Ethical Recruitment of Health Workers: Using Bilateral Cooperation to Fulfill the World Health Organization's Global Code of Practice

Michael A. Clemens and Helen Dempster

Abstract

In a bid to better manage the increasing migration of health workers, in 2010 the World Health Organization (WHO) adopted its Global Code of Practice on the International Recruitment of Health Personnel. The Code has been misinterpreted by many as banning all recruitment from the 57 countries it deemed to have a "critical shortage" of health workers. But that is neither what the WHO intended, nor what the Code says. Recruitment from these countries was always allowed, even encouraged, as long as it was conducted under a mutually beneficial government-to-government agreement. In this policy paper, we outline how the WHO defined a "critical shortage" of health workers, both for the original Code and for its newly published Health Workforce Support and Safeguards List. The paper then goes onto explore how countries of migrant destination and origin can (and should) design ethical and sustainable health worker migration partnerships that fulfil the requirements of the Code.

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Introduction

The international migration of health workers,[1] especially from low- to high-income countries, is increasing. The number of migrant doctors and nurses working in OECD countries has risen by 60 percent in the last decade.[2] In 2018, 11 percent of doctors in Western Europe, 25 percent in the United States (US) and Canada, and 34 percent in Australia and New Zealand, were foreign-trained. Most of these were trained in non-OECD countries—78 percent in the United Kingdom, 89 percent in the US.[3]

This large and increasing trend has raised questions as to whether actively facilitating the international migration of health workers is ethical. Many of these migrants left countries that are suffering from a lack of health workers. It has been argued that the international recruitment of these migrants has contributed to "brain drain" and worse health outcomes in their countries of origin. But would preventing the movement of people, simply because of their profession, be an ethical way to improve access to skilled health workers in countries of origin?

A decade ago, the world gained a clear, universal standard to answer these questions. In May 2010, the World Health Organization (WHO) adopted its *Global Code of Practice on the International Recruitment of Health Personnel* (the "WHO Code").[4] In the WHO Code, active recruitment was discouraged from 57 countries where there was a "critical shortage" of health workers, defined using health worker density and skilled birth attendance.

The WHO Code has been misinterpreted by many as banning all recruitment from these 57 countries. This is not what the WHO Code says. In fact, the researchers who created the definition of "critical shortage" specifically warned it should *not* be used in this way. The WHO Code was written to discourage unilateral active recruitment from those 57 countries but does not apply to recruitment conducted under a government-to-government agreement.[5]

Therefore, to fulfill the WHO Code, ministries of health in countries of origin must be given a seat at the table. Bilateral agreements must include substantial benefits to health worker training, recruitment, and retention, as well as health care systems, within the country of origin. Ensuring an agreement is developed with the interests of all parties in mind will help balance the migration power dynamic and satisfy the WHO Code. An example of such an agreement is a Global Skill Partnership, developed by the Center for Global Development (CGD) in 2012.

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[1] The World Health Organization (WHO) definition of "health worker" includes all people who are engaged in actions whose primary intent is to enhance health. In this note, we will use "health worker" to refer to those in patient-fronting roles, primarily doctors, nurses, and midwives.
[2] WHO (2021) "Health workforce – Migration," https://www.who.int/hrh/migration/en/
[3] The fraction of *nurses* that are foreign-trained is 7 percent in Western Europe, the US, and Canada collectively; in Australia and New Zealand, collectively, it is 19 percent. Source: OECD (2019), *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, OECD Publishing: Paris, https://doi.org/10.1787/5571ef48-en, Table 1.3 and Annex Figure 1.B.1 (underlying data at: https://doi.org/10.1787/888933970171).
[4] WHO (2010) *The WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva: WHO. https://www.who.int/hrh/migration/code/code_en.pdf
[5] Here, 'unilateral active recruitment' refers to employers or their agents advertising to workers in the migrant country of origin, and interviewing and processing applications there, without consent or cooperation of the government of that country.

This paper will explore the text of the WHO Code, how it defines "critical shortage," and what the "critical shortage" list would look like if the same criteria were applied today. It will then go on to discuss the new WHO *Health Workforce Support and Safeguards List* (the "WHO Safeguards List"), released in February 2021, and its implications for this debate. This new WHO Safeguards List has been released during COVID-19 and a concurrent surge in interest in health worker migration. To help guide these debates, this note will finish with an exploration of the Global Skill Partnership model and how it could be applied to ensure international health worker migration is ethical and sustainable.

