultation was very limited on the side of the Philippines. This situation has gradually improved, in particular in the case of JPEPA. However, it didn't manage to prevent the problems with the implementation of the agreement.

The unsuccessful Philippines' experiences with BLAs for health-care professional migration do not mean that the BLAs are doomed to failure in satisfying its three objectives. On the contrary, it shows that BLAs go through rigorous processes such that the negotiation and implementation of the agreements can be very difficult. BLAs are migration management tools that are not very easily applied. The following recommendations could, however, be helpful to improve its effectiveness:

Recommendation #1:

Nowadays, the objectives of BLAs, in particular those concerning the migration of health-care professionals, can no longer be limited to the recruitment and protection of migrants' rights. Due to the

⁵⁶ Interview with Filipino recruitment agencies.

⁵⁷ Interview with ICN.

severe negative consequences the migration of health professionals could have for the sending country, the BLAs should also include measures to address the challenges for the sending country's health-care system resulting from the outflow. These could include setting safe recruitment targets, monitoring of the health-care system situation in the sending country during the whole duration of the agreement, and inclusion of compensation measures. For example, scholarships and exchanges of experts, joint ventures and investments in health-care system facilities in sending countries, and support by return and reintegration.

Recommendation #2:

Although negotiation of BLAs with receiving countries is a very difficult and challenging process, the approach "something is better than nothing" is not very effective in practice. Many agreements exist only on paper (lack of implementation) and/or the recruitment is done through alternative channels. In order to enhance the chances for BLAs' implementation, the negotiation and implementation of the agreement should be supported by other mechanisms (including engagement of non-governmental actors in both countries, engagement in multi-stakeholders' initiatives, promotion of international soft law and best practices, introduction of national regulations enhancing the BLAs' effectiveness), and agreements should be tailor-made for the sending and receiving countries (but including all three objectives as described in above) and have the right timing. Moreover, the recruitment and implementation of the agreement must be interdependent processes, as otherwise the receiving country has little incentives to enter into any commitments, in particular those concerning the guarantee of protection of migrants' rights, and mitigation of negative effects of recruitment for the sending country.

Recommendation #3:

Monitoring and evaluation of any bilateral labour agreement is very important and this importance should not be neglected. These elements must be carefully thought through at the time of the BLAs' negotiation and should be implemented on a regular basis. Without a clear idea about BLAs' specific objectives and indicators of its success, it is afterwards very difficult to assess and improve it. Any vagueness in the content of the BLAs and/or excessive complexity of its implementation decreases the BLAs' effectiveness. The regular monitoring and evaluation of the BLAs' effectiveness helps to better adjust the implementation process to both sending and receiving countries' current needs, and increases its effectiveness in meeting the three main BLA objectives (e.g. helps to react on any negative consequences that the outflow could have for the sending country and other problems resulting from the BLAs' implementation).

Recommendation #4:

Due to the increased circularity of migration flows and the increased popularity of the circular migration concept in many receiving countries, the BLAs should pay special attention to addressing the special challenges linked to circular migration in terms of the protection of migrants' rights (i.e. the issue of portability of social entitlements, integration support in the receiving country, and access to skills and professional development) and costs and consequences of circular mobility process (in particular challenges linked to return and reintegration of migrants in their country of origin). Moreover, regular monitoring and evaluation of the agreements in the case of circular migration is even more important in order to secure the benefits from migration to all -- migrants, receiving and sending countries.

Bibliography

Agunias, D.R. 2012. *Regulating private recruitment in the Asia-Middle East labour migration corridor*. IOM MPI Issue in Brief, (4). International Organization for Migration, Brussels.

Alonso-Garbayo, A.; Maben, J. 2009. "Internationally recruited nurses from India and the Philippines in the United Kingdom: the decision to emigrate. *Human Resources for Health*, Vol. 7, No. 37.

Asato, W. 2012. "Nurses from abroad and the formation of a dual labour market in Japan". *Southeast Asian Studies*, Vol. 49, No. 4, pp. 652-669.

Bach, S. 2003. *International migration of health workers: labour and social issues*. International Labour Organisation (WP.26). International Labour Office, Geneva.

Barrett, A.; Goggin, J. 2010. "Returning to the question of a wage premium for returning migrants". IZA DP No. 4736. Institute for the Study of Labour, Bonn.

Barrett, A.; O'Connell, P. 2001. "Is there a wage premium for returning Irish migrants?" *The Economic and Social Review*, Vol. 32, No. 1, pp. 1-21.

Batata, Amber S. 2005. "International nurse recruitment and NHS vacancies: a cross-sectional analysis". *Globalization and Health*, Vol. 1, No. 7.

Beine, M.; Docquier, F.; Rapoport, H. 2001. "Brain drain and economic growth: theory and evidence". *Journal of Development Economics*, Vol. 64, No. 1, pp. 275-289.

