

WHO Global Code of Practice on the International Recruitment of Health Personnel National Reporting Instrument

On May 21, 2010 the WHO Global Code of Practice on the International Recruitment of Health Personnel (the “Code”) was adopted by the 193 Member States of the World Health Organization including the United States. This ground breaking instrument marks the first time in thirty years that WHO Member States have used the constitutional authority of the Organization to develop a non-binding code. The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation to address challenges associated with the international migration of health personnel.

The Code encourages information exchange on issues related to health personnel and health systems in the context of migration, and suggests regular reporting every three years on measures taken to implement the Code. The reporting process is an integral component of the effective implementation of the voluntary principles and practices recommended by the Code.

To facilitate the reporting process under the Code and in accordance with the request of the World Health Assembly (Resolution WHA 63.16) a series of consultations and discussions on the reporting requirements were conducted between June 2010 and November 2011, including consultation with Member States and other stakeholders concerned with the Code. Upon review by experts, member states and regional offices, the National Reporting Instrument was developed as a “kick start” country-based, self-assessment tool to monitor the progress made in implementing the Code. Comprising 15 questions, the instrument will enable WHO to examine the global status of health personnel recruitment and where possible assess the availability of data to explore time trends with inputs from governments and other stakeholders.

A key purpose of this *instrument* is to provide a simple, user-friendly method for governments and other stakeholders to monitor the implementation of the Code. The common use of this instrument will facilitate participation as well as promote the comparability of data and regularity of information flow. Member States were asked to directly complete through online reporting.

Name of Member State: **United States of America**

Date National Report submitted: August 28, 2012

If your country has designated a national authority (the “national authority”) responsible for the exchange of information regarding health personnel migration and the implementation of the Code as recommended by Article 7.3, please provide the following information:

Full name of institution:

Joint National Authority:

- 1) U.S. Department of Health and Human Services (DHHS) Office of Global Affairs;*
- 2) Health Resources and Services Administration, DHHS.*

Name and title of contact officer:

Edward Salsberg, Director, National Center for Health Workforce Analysis, Health Resources and Services Administration, U.S. Department of Health and Human Services

Peter Mamacos, Multilateral Branch Chief, Office of Global Affairs, U.S. Department of Health and Human Services

Mailing address:

5600 Fishers Lane, Rm 9-57, Rockville, MD 20857

Telephone number:

+1-301-443-9355

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+1-301-443-0463

Email:

Us.who.irhp@hhs.gov

If your country has not designated a national authority, please indicate if your country intends to designate a National Authority in the future.

Yes No *N/A*

In addition, please provide information on the national contact responsible for

the preparation of this report.

Full name of institution: *U.S. Department of Health and Human Services*

Name and title of contact officer:

Edward Salsberg, Director, National Center for Health Workforce Analysis, DHHS

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National Reporting instrument

1. In your country, do equally qualified and experienced migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in terms of employment and conditions of work?

Yes No (If "No", please proceed to Q(4))

Yes.

2. Which legal mechanisms are in place to ensure that migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce? Please tick all options that apply from the list below:

2a. Health personnel are recruited internationally using mechanisms that allow them to assess the benefits and risk associated with employment positions and to make timely and informed decisions regarding them?

No.

2b. Health personnel are hired, promoted and remunerated based on objective criteria such as levels of qualification, years of experience and degrees of professional responsibility on the same basis as the domestically trained health workforce

Yes.

2c. Migrant health personnel enjoy the same opportunities as the domestically trained health workforce to strengthen their professional education, qualifications and career progression

Yes.

2d. Other mechanism, please provide details if possible:

1) *Worker protections associated with the H1B visa for nonimmigrants temporarily moving to the United States to work in a specialty occupation*

2) *The U.S. Department of Labor Occupational Safety & Health Administration (includes regulations regarding work environment)*

3) *The U.S. Department of Labor Wage and Hour Division (including enforcement of the Fair Labor Standards Act, which provides minimum wage and overtime requirements)*

3. Please provide evidence of the legal mechanisms identified in Q(2) either as attachments or links to on-line files.

1) *Link to H1B visa protections, 20 CFR Part 655, Subparts H and I:*

<http://ecfr.gpoaccess.gov/cji/t/text/text-idx?c=ecfr;sid=e71fa39bcb4136363c9d537177628893;rgn=div5;view=text;node=20%3A3.0.2.1.3.5;idno=20;cc=ecfr>

2) *The U.S. Department of Labor Occupational Safety & Health Administration:*

<http://www.osha.gov/law-reqs.html>

3) *The U.S. Department of Labor Wage and Hour Division: <http://www.dol.gov/whd/>*

4. Has your country or its sub-national governments entered into bilateral, regional or multilateral agreements or arrangements addressing the international recruitment of health personnel?