The 2006 WHO Global Code of Practice on the International Recruitment of Health Personnel (the "WHO Code")

By 2030, the global demand for health workers has been predicted to rise to 80 million, 15 million more than the world is on track to produce.[6] These shortages are universal, but not universally distributed. For example, the WHO has shown that the African region experiences 24 percent of the disease burden but has only three percent of the world's health workforce.[7]

At the same time, the international migration of health workers is increasing. Rigid health worker supply systems and aging populations in high-income countries are increasing demand, and migration is expected to grow to meet this demand.[8] While the mobility of health workers is not solely from low-income countries to high-income countries, the presence of such pathways, and recruitment agencies to service them, is increasing.

Recognizing the impact of such dynamics, in 2004, the World Health Assembly mandated that its Director-General develop a non-binding code of practice on the international recruitment of health workers, in consultation with Member States and all relevant partners.[9] Such a code was to build on the multitude of similar initiatives that had been developed, including the *Commonwealth Code of Practice for the International Recruitment of Health Workers.*[10] This was further discussed at the first ever Global Forum on Human Resources for Health, held by the Global Health Worker Alliance in March 2008. The resultant *Kampala Declaration* recognized both the impact of this shortage and of health worker migration and reiterated calls for a code of practice.[11]

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[6] Jenny X. Liu, Yevgeniy Goryakin, Akiko Maeda, Tim Bruckner, and Richard Scheffler (2017) "Global Health Workforce Labor Market Projections for 2030," *Human Resources for Health*, 15:11, https://doi.org/10.1186/s12960-017-0187-2

[7] Stella C. E. Anyangwe and Chipayeni Mtonga (2007) "Inequities in the Global Health Workforce: The Greatest Impediment to Health in Sub-Saharan Africa," *International Journal of Environmental Research and Public* Health, 4:2, 93-100. https://doi.org/10.3390/ijerph2007040002

[8] WHO (2016) *Global Strategy on Human Resources for Health: Workforce 2030*, Geneva: WHO. https://www.who.int/hrh/resources/pub_globstrathrh-2030/en/

[9] Fifty-Seventh World Health Assembly (2004), *International migration of health personnel: a challenge for health systems in developing countries*, WHA57.19. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf

[10] Pre-WHA Meeting of Commonwealth Health Ministers (2003) *Commonwealth Code of Practice for the International Recruitment of Health Workers*, Geneva: WHA, https://www.aspeninstitute.org/wp-content/uploads/files/content/images/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf

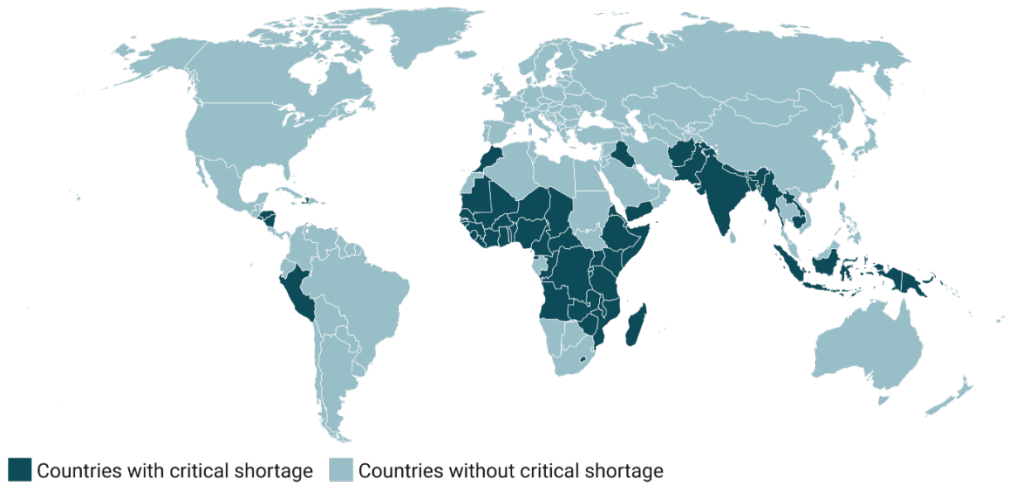
[11] WHO (2008) *The Kampala Declaration and Agenda for Global Action,* Geneva: WHO. https://www.who.int/workforcealliance/knowledge/resources/kampala_declaration/en/