Beine, M.; Docquier, F.; Rapoport, H. 2002. *Brain drain and LDC's growth: winners and losers*. CREDPR Working Paper, No. 129. Stanford University.

Bhagwati, J. 1976. "Taxing the brain drain". *Challenge*, Vol. 19, No. 3, pp. 34-38.

Bhagwati, J.; Hamada, K. 1974. "The brain drain, international integration of markets for professionals and unemployment: A theoretical analysis". *Journal of Development Economics*, Vol. 1, pp. 19-24.

Bhargava, A.; Docquier, F. 2008. "HIV pandemic, medical brain drain, and economic development in Sub-Saharan Africa". *World Bank Economic Review*, Vol. 22, No. 2, pp. 345-366.

Bhargava, A.; Docquier, F.; Moullan, Y. 2011. "Modelling the effect of physician emigration on human development". *Economics and Human Biology*, Vol. 9, No. 2, pp. 172-183.

Brauner, Y. 2010. *Brain drain taxation as development policy*. University of Florida Legal Studies Research Paper, pp. 2010-17.

Buchan, J. 1999. "The 'greying' of the United Kingdom nursing workforce: implications for employment policy and practice". *Journal of Advanced Nursing*, Vol. 30, No. 4, pp. 818-826.

Buchan, J.; Edwards, N. 2000. "Nursing numbers in Britain: the argument for workforce planning". *British Medical Journal*, No. 320, pp. 1,067-1,070.

Buchan, J.; McPake, B., Mensah, K., Rae, G. 2009. "Does a code make a difference -- assessing the English code of practice on international recruitment". *Human Resources for Health*, Vol. 7, No. 33.

Buchan, J.; Seccombe, I. 2012. *Overstretched. Under-resourced. The UK nursing labour market review 2012*. Royal College of Nursing.

Carlos, R.D. 2013. *The multistep international migration of Filipino Nurses and its policy implications on their retention in Japan*. Paper presented at the Asian nurses at the global labour market: post-crisis dynamics of demand and supply and nurse mobility regulation, Edinburgh.

CHED -- Commission on Higher Education. 2006. List of Nursing Schools and Permit Status, from <http://www.ched.gov.ph/chedwww/index.php/eng/Information/List-of-Higher-Education-Institutions-HEIs>.

Chellaraj, G.; Maskus, K.E., Mattoo, A. 2006. *Skilled Immigrants, Higher Education, and U.S. Innovation*. Washington: World Bank and Palgrave Macmillan.

Clemens, M. 2007. *Do visas kill? Health effects of African health professional emigration*. Centre for Global Development Working Paper, (No. 114). Centre for Global Development, Washington.

Code of Practice for the international recruitment of health-care professionals (2004).

Commander, S.; Chanda, R.; Kangasniemi, M.; Winters, A. 2004. *Must skilled migration be a brain drain?* Evidence from the Indian software industry. IZA Discussion Papers, No. 1422.

Deeming, C. 2002. "Data briefing, nurse vacancies". *Health Service Journal*, Vol. 112, No. 5811, pp. 36.

Deeming, C. 2004. "Policy targets and ethical tensions: UK nurse recruitment". *Social Policy and Administration*, Vol. 38, No. 7, pp. 775-792. ;

Desai, M.A.; Kapur, D.; McHale, J. 2003. The fiscal impact of high skilled emigration: *flows of Indians to the US*, Working Paper 03-01, Harvard University, Centre for International Affairs.

Dhillon, I.; Clark, M.; Kapp, R. 2010. *Innovations in cooperation. a guidebook on bilateral arrangements to address health worker migration*. Washington: Aspen Institute.

Docquier, F.; Rapoport, H. 2011. *Globalization, brain drain and development*. CReAM Discussion Paper, 08/11.

Dustmann, C.; Kirchkamp, O. 2002. "The optimal migration duration and activity choice after re-migration". *Journal of Development Economics*, Vol. 67, pp. 351-372.

Dustmann, C.; Weiss, Y. 2007. *Return migration: theory and empirical evidence*. CReAM Discussion Paper, (02/07). Centre for Research and Analysis of Migration, London.

Fan, S.; Stark, O. 2007. "The brain drain, 'educated unemployment', human capital formation, and economic betterment. *Economics of Transition*, Vol. 15, No. 4, pp. 629–660.

Gibson, J.; McKenzie, D. 2011. *Eight questions about brain drain*. CReAM Discussion Paper, (11/11). Centre for Research and Analysis of Migration, London.

Go, S.P. 2007. *Asian labour migration: The role of bilateral labour and similar agreements*. Paper presented at the Regional Informal Workshop on Labour Migration in Southeast Asia: What Role for Parliaments, 21-23 September 2007, Manila, Philippines.