Yes No(If "No", please proceed to Q(6))

No.

5. Please use Table A below to describe these bilateral, regional or multilateral agreements or arrangements: *N/A*

6. Does your country have any (government and/or non-government) programs or institutions undertaking research in health personnel migration?

Yes No(If “No”, please proceed to Q(8))

Yes.

7. Please use Table B below to provide the contact details for these research programs or institutions

Table B Detailed information on research programs or institutions assessing health personnel migration

Name of Program or Institution: *National Center for Health Workforce Analysis*

Name of Contact Person: *Edward Salsberg*

Contact details: *esalsberg@hrsa.gov*

Web-link (if available): <http://bhpr.hrsa.gov/healthworkforce/>

7.1 *The Alliance for Ethical International Recruitment*

Patricia Pittman, PhD

ppittman@gwu.edu

<http://www.fairinternationalrecruitment.org/>

7.2

The Educational Commission on Foreign Medical Graduates (ECFMG)

info@ecfm.org

<http://www.ecfm.org/>

7.3

Commission on Graduates of Foreign Nursing Schools (CGFNS) International

Franklin Shaffer, EdD, RN, FAAN

fshaffer@cgfns.org

<http://www.cgfns.org/>

8. Has your country taken any steps to implement the Code?

Yes No (If “No”, please proceed to Q(10))

Yes.

9. To describe those steps taken to implement the code, please tick all items that apply from the list below – the box can be ticked even if only some of the elements per step have been applied:

9a Actions have been taken to communicate and share information across sectors on health worker recruitment and migration issues, as well as the Code, among relevant ministries, departments and agencies, nationally and sub-nationally

Yes.

9b. Measures have been taken to involve all stakeholders in any decision making processes involving health personnel migration and international recruitment.

No.

9c. Actions are being considered to introduce changes to laws or policies on the international recruitment of the health personnel.

No.

9d. Records are maintained of all recruiters authorized by competent authorities to operate within their jurisdiction.

No.

9e. Good practices are encouraged and promoted among recruitment agencies.

Yes.

9f. If other steps have been taken, please give more details: *N/A*

10. Please list in priority order, the three main constraints to the implementation of the Code in your country and propose possible solutions.

Main constraints and Possible solution:

10.a1 10.a2

Constraint: The federal/state structure of the government of the United States, the privatized nature of the U.S. health care system, and the independent/private health worker recruitment process increase the complexity both of implementing and of reporting on the implementation of the Code of Practice.

Possible Solution: The National Authority is developing relationships both across and outside of government in order to promote practices that are in line with the spirit of the COP. In addition, relationships are being explored with appropriate non-governmental stakeholder groups such as the Alliance for Ethical International Recruitment. Though the United States does not intend to change its policies or centralize processes related to international recruitment, these actions are designed to foster collaboration and policies consistent with the Code of Practice.

10.b1 10.b2

Constraint: Complete data and information regarding international migration and recruitment does not exist, making it very difficult to track migration trends. The lack of a national structure for workforce data collection and planning complicates designing a comprehensive data system.

Possible Solution:

The U.S. National Authority and the Interagency COP committee are working to develop a fuller catalogue of existing data sources and the data elements collected by each agency. This work is aided in part by the new health workforce analysis structure set in place by the Patient Protection and Affordable Care Act to improve data and information on the national level. The National Center for Health Workforce Analysis, located in the Health Resources and Services Administration, is working to develop more complete data regarding the supply and demand of the U.S. health workforce, including foreign-educated health workers. In addition to characterizing the patient care workforce (including physicians, nurses, physician assistants, nurse practitioners, and all other traditional care providers), additional efforts in collaboration with the Centers for Disease Control will focus on the enumeration and characterization of the federal, state, and local public health workforce.

10.c1 10.c2

Constraint: The legal process and regulations related to the many aspects of migration to and obtaining employment in the United States are spread across a number of federal government agencies.