On May 21, 2010, the 63rd World Health Assembly adopted the *Global Code of Practice on the International Recruitment of Health Personnel* (the "WHO Code"). The WHO Code established voluntary principles and practices to guide the ethical international recruitment of health workers and strengthen health systems. Crucially, it recommends that "*Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.*"[12]

The original definition of "critical shortage"

Initially, the WHO defined a "critical shortage" country as one with fewer than 2.28 health workers per thousand population. To calculate this, researchers first looked at the relationship between health worker density (the number of health workers per thousand population) and the percentage of births attended by skilled health personnel. Broadly, countries with a higher health worker density have a larger fraction of births attended. They then selected a minimal acceptable level of skilled birth attendance: 80 percent of births. An average country reaches this level at a health worker density that, with 95 percent statistical confidence, lies between 2.02 and 2.54. The middle of that range is 2.28.[13] Based on this definition, in 2006 the WHO's flagship *World Health Report* determined that 57 countries were in "critical shortage" (figure 1).[14]

Figure 1. Countries originally designated by the WHO, in 2006, as having a "critical shortage" of health workers



Note: The full list is available in Table 1. *Source*: WHO (2006) World Health Report 2006. Geneva: WHO.

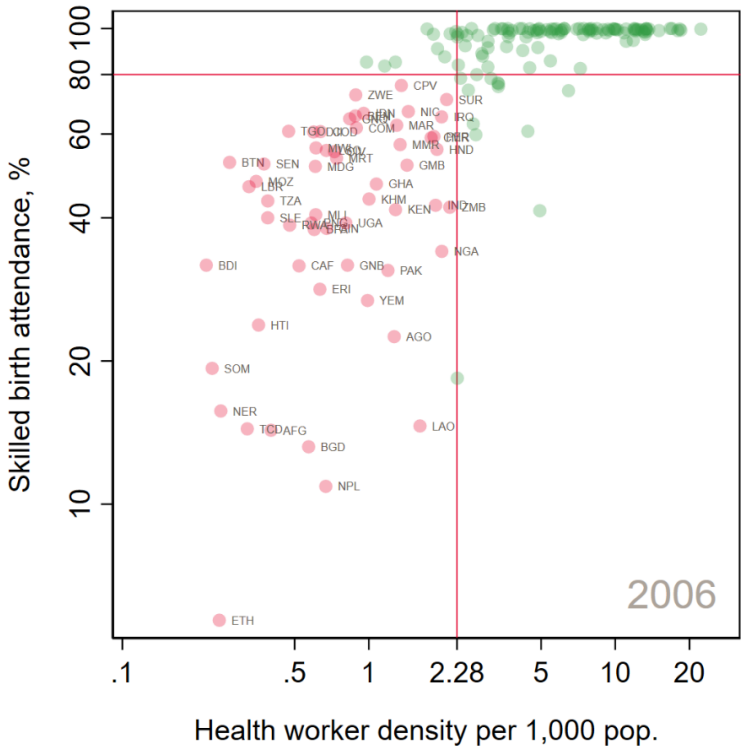
[12] WHO (2010) *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva: WHO. https://www.who.int/hrh/migration/code/practice/en/

[13] This calculation is performed by Niko Speybroeck, Yohannes Kinfu, Mario R. Dal Poz, and David B. Evans (2006) "Reassessing the relationship between human resources for health, intervention coverage and health outcomes," Background paper for the *World Health Report 2006*. Geneva: WHO. http://www.who.int/hrh/documents/reassessing_relationship.pdf. They use the same method employed by the Joint Learning Initiative in Lincoln C. Chen and Tim Evans (2004) "Human resources for health: overcoming the crisis," *Lancet*, 364:1984–1990. http://www.who.int/hrh/documents/JLi_hrh_report.pdf

[14] WHO (2006) *World Health Report 2006*. Geneva: WHO. Table 1.3, page 13. https://www.who.int/whr/2006/en/

Figure 2 reconstructs how this list of "critical shortage" countries was made. The horizontal axis shows the density of health workers—the number of health workers per population—on a logarithmic scale.[15] The vertical axis shows the percentage of births in each country attended by skilled health personnel. The cutoff density of health workers is the vertical red line, and the cutoff level of skilled birth attendance is the horizontal red line. Thus, the original "critical shortage" countries were the 57 countries in the lower-left quadrant.