Go, S.P. (Ed): *Fighting for the rights of migrant workers: the case of the Philippines* (Paris, OECD Publishing, 2004).

Hirano, Y.; Reiko, O.; Shun, O. 2012. "A comparative study of Filipino and Indonesian candidates for registered nurse and certified care worker coming to Japan under economic partnership agreements: an analysis of the results of questionnaire surveys on the socioeconomic attribution of the respondents and their motivation to work in Japan". *Southeast Asian Studies*, Vol. 49, No. 4, pp. 594-610.

ILO: *The ILO multilateral framework on labour migration: Non-binding principles and guidelines for a rights-based approach to labour migration*. Geneva, 2006.

ILO: *International labour migration*. A right-based approach. Geneva, 2010.

International Ethical Recruitment: The UK Experience (2007).

Kapur, D.; McHale, J. 2005. *Give us your best and brightest. the global hunt for talent and its impact on the developing world*. Washington: Centre for Global Development.

Kwok, V.; Leland, Hayne. 1982. "An economic model of the brain drain". *American Economic Review*, March, pp. 91-100.

Lorenzo, F.M.E.; Galvez-Tan, J.; Icamina, K.; Javier, L. 2007. "Nurse migration from a source country perspective: Philippine country case study. HSR: *Health Services Research*, Vol. 42, No. 3, Part II, pp. 1,406-1,418.

Luo, Y.L.; Wang, W.J. 2002. *High skilled migration and Chinese Taipei's industrial development* (Vol. OECD editions). Paris.

Makulec, A. 2013. *Konsekwencje migracji wysoko wykwalifikowanego kapitału ludzkiego dla krajów wysyłających i migrantów na przykładzie personelu medycznego*. CMR Working Paper, (61, 119). Centre of Migration Research, Warsaw.

Mayr, K.; Peri, G. 2008. *Return migration as channel of brain gain*. CReAM Discussion Paper, (04/08). Centre for Research and Analysis of Migration, London.

McCormick, B.; Wahba, J. 2003. "Return international migration and geographical inequality: the case of Egypt". *Journal of African Economies*, Vol. 12, No. 4, pp.500-532.

Mejia, A.; Pizurki, H.; Royston, E. 1979. *Physician and nurse migration: analysis and policy implications*. World Health Organization, Geneva.

Mountford, A. 1997. "Can a brain drain be good for growth in the economy? *Journal of Development Economics*, Vol. 53, No.2, pp. 287-303.

OECD -- Organization for Economic Co-operation and Development. (2004). *Migration for employment: Bilateral agreements at a crossroads*. Paris: OECD.

OECD -- Organization for Economic Co-operation and Development. (2007a). *Handbook on establishing effective labour migration policies*. Mediterranean edition. Paris: OECD.

OECD -- Organization for Economic Co-operation and Development. (2007b). *Immigrant health workers in OECD countries in the broader context of highly skilled migration*. International Migration Outlook: SOPEMI 2007. OECD, Paris.

Ohno, S. 2012. "Southeast Asian nurses and care-giving workers transcending the national boundaries: an overview of Indonesian and Filipino workers in Japan and abroad". *Southeast Asian Studies*, Vol. 49, No. 4, pp. 541-569.

Okólski, M. 2004. Seasonal labour migration in the light of the German-Polish bilateral agreement. In OECD (Ed), *Migration for Employment: Bilateral Agreements at a Crossroads*. Paris: OECD.

Pillinger, J. 2012. *Quality healthcare and workers on the move: Philippines National Report*. Cedex, France: Public Services International. International Migration and Women Health and Social Care Workers Programme.

Pittman, P. 2013. *Alternative approaches to the governance of transnational labour recruitment: the case of nurses*. Paper presented at the Asian nurses at the global labour market: post-crisis dynamics of demand and supply and nurse mobility regulation, Edinburgh, UK.

Plotnikova, E. 2012. "Cross-border mobility of health professionals: contesting patients' right to health". *Social Science & Medicine*, Vol. 74, pp. 20-27.

Proposal for measures under Norwegian foreign and international development policy to address the global health workforce crisis. (2009): Working Group chaired by the Ministry of Foreign Affairs with participation by the Ministry of Labour and Social Inclusion, the Ministry of Health and Social Affairs, the Ministry of Education and Research, the Norwegian Directorate of Health and Norad.

Reiko, O. 2012. "Globalization of care and the context of reception of Southeast Asian care workers in Japan". *Southeast Asian Studies*, Vol. 49, No. 4, pp. 570-593.

Scalera, D. 2011. "Skilled migration and education policies: is there still scope for a Bhagwati tax?" *The Manchester School*, Vol. 80, No. 4, pp. 447-467.