Possible Solution:

The U.S. interagency task force, convened by the National Authority, brings together the variety of federal government stakeholders involved in the immigration process. In order to increase knowledge and transparency around this issue, the National Authority is encouraging the sharing of data and information across federal government entities.

11. Has your country established a database of laws and regulations related to

international health personnel recruitment and migration and, as appropriate, information related to their implementation?

Yes No (If "No", please proceed to Q(12))

No.

11.1 Please provide details of the database reference or a web-link:

12. Does your country have any technical cooperation agreement, provides or receives financial assistance related to international health personnel recruitment or the management of and migration?

No.

12.1 Please provide more information or evidence of agreements as appropriate: N/A

12.2 Please provide more information or evidence of financial assistance provided or received as appropriate: N/A

13. Does your country have any mechanism(s) or entity(ies) to maintain statistical records of health personnel whose first qualification was obtained overseas?

Yes.

13.1 Please use Table C below to provide the contact details of each entity.

Table C Contact details of mechanism(s) or entity(ies) maintaining statistical records of health personnel whose first qualification was obtained overseas

Name of mechanism or entity Contact details Web-link (if available)

13.1a

- 1) *American Medical Association, <http://www.ama-assn.org/>;*
- 2) *National Council on State Boards of Nursing, <https://www.ncsbn.org/index.htm>; and*
- 3) *Educational Commission for Foreign Medical Graduates, <http://www.ecfmg.org/>*

13.2 For the entity named in Q(13.1) please use Table D below to

specify whether the information gathered include the following:

Table D Description of the statistical information available on the internationally recruited health personnel.

Entity	Occupation Category	Country of First Qualification	Year of First Recruitment	Age	Sex
American Medical Association	Doctors	Yes	No	Yes	Yes
National Council of State Boards of Nursing	Nurses, midwives, nurses/midwives	Yes	No	Yes	Yes
Educational Commission for Foreign Medical Graduates	Doctors	Yes	No	Yes	Yes

13.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):

Entity	Information Sharing Status
American Medical Association	Information may be shared (2)
National Council of State Boards of Nursing	Sharing relationships not yet explored (3)
Educational Commission for Foreign Medical Graduates	Sharing relationships not yet explored (3)

14. Does your country have any mechanism(s) or entity(ies) to regulate or grant authorization to practice to internationally recruited health personnel and maintain statistical records on them?

Yes No(If "No", please proceed to Q(15))

No.

14.1 Please use Table E below to provide the contact details of each entity.

Table E Contact details of mechanism(s) or entity(ies) regulating or granting authorization to practice to

internationally recruited health personnel

14.2 For the entity named in Q(14.1) please use Table F below to indicate whether the information gathered include the following details:

Table F Description of information available on authorization and regulation of practice of internationally recruited health personnel

14.3 For the entity(ies) named in Q(13.1) which status best describes the possibility of accessing and sharing the information detailed in Q(13.2):

Entity Information-sharing status

- (1) Information cannot be shared
- (2) Information may be shared
- (3) Sharing relationships not yet explored

15. Please submit any other complementary comments or material you wish to provide regarding the international recruitment and management of migration of the health workforce that would relate to implementation of the Code.

The United States appreciates the opportunity to report on progress in implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel, and applauds the efforts of the WHO in addressing the critical issue of health worker migration. The additional commentary as follows divides into three sections:

- 1. Additional context and explanation for reporting instrument items*
- 2. Health workforce planning and analytic efforts in the United States*
- 3. Sample international health system strengthening activities supported by the U.S. government*

1. Additional context and explanation for reporting instrument items

The United States appreciates the work done by the WHO to produce a comprehensive yet simple reporting document. However, there are certain questions for which a binary yes/no answer is incomplete. The following documentation provides additional context by question (numbered).

Question #1:

To the extent that the eligible individual works for a covered employer then that individual has some protections, regardless of immigration status. Please note that protections may not be specific to health workers. Although all workers are covered, some remedies may not be available for unauthorized work under certain labor laws, pursuant to the U.S. Supreme Court's decision in Hoffman Plastic Compounds, Inc. v. NLRB, 535 U.S. 137 (2002).