Figure 2. How 57 countries with a "critical shortage" (red dots) were identified in the 2006 data

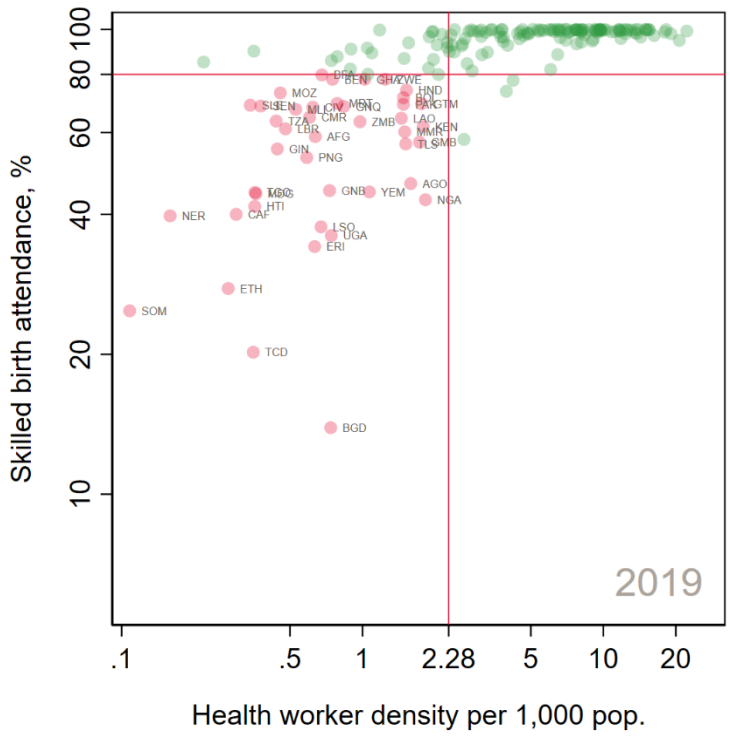


Source: WHO and UNICEF as reported in the WHO (2006) World Health Report 2006. Geneva: WHO. Countries identified by ISO three-letter code.

Since 2006, the world has advanced—improving health outcomes and increasing health worker density. If we apply the same calculation to the most recent data available as of 2020, the number of countries with a "critical shortage" would be reduced from 57 countries to 43 (figure 3). Three new countries would be added to the list and 17 countries removed (see table 1). For example, India fell below both thresholds in 2006. (At that time, India had 1.87 skilled health workers per 1,000 population and 43 percent skilled birth attendance.) But today India exceeds both thresholds. (India now has 2.85 skilled health workers per 1,000 population and 81 percent skilled birth attendance).

[15] Health worker density defines "health workers" as doctors, nurses, and midwives. This adheres to the definition for health worker density, or health workforce density, as used by the WHO.

Figure 3. If the same exercise from 2006 were repeated, using the same method but updated data, 43 countries would be classified as having a "critical shortage" (red dots)



Source: WHO Global Health Observatory; UNICEF/WHO Joint Database on SDG 3.1.2 Skilled Attendance at Birth. The underlying data come from multiple years but represent the most current data available in 2019.

Figures 2 and 3 offer a portrait of progress. Even if the objective criteria for discouraging unilateral active recruitment under the WHO Code had not changed, that portion of the Code would apply to substantially fewer countries today than it originally did.

Understanding the "ban" on active recruitment

As discussed above, the WHO Code was adopted during a period of great concern about health workforce shortages and the negative impacts of health worker migration. In a bid to recognize these impacts, Article 5.1 of the WHO Code states that:

> *"In accordance with the guiding principle[s] as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers" (Article 5.1).*

The last sentence of this Article has often been interpreted as recommending an outright ban on any recruitment of health workers from "critical shortage" countries. Many high-income countries even codified this interpretation. For example, Germany's *2013 Employment Ordinance* prohibited all recruitment of health workers from these 57 countries.[16]

Promoting recruitment through government-to-government agreements

Bans of this sort, however, do not implement the recommendations of the WHO Code. The 'Article 3' referred to the passage quoted above is the WHO Code's "guiding principle." It notes that "*International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed.*" That is also true, the WHO Code notes, in countries with a "critical shortage" of health workers.