Stark, O.; Bloom, D.E. 1985. "The new economics of labour migration". *American Economic Review*, Vol. 75, pp. 173-178.

Stark, O.; Wang, Y. 2002. "Inducing human capital formation: migration as a substitute for subsidies". *Journal of Public Economics*, Vol. 86, No. 1, pp. 29-46.

Stilwell, B.; Diallo, K.; Zurn, P.; Vujicic, M.; Adams, O.; Dal Poz, M. 2004. "Migration of health-care workers from developing countries: strategic approaches to its management". *Bulletin of the World Health Organization*, Vol. 82, No. 8, pp. 595-600.

UN ESCAP. (2011). *Report. UN ESCAP-UNECSWA Workshop on strengthening dialogue between ESCWA and ESCAP countries on international migration and development. Beirut, 28-30 June 2011.*

United Nations. (1999). *United Nations Treaty Collection: Treaty Reference Guide*. New York.

Vidal, J.P. 1998. "The effect of emigration on human capital formation". *Journal of Population Economics*, Vol. 11, pp. 589-600.

WHO: *The world health report 2006: working together for health*. World Health Organization, Geneva, 2006.

WHO: *WHO global code of practice on the international recruitment of health personnel*. World Health Organization, Geneva, 2010.

Wickramasekara, P. 2003. *Policy responses to skilled migration: retention, return and circulation*. International Labour Office, Geneva.

Wickramasekara, P. 2006. *Labour Migration in Asia role of Bilateral Agreements and MOUs*. Paper presented at the ILO presentation at the JIPLT workshop on International Migration and Labour Market in Asia, 17 February 2006, Tokyo.

Wickramasekara, P. 2012. *Something is better than nothing. Enhancing the protection of Indian migrant workers through bilateral agreements and memoranda of understanding*. Migrant Forum in Asia, Quezon City, Philippines.

Wilson, J.D. 2008. "A voluntary brain-drain tax". *Journal of Public Economics*, Vol. 92, pp. 2,385-2,391.

Yap, J.T.; Medalla, E.M.; Aldaba, R.M. 2006. "Assessing the Japan-Philippines Economic Partnership Agreement (JPEPA)". *Philippine Institute for Development Studies*, 2006-10.

Annex 1: List of respondents

List of respondents of interviews

a) Philippines

- 1) Dr Kenneth Ronquillo, Department of Health (DOH)
- 2) Ms Anne Kristine D. Salvador, Department of Foreign Affairs (DFA), OUMWA
- 3) Dr Teresita Barcelo, Philippines Nurses Association (PNA)
- 4) Mrs Annie Enriquez Geron, Public Services Labour (PSI-Link)
- 5) Mr Nestor Flores, recruitment agency ABBA Personnel Services Inc
- 6) Mr Loreto Soriano, recruitment agency LBS
- 7) Mr Vic Bautista, recruitment agency IPAMS
- 8) Mr Josefino I. Torres, Overseas Workers Welfare Administration (OWWA)
- 9) Mrs Liberty Casco, Philippine Overseas Employment Administration (POEA)
- 10) Mrs Elizabeth P. Buensuceso, Department of Foreign Affairs, Office of European Affairs
- 11) Ms Marie Cris P. Chieng, Department of Foreign Affairs, Office of European Affairs
- 12) Ms Maria Rosanna O. Josue, Department of Foreign Affairs, Office of European Affairs
- 13) Mr Jun Sta. Barbara, Alliance of Filipino Workers (AFW)
- 14) Mr Lito Calderon, Alliance for Filipino Workers (AFW)
- 15) Mr Julius Cainglet, Federation of Filipinos Workers (FFW)
- 16) Dr Andres Reyes, Philippine Medical Association (PMA)
- 17) Mr Royson Mercado, Philippines Physical Therapy Association
- 18) Ms Gayline Manalang, Philippines Physical Therapy Association

b) International

- 19) Mrs Genevieve J. Gencianos, Public Service International (PSI)
- 20) Mr Mathias Maucher, European Public Service Union (EPSU)
- 21) Mr Pascal Garel, European Hospital and Health-care Federation (HOPE)
- 22) Mr David Benton, International Council of Nurses (ICN)
- 23) Ms Lesley Bell, International Council of Nurses (ICN)

c) United Kingdom

- 24) Mr David Amos, former deputy Director of National Health Service (NHS)
- 25) Mrs Susan Cueva, UNISON
- 26) Mr Tanveer Hussain, Department of Health (DoH), Workforce Division

d) Norway

- 27) Mrs Randi Tevik, Fagforbundet
- 28) Mrs Lenna de Dios, Philippines' Embassy in Norway
- 29) Mrs Silje Anne Bell, Directorate of Health (written questionnaire)
- 30) Mr Otto Christian Rø, Health Directorate

e) Japan

- 31) Dr Yuko Hirano, University of Nagasaki
- 32) Labour Attaché of Japanese Embassy in the Philippines