Regarding legal responsibilities, it is unclear which responsibilities the question stem asks respondents to consider. Foreign-educated health personnel are held to the same professional standards and subject to the same licensure rules as the domestically trained workforce (e.g., physicians must be licensed, etc).

Question #2a:

Under the H-1B program, the Department of Labor requires that the terms and conditions of employment (the Labor Condition Application) be given to workers no later than the date he/she reports

to a permanent place of work. However, since July 2009, U.S. consular officers have distributed and ensured the understanding of the “Wilberforce Pamphlet” during visa interviews of foreign health care workers. The pamphlet explains workers’ legal rights, and describes resources available to foreign workers to fight unlawful labor practices and prevent human trafficking.

Question #2b:

The U.S. government cannot speak to promotions or remuneration of foreign-educated health personnel once they are in position.

Question #2c:

The U.S. government is not aware of any legal or structural impediments to professional education, qualifications, or career progression for foreign workers and notes that opportunities in public education are primarily the domain of state governments.

Question #4:

Though the U.S. facilitates a broad number of international activities devoted to health system strengthening, there are no agreements or arrangements specifically devoted to international migration.

Question #9b:

The U.S. government has made efforts to engage non-governmental stakeholders in information dissemination and discussion regarding the U.S. implementation of the WHO Code of Practice, including hosting an open public meeting regarding the U.S. implementation in December of 2011. However, the United States does not view this stakeholders’ meeting or any other public actions taken to date a “decision-making” process.

Question #9e:

Though the U.S. government does not work directly with recruiters, the Alliance for Ethical International Recruitment Practices, a non-profit, non-governmental organization operating in the U.S., works directly with recruiting agencies and foreign health personnel to promote the use of good practices amongst recruiters.

Question #13:

The American Medical Association (AMA) maintains a “Physician MasterFile” that provides data on physicians practicing in the U.S. Although this was not specifically designed as a tracking mechanism for physicians who have migrated to the US, it is inclusive of physicians whose first qualification was obtained overseas.

Question #13.3:

The AMA MasterFile is available for purchase; HRSA purchases this file for analytic purposes.

Question #14:

The compound structure of this question makes it difficult to answer with a binary yes/no. In the United States, there are mechanisms to grant authority to practice to foreign-educated personnel; however, these mechanisms are not specific to individuals educated outside the United States. In addition, there is no single entity charged with responsibility for maintaining statistical records on foreign-educated health personnel specifically. Additional details on the pathways to licensure in the United States follow.

There are no exceptions to U.S. licensing policies made for foreign-educated health personnel.

Individuals who wish to practice medicine in the United States must complete at least 2 years of U.S.-accredited residency training and acquire a U.S. license. To enter residency training programs a foreign-educated physician must pass an examination and be certified by the Educational Commission for Foreign Medical Graduates. Individual residency training programs decide who to accept into their program under the policies and procedures established by the Accreditation Commission on Graduate Medical Education. Licensure responsibility rests with the individual state boards of medicine, which are represented on the national level by the Federation of State Medical Boards. Similarly, nurses who wish to practice as registered nurses must take and pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) in order to obtain a state license; individuals who wish to work as a licensed practical nurse in the U.S. must take and pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN®). These exams are both administered by the National Council of State Boards of Nursing. Nurse licensure parallels medicine: licensure responsibilities rest with the individual states and state boards are represented on the national level by the National Council of State Boards of Nursing.

While there are disparate sources from which one could gather information regarding foreign-educated health personnel working in the United States, there is no single authority charged with maintaining statistical records. Please see Question 13 for additional detail.

2. Health Workforce Planning and Analytic Efforts in the United States

In response to the challenges the United States will face in developing, training, and supporting a sufficiently-sized and culturally competent health workforce over the coming years, the Affordable Care Act is encouraging a series of innovative programs and initiatives, including the National Center for Health Workforce Analysis (NCHWA) at the Health Resources and Services Administration (HRSA). The NCHWA represents a dedicated effort by the United States to expand and improve health workforce data and information to support more informed public and private sector decision-making related to the health workforce.

Key responsibilities of the NCHWA include:

- *Improving the collection and analysis of data to describe the health workforce;*
- *Identifying and monitoring key workforce trends;*
- *Regularly projecting future supply of and demand for health occupations and therein identifying potential gaps and needs;*
- *Providing guidance to inform federal and state workforce policies;*
- *Assisting state health workforce data collection, analysis and planning; and*
- *Encouraging relevant health workforce research.*

Through the work of the NCHWA and other provisions in the Affordable Care Act, the United States is undertaking numerous steps to help assure the education and training of a health workforce of sufficient size and distribution to better meet the needs of the nation with a more limited reliance on migration.