To implement the WHO Code, therefore, countries of destination should not ban all active recruitment from those 57 countries, but instead manage mobility through government-to-government agreements in which active recruitment occurs on mutually agreed terms. What Article 5.1 "*discourages*" is unregulated and unilateral recruitment of workers in "critical shortage" countries without an offsetting obligation for the country of destination to "*collaborate … to sustain and promote health human resource development and training.*" Article 3.3 goes even further, advising countries of destination to "*provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.*"

In other words, the WHO Code does not ban, and was never intended to ban, countries with a "critical shortage" of health workers from developing government-to-government agreements that would benefit them. Categorical bans on such cooperative agreements do not implement the WHO Code but run counter to it. The WHO Code mentions "cooperation", "collaboration", and "bilateral agreements" 16 times in its slim 12 pages. It is clearly not a call for unilateral bans, but for careful and respectful intergovernmental cooperation that contributes to the strengthening of health systems and improved health outcomes.

What the authors intended

Both the authors of the "critical shortage" definition used in relation to the WHO Code, and the WHO itself, stated explicitly that no numeric cutoff by itself should suffice to ban recruitment. The designers of the "critical shortage" threshold warned, "*Because of the confounding effects of other social factors, such as education and economics, and of the way countries mobilize and deploy workers not classified under existing international systems*," the threshold they calculated must be "*a suggestive guideline, not a definitive benchmark.*"[17] The WHO agreed: "*These estimates … are not a substitute for specific country assessments of sufficiency.*"[18]

[16] OECD (2016) *OECD Health Policy Studies Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places*, OECD: Paris, page 120.
[17] Lincoln C. Chen and Tim Evans (2004) "Human resources for health: overcoming the crisis," *Lancet*, 364:1984–1990. http://www.who.int/hrh/documents/JLi_hrh_report.pdf
[18] WHO (2006) *op. cit.* pages 12–13.

They made these warnings because they understood the inherent limitations of the numeric calculation that underlies the definition, for several reasons:

- **The true value of any threshold in health worker density is uncertain.** The underlying analysis only finds that the health worker density allowing 80 percent skilled birth attendance lies somewhere between 2.02 and 2.54. In the data of the same original WHO analysis, 14 countries lay within this uncertainty interval.[19]

- **There is no medical basis for a sharp cutoff at 80 percent coverage.** The WHO bases its health worker density threshold on a "minimum desired level" of 80 percent skilled birth attendance. That figure originates in a paper in *The Lancet* that chooses the level of 80 percent as an arbitrary round number to summarize the data in one of its figures.[20] There is no sharp change at, or near, 80 percent that would justify the choice of that particular number, as figures 2 and 3 here illustrate.[21]

- **The true number of health workers is uncertain.** The method used to count health workers differs from country to country. In its original calculation, the WHO used four different types of data sources to estimate of the number of health workers in a country. Many of these sources define health workers differently and all have different margins of error.[22] For example, at the same time that the WHO determined Kenya to have a "critical shortage" of nurses, Kenya had a surplus of at least five thousand nurses that could not find employment as nurses and thus were not included in active health worker density estimates.[23]

- **There is no mechanical relationship between health worker density and skilled birth attendance.** In the original 2006 classification, ten countries fell below the health worker density threshold and nevertheless fell *above* the skilled birth attendance threshold.[24] Conversely, eight countries fell above the health worker density threshold but *below* the skilled birth attendance threshold. For example, Laos and Chile had almost the same health worker density (1.61 and 1.72 respectively) but vastly different skilled birth attendance (Laos at 19 percent and Chile at 100 percent). Moreover, skilled birth attendance is a narrow measure of the impact of health workers.

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[19] Belize, China, Costa Rica, Egypt, El Salvador, Fiji, Jamaica, Malaysia, São Tomé and Príncipe, Sri Lanka, Surinam, Timor Leste, Vanuatu, and Zambia.

[20] Chen and Evans. *op. cit.*

[21] This is the difference between the number of countries below 3.9 per 1,000 (the level at which average skilled birth attendance is 90 percent) *and* below 90 percent skilled birth attendance, and the number of countries below 1.4 health workers per 1,000 population (the level at which average skilled birth attendance is 70 percent) *and* below 70 percent skilled birth attendance—in Figure 1.4, page 11 of WHO (2006) *op. cit.*

[22] These sources include, in different countries: administrative records such as registers of professional associations (which are available in very few countries), health facility surveys (which "may suffer from omission of some establishments and types of health workers, particularly those working outside of health facilities and the unemployed"), labor force surveys (which can "suffer from sampling error"), and national population censuses (which are conducted infrequently). See Mario R. Dal Poz, Yohannes Kinfu, Sigrid Dräger, and Teena Kunjumen (2006) "Counting health workers: definitions, data, methods and global results," Background paper for the *World Health Report 2006*. WHO: Geneva http://www.geopsy.com/memoires_theses/counting_health_workers.pdf

[23] Ummuro Adano (2008) "The health worker recruitment and deployment process in Kenya: an emergency hiring program," *Human Resources for Health,* 6:19. https://doi:10.1186/1478-4491-6-19

[24] Ten countries in the data of the *World Health Report 2006* have health worker densities below 2.28 but skilled birth attendance *above* 80 percent: Cape Verde, Chile, China, Colombia, Costa Rica, Iran, Solomon Islands, Sudan, Suriname, and Vietnam.