List of participants of roundtable discussion

- 1) Mrs Carmencita M. Abaquin, Professional Regulation Commission (PRC), Board of Nursing (BON)
- 2) Mrs Liberty Casco, Philippine Overseas Employment Administration (POEA)
- 3) Ms Marla Cine,
- 4) Mr Juanito D. Taleon, DOH-NCHFD
- 5) Mr Vic Bautista, recruitment agency IPAMS
- 6) Mrs Rapunzel Acop, DFA
- 7) Mr Jaime P. Gimenez, DOLE-OSEC-ILAB
- 8) Mr Noel Cadete, PNA
- 9) Dr Teresita Barcelo, PNA
- 10) Mrs Leonila Ocampo, PPhA
- 11) Mrs Julin Jelile, WHO
- 12) Mr Josefino I. Torres, OWWA
- 13) Mrs Aurora Abella, OWWA
- 14) Mr Bu Castro, PHA
- 15) Mrs Stella P. Go, PMRN
- 16) Mr Rene Cristobal, ECOP/ASPROE
- 17) Mrs Yolanda Rables, Philippines Pharmacists Association
- 18) Mr Royson A. Mecado, PPTA
- 19) Mrs Nimfa De Gmznfr, POEA
- 20) Mrs Jullina Roy, PSLINK
- 21) Mr Jun Sta. Barbara, AFW

Annex 2 Research questions and methods

Dimensions	Question	Methods
I. CONTEXT	<ol style="list-style-type: none"> 1. What were the political, social, health and economic interests of the countries of BLAs, which resulted in the development and implementation of BLA? 2. What is the migration policy of the Philippines and the 5 receiving countries with regard to the outmigration and reception of health professionals? 3. What are the push and pull factors influencing the migration of Filipino health professionals to the 5 countries? 4. How are the 5 BLAs different from other BLAs the Philippines concluded with the receiving countries and how they fit into the Philippines' policy towards migration of health professionals? 5. How intensive is migration of Filipino health professionals to the 5 receiving countries and how intensive it was before the conclusion of BLAs? What are the most important factors influencing on the magnitude of migration flows? What is the BLA's impact? 6. What is the profile of migrants being sent to these countries? How is migration of Filipino health professionals to these countries different from migration to other countries? 7. How much of the migration of Filipino health professionals to these countries is not covered by BLAs? What is the scale of illegal migration to these countries? 8. What jobs are occupied by the Filipino health professionals employed in the receiving countries? 9. How long they stay abroad and how many of the migrant health professionals are returning from these 5 countries? 	<ol style="list-style-type: none"> 1. Interviews in sending and receiving countries, Desk research – secondary literature 2, 3. Desk research – secondary literature 4 Mapping of legislation, review of secondary literature 5 - 9. Desk research – statistics, secondary literature;
II. DESCRIPTION OF BLA – process and actors	<p>Development phase</p> <ol style="list-style-type: none"> 1. Who were the actors involved in the negotiation of the bilateral agreements? What roles they played in the development of BLAs (degree of influence)? What other actors should be involved and why they weren't? 2. Were they sufficiently trained? 3. How long did the process take between the first negotiations to the ratification of the agreement? 	<ol style="list-style-type: none"> 1-8 - Interviews in sending and receiving countries

Dimensions	Question	Methods
	<p>4. Were there any power asymmetries between the negotiating parties and between the various stakeholders who were involved? If yes, could they affect the negotiation's outcome?</p> <p>Implementation</p> <p>5. Who were the actors involved in the implementation of the agreement and their roles?</p> <p>6. What are the mechanisms used to raise the awareness of the existence of the BLA among the targeted individuals? (re: transparency)</p> <p>7. What are the different processes/ procedures involved to ensure the implementation of the agreement? Were they all fulfilled?</p> <p>8. Were there problems/ concerns encountered in the processes/ procedures and implementation of the BLA?</p>	
III. DESCRIPTION OF BLA as policy	<p>1. What are the objectives of the BLA? Have they been clearly stated?</p> <p>2. Do the objectives of the BLAs and its character correspond to the previous and current needs of the sending and receiving countries?</p> <p>3. Does the BLA respect the principles of "transparency, fairness and the promotion of sustainability of health systems in developing countries" as stated in the WHO Code?</p> <p>4. Is the BLA in conformity with ethical recruitment standards stated in the WHO Global Code of Practice (in particular, not recruiting migrant health personnel with outstanding legal responsibility to the health system of the country of origin, not recruiting from countries with critical shortages of health workers, non-discrimination in employment and treatment, right to information of migrants, providing induction and orientation programmes for migrants, including in BLAs provisions aiming at strengthening the human resources for health in the sending countries and encourage return, collaboration in information exchange and data gathering and research)?</p> <p>5. Is the BLA in conformity with minimum international standards on human rights and labour according to the ILO R86 (right to information, education, family life including family reunification, to leave the country, to leisure time, to decent living and working conditions, non-discrimination/equality of treatment on the labour</p>	<p>1-11 (except 2). Legislation mapping</p> <p>2, 12 Interviews</p>