3. Sample international health system strengthening activities supported by the U.S. government

The WHO Global Code of Practice emphasizes the importance of health system strengthening activities internationally. This year's reporting instrument did not incorporate any specific questions regarding international health system strengthening activities supported by individual countries. Though the U.S.

recognizes that the main focus of the Global Code for this reporting cycle is international recruitment of health personnel, we firmly believe that our international health system strengthening (HSS) activities – particularly those specifically devoted to building HRH capacity abroad – demonstrate support for the principles espoused by the Code. The following paragraphs provide a brief summary of relevant U.S. international HSS activities.

President Obama’s Global Health Initiative includes building sustainability through health systems strengthening as one of its seven core principles. Support for health systems strengthening is included in GHI plans currently being prepared in many developing countries. The U.S. government is engaged in a number of activities to strengthen health systems globally, such as its microfinance programs and many activities in sub-Saharan African countries under the President’s Emergency Plan for AIDS Relief (PEPFAR).

The U.S. Department of Health and Human Services’ (HHS) Health Resources and Services Administration (HRSA) Global HIV/AIDS Program (GHAP) strengthens health service delivery and systems of care in resource limited-countries through the establishment of training centers and collaborative partnerships with local universities and organizations. HRSA-supported programs increase workforce capacity through technical assistance, task shifting, strengthening medical and nursing education systems to train and retain health workers in their home countries, and strengthening health systems by building local capacity and utilizing local human resources to ensure sustainability.

The U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention (CDC) has been improving the key elements of health systems and managing interactions in ways that achieve more equitable and sustained improvements across health services and outcomes. CDC is committed to improving health outcomes around the world by helping countries establish core public health functions that strengthen health systems. Central to all of CDC’s health systems strengthening activities are the tenets of working with Ministries of Health (MOH) and other public health institutions to create sustainable health outcomes, and ensuring the coordination and integration of HHS activities at the country-level. CDC achieves this through surveillance and other health information systems; research; workforce development; and laboratory strengthening and networks, which support the implementation of all evidence-based public health actions and programs. Monitoring and evaluation, public health policy, guideline development, and health communications are integral components that support

evidence-based public health action and program implementation. Furthermore, implementation of the core functions depends on the development of the necessary health infrastructure (e.g., laboratories, information technology systems, and clinics).

The U.S. Agency for International Development has worked with all cadres of public and private sector health providers in developing countries for more than 35 years. USAID's investments in HRH are guided by principles of country ownership and building sustainability through health systems strengthening (HSS). Based on these principles, USAID collaborates closely with countries to design and implement programs that will address both the quality and quantity of workers available to serve their population's health care needs. Capacity building is an integral part of programming at all levels. USAID's HRH/HSS interventions span the health system, including: data-driven policy and planning, including human resources management; workforce development (education and training); and performance support systems to improve retention and productivity of the workforce. The interaction of human resources with other areas of the health system, such as finance and governance, is also been addressed through, for example, creation of financing schemes such as vouchers, insurance, franchising, contracting out and helping providers access credit to grow health care businesses. More recent work is focused on the public health sector to develop and enhance the policy environment for expanding and fostering the role of the private health sector and its providers. For more than 25 years USAID has also supported public private partnerships in health to expand private sector products and services in developing countries.

PEPFAR also incorporates a number of inter-agency initiatives. Of particular interest to the health system strengthening goals of the Code of Practice are the Medical and Nursing Education Partnership Initiatives (MEPI and NEPI), which are dedicated to developing increased educational capacity in sub-Saharan Africa. These programs are designed to improve and expand the medical and nursing educational systems and are considered a key component of PEPFAR's goal of increasing the number of new health care workers by 140,000. Governmental organizations participating in MEPI are the Office of the U.S. Global AIDS Coordinator (OGAC), National Institutes of Health (NIH), HRSA, CDC, and the Department of Defense (DoD) HIV/AIDS Prevention Program. U.S. government organizations participating in NEPI include OGAC, HRSA, and USAID.