- **There is currently no published evidence showing that limits on recruitment have affected staffing levels or health outcomes in migrant countries of origin.** For example, the UK originally banned recruitment from 152 countries—almost the entire developing world.[25] Neither that policy nor related policies in other countries have ever been shown to have caused a measurable increase in health worker staffing, quality of care, or health outcomes.[26]

Therefore, while the "critical shortage" classification contains useful information, it can only be one of many useful inputs to a policymaker's overall assessment of whether any given act of recruitment occurs in a context that tends to ameliorate or exacerbate a "critical shortage." There have been valuable recent efforts to build better quantitative indicators of health worker shortage, but similar concerns will hold about any such quantitative indicator.[27]

The 2021 WHO Health Workforce Support and Safeguards List (the "WHO Safeguards List")

Following the recommendations of the 68th World Health Assembly in May 2015, the Director-General of the WHO convened an Expert Advisory Group (EAG) to conduct a second review of the WHO Code (the first review was conducted in 2015). Following extensive consultations, the *Report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel* ("the Report") was presented to the 73rd World Health Assembly in November 2020.[28]

Fifteen years after the establishment of the original WHO Code, the Report found that it has become the "universal ethical framework linking the international recruitment of health workers and the strengthening of health systems." Both the knowledge of and relevance of the WHO Code had increased in recent years, as had the availability of information to assess its effectiveness. The EAG affirms that the WHO Code can help advance universal health coverage (UHC); safe, regular, and orderly migration; human capital development; and international trade.

Yet the authors note that the 2006 list of countries referenced above was developed for research, policy dialogue, and advocacy purposes relating to the Millennium Development Goals (MDGs). It is therefore "not currently suitable for fulfilling the purpose of identifying countries which should be prioritized for health personnel development support and for which safeguards related to active recruitment are required."

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[25] See Department of Health (2004) *Code of Practice for the International Recruitment of Healthcare Professionals*. London: Department of Health. http://www.nursingleadership.org.uk/publications/codeofpractice.pdf; and James Buchan (2007) "International Recruitment of Nurses: Policy and Practice in the United Kingdom," *Health Services Research*, 43:3, 1321-1335. https://dx.doi.org/10.1111%2Fj.1475-6773.2007.00710.x

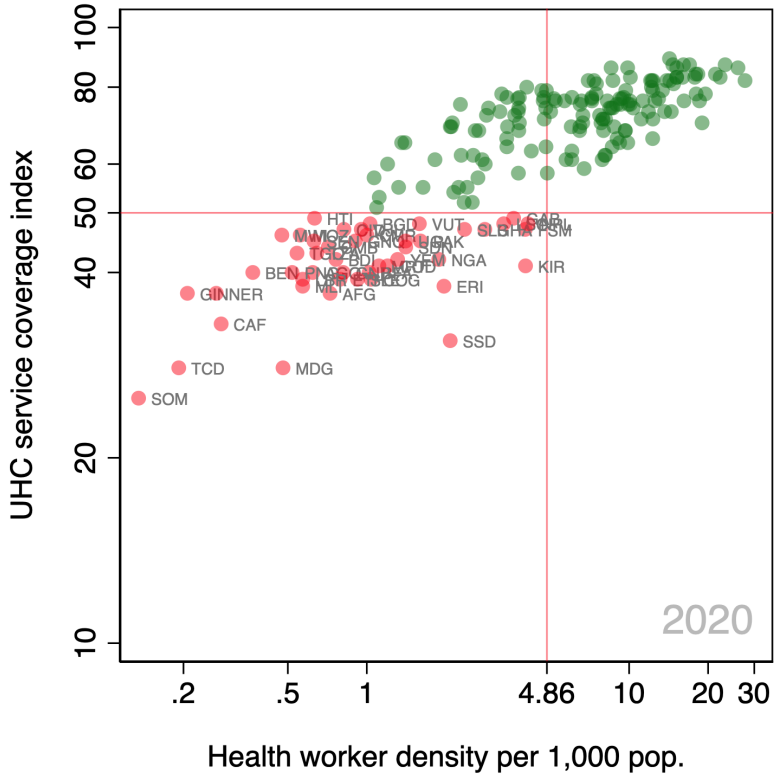
[26] See Jennifer S. Edge and Steven J. Hoffman (2013) "Empirical impact evaluation of the WHO Global Code of Practice on the International Recruitment of Health Personnel in Australia, Canada, UK and USA," *Globalization and Health*, 9:60. http://dx.doi.org/10.1186/1744-8603-9-60