Dimensions	Question	Methods
	<p>market, right to acquire property, to social security, change of employment, fair employment contract, employment stability)?</p> <p>6. Is the BLA in conformity with Model Bilateral Agreements I described by Aspen Institute's report? (in case of sharing the same objectives of the agreement, on standards of recruitment and employment i.e. for labour contract and equal treatment/workers' rights, for including measures for development of health systems in sending and receiving countries)? 7. Does the BLA go beyond the minimum international standards stated above?</p> <p>8. Does the BLA cover the whole migration process? (pre-departure, departure, arrival/reception, stay, return and reintegration?)</p> <p>9. Are there any provisions that violate any human or labour rights (e.g. prohibition to join a trade union, to marry, etc.)?</p> <p>10. Does the BLA cover all the dimensions included in the WHO Code of Practice, ILO R 86 and Model Agreement of Aspen Institute?</p> <p>11. What are the measures identified to address the impact of health-care professional recruitments? In source and destination countries?</p> <p>12. Under the BLA, how many health-care professional were recruited? What were their profiles (education, work experience?) How does it meet the set targets and needs?</p>	
IV. CONTENT - Recruitment of health professionals	<p>Recruitment process</p> <ol style="list-style-type: none"> 1. Does the BLA refer to how the recruitment process should take place? 2. Have the parties established/used any mechanism to increase the exchange of information related to health-care migration? 3. What are the measures taken to facilitate the matching of the labour demand and supply? 4. Does the BLA refer to any mechanisms for pre-departure training? Post arrival information? 5. Does the BLA provide for quotas? How would have these quotas been defined? And have these quotas been respected? 6. Does the BLA mention specifically the way recruitment fees should be handle? <p>Regulation of recruitment agencies</p>	1-6 and 9-10 Legislation mapping

Dimensions	Question	Methods
	<p>7. Does the recruitment go through government to government practices only? How far are the private recruitment agencies involved?</p> <p>8. If recruitment is undertaken through private agencies, does the BLA contain measures to ensure compliance of these agencies with best practices? And that employers and recruiters should observe "fair and just recruitment and contractual practices"?</p> <p>9. Does the BLA refer to any mechanisms against misleading propaganda?</p> <p>10. Does the BLA include mechanisms for the destination country to address its own health care professional shortages (planning, education, retention strategies)?</p> <p>11. Had the BLA have had any effect on the availability and quality of the health-care professionals in sending countries? What has been the evolution of the ratio health-care professional/patient during the period of the BLA?</p> <p>12. Were there problems/concerns encountered in the recruitment of health professionals within the BLA? Are all provisions in the field of recruitment from BLAs implemented?</p> <p>13. Are there any measures in the sending or receiving countries, which complement the provisions stated in the BLAs in terms of recruitment (e.g. other measures aimed at regulation of the recruitment process or regulation of recruitment agencies)?</p>	<p>7 Interviews</p> <p>8. Interviews, legislation mapping</p> <p>11 Interviews in the sending country, literature review, statistics</p> <p>12, 13 Interviews in sending and receiving countries</p>
V. CONTENT - Employment of health professionals	<p>1. What are the mechanisms put in place to ensure that migrants are informed of their rights and responsibilities prior to departure? Are they effective?</p> <p>2. Does the BLA contain measures for migrants to receive their employment contract before departure?</p> <p>3. Does the BLA state the minimal prescriptions that should be included in the employment contract?</p> <p>4. Does the BLA contain any obligations on the part of the employer to provide for accommodation, transport or other benefits? And if so, are there any prescriptions on how the cost of those benefits should be handled?</p> <p>5. Does the BLA make reference to skills development opportunities for migrants?</p> <p>6. Does the BLA refer directly to the national labour law stipulating that it fully covers the migrant?</p>	<p>1 Interviews in sending country</p> <p>2-8 Legislation mapping</p>

Dimensions	Question	Methods
	<p>7. Does the BLA provide for equal treatment between nationals and migrants (pay, employment conditions, training, education), and access to legal proceedings and remedies in case of violations?</p> <p>8. Does BLA provides for equal treatment between nationals and migrants (pay, employment conditions, training, education), and access to remediation in case not?</p> <p>9. Were there problems/concerns encountered in the employment of Filipino health professionals within the BLA? Are all the provisions from BLAs concerning employment conditions implemented?</p>	<p>9 Interviews in sending and receiving countries, literature review</p>
VI. CONTENT - Development provisions of the agreement	<p>1. Are there provisions that promote the development of receiving or source country?</p> <p>2. Does the BLA contain any measures to facilitate the transfer of remittances?</p> <p>3. Does the BLA contain any measures to promote the use of remittances/investments for development at the community/regional/national levels?</p> <p>4. Does the BLA contain any measures to facilitate exchanges between educational institutions? Scholarships programme? Joint research programmes? Twinning arrangements?</p> <p>5. Does the BLA include any measures facilitating the movement of destination country health professionals to work/study/research in the source country?</p> <p>6. Does BLA include any measure to support the development/strengthening of the health-care system in the source country?</p> <p>7. Does the BLA include any measures to support the development/strengthening of the health-care system in the source country?</p> <p>8. Does the BLA contain mechanisms that allow for the assessment of the needs in terms of health-care professionals in the source country in relation to the number of migrants?</p> <p>9. Does the BLA contain any measure to encourage the return of the migrant? If so, what are these measures? Have they been implemented?</p> <p>10. Does the BLA contain any measures to facilitate the (re)emigration of migrants (circular migration)?</p>	<p>1-11 Legislation Mapping</p> <p>12 Interviews</p>

Dimensions	Question	Methods
	<p>11. Does the BLA refer to any resource commitments by participating governments earmarked for "development" programmes?</p> <p>12. Has the BLA yielded more stakeholder (governments, trade unions, professional organizations, employers) collaboration centred around the interest of health professionals, patients, health-care systems and society?</p>	
VII. CONTENT - Administration of the agreements	<p>1. Does the BLA include a monitoring and evaluation mechanism? Creation of an observatory on migration flows?</p> <p>2. Have these mechanism (of monitoring and evaluation) been used over the duration of the BLA?</p> <p>3. Which actors/stakeholders are participating in the monitoring of the BLA?</p> <p>4. Have any of the monitoring recommendations been put in place?</p> <p>5. Have there been any reports produced under the BLA?</p> <p>6. Does the BLA refer to any dispute-settlement mechanisms?</p> <p>7. Were there problems/ concerns encountered in the M/E of the BLA?</p>	<p>1 Legislation mapping</p> <p>2-5 and 7 Interviews</p> <p>6 Legislation mapping</p>
VIII. Other Policy Outcomes and questions	<p>1. What are the specific outcomes of the BLA?</p> <p>2. What is the perceived effectiveness of the BLA in achieving its objectives?</p> <p>3. What are the other positive or negative impacts brought about by this BLA? (e.g. better collaboration on other issues between the government? Increased collaboration between trade unions or other stakeholders, increased cultural exchanges? etc.)</p> <p>4. Have there been any other challenges in the negotiation of the BLA? Misunderstandings?</p> <p>5. What recommendations could be made in terms of improving the effectiveness of BLAs (in terms of both legislation change and implementation)?</p>	<p>1 – 5 interviews, FGD</p>

Annex 3 Frameworks and model agreements on content of BLAs

PROVISIONS	FRAMEWORKS			TEMPLATES	
	ILO Multilateral Framework on Labour Migration (2005)	WHO Global Code of Practice on International Recruitment of HPs (2010)	ILS Framework for determining migrant friendliness (2010)	ILO R86 Migration for Employment & Annex (1949)	HWMI (WHO, GHWA, Aspen Institute) (2010)
RECRUITMENT STANDARDS					
Exchange of information on policies and supply/demand	✓	✓	✓	✓	✓
Promotion of direct contact between employers and agencies					✓
Elimination of misleading propaganda	✓			✓	
Pre-departure information for migrants	✓	✓		✓	✓
Recognition of qualifications	✓				
Recruitment fees not paid by migrants	✓			✓	✓
Facilitating transport	✓				
Setting the recruitment target (number)	✓			✓	
Course of recruitment process				✓	
EMPLOYMENT STANDARDS & HUMAN RIGHTS					
Fair contract of employment	✓			✓	✓
Professional development opportunities, access to training		✓		✓	✓
Equal treatment of migrants with natives	✓	✓	✓	✓	✓
Social security rights	✓		✓	✓	✓
Right to due process in cases of violation	✓		✓ (any assistance)	✓	✓
Right to join trade unions	✓			✓	