[27] For example, a criterion of 4.45 physicians, nurses, and midwives per 1,000 population was proposed by: WHO (2016) *Global strategy on human resources for health: Workforce 2030*. WHO: Geneva. https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf

[28] WHO (2020) *Report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel*, WHO: Geneva. https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_9-en.pdf

As a result, the authors recommended a new definition. Countries that both score in the first quartile of the UHC service coverage index (UHC SCI) and have less than the median density of doctors, nurses, and midwives should be prioritized for health workforce support and active recruitment safeguards. The new WHO *Health Workforce Support and Safeguards List* was published on February 25, 2021.[29] The list references the methodology included in the Report (with an increased global health worker density of 48.6 per 10,000 population but maintaining a previous standard UHC service coverage index of 50). This yields 47 countries classified as requiring support and safeguards (figure 4). It has now replaced the "critical shortage" list included in the *2006 World Health Report*, and the WHO intends to review the new list in a dynamic manner at least every three years.

Figure 4. Support and Safeguards countries: 47 countries have both low UHC service coverage index scores and low health worker density



Source: WHO (2020) National Health Workforce Accounts (NWHA) [data file]. WHO: Geneva. https://apps.who.int/nhwaportal/. The underlying data come from multiple years but represent the most current data available in 2020.

Comparing the new list to the old lists is informative (table 1). The new definition is simpler, clearer, and better linked to ongoing policy discussions. For example, both UHC SCI and health worker density are included as Sustainable Development Goal (SDG) indicators. As a result, the new definition is more sustainable, comparable, regularly monitored, and better in

[29] WHO (2021) *Health Workforce Support and Safeguards List, 2020*, WHO: Geneva. https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5

line with the role of health workers within the health system. It has had the effect of both reducing the overall number of countries on the list, and slightly shifting the countries that are included. In the new list, gone are countries including India, Indonesia, Kenya, Zambia, and Zimbabwe, and all Western Hemisphere countries except Haiti. Much of the Pacific, in turn, has been added to the new list. The list is not static—it will be revisited regularly based on new data acquired through the National Health Workforce Accounts (NHWA) and external shifts.

Table 1. Countries with a "critical shortage": under the 2006 definition, the 2006 definition applied to today, and the new 2021 definition

2006 definition (57 countries)	2006 definition applied to today (43 countries)	2021 definition (47 countries)
Africa		
Angola	Angola	Angola
Benin	Benin	Benin
Burkina Faso	Burkina Faso	Burkina Faso
Burundi		Burundi
Cameroon	Cameroon	Cameroon
Central African Republic	Central African Republic	Central African Republic
Chad	Chad	Chad
Comoros		
Congo, Dem. Rep.	Congo, Dem. Rep.	Congo, Dem. Rep.
Congo, Rep.	Congo, Rep.	Congo, Rep.
Côte d'Ivoire	Côte d'Ivoire	Côte d'Ivoire
Equatorial Guinea	Equatorial Guinea	Equatorial Guinea
Eritrea	Eritrea	Eritrea
Ethiopia	Ethiopia	Ethiopia
Gambia	Gambia	Gambia
Ghana	Ghana	Ghana
Guinea	Guinea	Guinea
Guinea-Bissau	Guinea-Bissau	Guinea-Bissau
Kenya	Kenya	
Lesotho	Lesotho	Lesotho
Liberia	Liberia	Liberia
Madagascar	Madagascar	Madagascar
Malawi		Malawi
Mali	Mali	Mali
Mauritania	Mauritania	Mauritania
Mozambique	Mozambique	Mozambique
Niger	Niger	Niger
Nigeria	Nigeria	Nigeria
Rwanda		
Senegal	Senegal	Senegal
Sierra Leone	Sierra Leone	Sierra Leone
		South Sudan
Tanzania	Tanzania	Tanzania