PROVISIONS	FRAMEWORKS			TEMPLATES	
	ILO Multilateral Framework on Labour Migration (2005)	WHO Global Code of Practice on International Recruitment of HPs (2010)	ILS Framework for determining migrant friendliness (2010)	ILO R86 Migration for Employment & Annex (1949)	HWMI (WHO, GHWA, Aspen Institute) (2010)
Right to find another employment when unemployed or change	✓			✓ (change)	
Integration assistance	✓		✓		
Respect for freedom of movement		✓			✓
Right to family reunification			✓	✓	
Integration assistance	✓		✓		
Language and cultural orientation	✓			✓	
Access to health care	✓			✓	✓
EMPLOYMENT STANDARDS & HUMAN RIGHTS					
Access to accommodation, food and clothing				✓	
Right to transfer remittances, acquisition and possession of urban/rural property				✓	
Access to recreation and welfare facilities				✓	
Avoidance of double taxation				✓	
COUNTER – BRAIN DRAIN MEASURES					
Not recruitment of HPs with valid contract		✓			✓
Considering situation in health-care system of sending country before recruitment	✓	✓			✓
Facilitation of circular migration	✓	✓			
Support for HPs retention		✓			
Return and reintegration	✓	✓ (return)		✓ (return)	✓
Exchange of students		✓		✓	✓

PROVISIONS	FRAMEWORKS			TEMPLATES	
	ILO Multilateral Framework on Labour Migration (2005)	WHO Global Code of Practice on International Recruitment of HPs (2010)	ILS Framework for determining migrant friendliness (2010)	ILO R86 Migration for Employment & Annex (1949)	HWMI (WHO, GHWA, Aspen Institute) (2010)
Exchange of visits of experts		✓			✓
Scholarship programmes					✓
COUNTER – BRAIN DRAIN MEASURES					
Joint ventures and investments in health facilities					✓
Twinning of health facilities		✓			✓
Support to initiatives to improve education and training facilities		✓			✓
Technology transfer (joint research, project, sharing of best practices)	✓ (best practices)	✓			✓
Participation of migrants to development of COI (e.g. use of remittances, entrepreneurship)	✓	✓			

Annex 3 Frameworks and model agreements on content of BLAs

PROVISIONS	MOA with Bahrain (2007)	JPEPA (2009)	Recruitment Agreement with Norway (2001)	MOU with Spain (2006)	Recruitment Agreement, MOU with UK (2002, 2003)
RECRUITMENT STANDARDS					
Exchange of information on policies and supply/demand			✓		✓
Promotion of direct contact between employers and agencies					
Elimination of misleading propaganda					
Pre-departure information for migrants			✓		✓
Recognition of qualifications	✓ (MRR)	✓ (MRR)			✓ (MRR)
Recruitment fees not paid by migrants		✓	✓	✓	✓
Facilitating transport					✓
Setting the recruitment target (number)					
Course of recruitment process		✓	✓	✓ (minimum)	✓
EMPLOYMENT STANDARDS & HUMAN RIGHTS					
Fair contract of employment	✓		✓		✓
Professional development opportunities, access to training	✓				
Equal treatment of migrants with natives	✓				✓ (protection ac.)

PROVISIONS	MOA with Bahrain (2007)	JPEPA (2009)	Recruitment Agreement with Norway (2001)	MOU with Spain (2006)	Recruitment Agreement, MOU with UK (2002, 2003)
Social security rights					national law)
Right to due process in cases of violation	✓				
Right to join trade unions					
Right to find another employment when unemployed or change					
Integration assistance					
Respect for freedom of movement					
Right to family reunification					
Integration assistance					
Language and cultural orientation		✓	✓		✓ (upon employment)
Access to health care					
Access to accommodation, food and clothing					
Right to transfer remittances, acquisition and possession of urban/rural property					

PROVISIONS	MOA with Bahrain (2007)	JPEPA (2009)	Recruitment Agreement with Norway (2001)	MOU with Spain (2006)	Recruitment Agreement, MOU with UK (2002, 2003)
Access to recreation and welfare facilities					
Avoidance of double taxation					
COUNTER – BRAIN DRAIN MEASURES					
Not recruitment of HPs with valid contract					✓
Considering situation in health-care system of sending country before recruitment					
Facilitation of circular migration					
Support for HPs retention	✓				✓
Return and reintegration	✓				
Exchange of students					✓
Exchange of visits of experts	✓				
Scholarship programmes	✓				
Joint ventures and investments in health facilities					
Twinning of health facilities	✓				
Support to initiatives to improve education and training facilities	✓	✓			

PROVISIONS	MOA with Bahrain (2007)	JPEPA (2009)	Recruitment Agreement with Norway (2001)	MOU with Spain (2006)	Recruitment Agreement, MOU with UK (2002, 2003)
Technology transfer (joint research, project, sharing of best practices)					
Participation of migrants to development of COI (e.g. use of remittances, entrepreneurship)					

ILO Country Office for the Philippines
19th Floor, Yuchengco Tower,
RCBC Plaza, 6819, Ayala Avenue
Makati City, Philippines
Telephone: +63-2-580-9900
Website: www.ilo.org/manila
Email: MANILA@ilo.org

DECENT WORK

A better world starts here.

ISSN: 2227-4391; 2227-4405