2006 definition (57 countries)	2006 definition applied to today (43 countries)	2021 definition (47 countries)
Africa *(continued)*		
Togo	Togo	Togo
Uganda	Uganda	Uganda
Zambia	Zambia	
Zimbabwe	Zimbabwe	
Americas		
	Bolivia	
El Salvador	El Salvador	
	Guatemala	
Haiti	Haiti	Haiti
Honduras	Honduras	
Nicaragua		
Peru	Peru	
Eastern Mediterranean		
Afghanistan	Afghanistan	Afghanistan
Djibouti		Djibouti
Iraq		
Morocco		
Pakistan	Pakistan	Pakistan
Somalia	Somalia	Somalia
		Sudan
Yemen	Yemen	Yemen
Western Pacific		
Cambodia		
		Kiribati
Laos	Laos	
		Micronesia, FSM
Papua New Guinea	Papua New Guinea	Papua New Guinea
		Solomon Islands
	Timor-Leste	
		Vanuatu
South-East Asia		
Bangladesh	Bangladesh	Bangladesh
Bhutan		
India		
Indonesia		
Nepal		Nepal
Myanmar	Myanmar	

Source: 2006 definition: WHO (2006) *List of 57 countries facing Human Resources for Health Crisis,* WHO: Geneva. https://www.who.int/workforcealliance/countries/57crisiscountries.pdf?ua=1; *2021 definition:* WHO (2021) *Health Workforce Support and Safeguards List, 2020,* WHO: Geneva. https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5

Note: Regions defined by WHO. See WHO, "Working with the regions," https://www.who.int/chp/about/regions/en/

Consistent with the guiding principles of the WHO Code outlined above, the WHO Safeguards List notes that these 47 countries should be prioritized for health personnel development, health system support, and provided with safeguards that discourage active international recruitment of health personnel. Government-to-government agreements are not banned for countries on the list; instead, they are encouraged. Such agreements should be informed by a health labor market analysis to ensure adequate supply in countries of origin, involve ministries of health and other health sector stakeholders, and be notified to the WHO Secretariat through the NHWA and WHO Code reporting processes.[30]

Such an approach requires all countries (particularly countries of destination) to analyze how they will apply the WHO Code. As an example, on February 25, 2021, the UK released their new *Code of practice for the international recruitment of health and social care personnel* (the "UK Code").[31] The UK Code aims to promote high standards of practice in ethical international recruitment along with health and social care system sustainability through international cooperation. To manage this, the UK has implemented a traffic light system. For red countries, no active recruitment is permitted. For amber countries, managed recruitment is permitted under the terms of a government-to-government agreement (if one is in place). For green countries, active recruitment is permitted, some of which may be done through a government-to-government agreement (if one is in place). All 47 countries on the WHO Safeguards List are classified as red countries and others are currently being prioritized for the development of new government-to-government agreements.

Promoting ethical international health worker recruitment

Under the WHO Code, recruitment in countries with a "critical shortage" of health workers is therefore only ethical if it is part of a government-to-government agreement with certain conditions. It must include assistance to the country of origin, "*to sustain and promote health human resource development and training*" (5.1) and "*provide technical and financial assistance to developing countries … aimed at strengthening health systems, including health personnel development*" (3.3). And it must be done in collaboration with the ministry of health and other relevant institutions in countries of origin.

The new WHO Safeguards List and its supporting documents go some way to clarify this interpretation, and at a time when it is needed most. Demand for health workers in countries of destination is at a high. Both demographic shifts and COVID-19 have exposed the necessity of migrant health workers within countries of destination, and this trend is likely to persist. Traditional countries of origin for health workers, such as the Philippines, are rapidly developing, thereby retaining talent and reducing a pipeline of emigration which countries of destination had long relied upon. And new countries of origin, such as Ghana, Nigeria, and Sri Lanka are therefore demanding more equitable agreements that channel meaningful assistance towards their health workforce development goals.

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[30] WHO (2021) *Health Workforce Support and Safeguards List, 2020*, WHO: Geneva. https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5

[31] UK Department of Health and Social Care (DHSC) (2021) *Code of practice for the international recruitment of health and social care personnel,* https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel

Global Skill Partnerships

One way to do this is through developing Global Skill Partnerships.[32] A Global Skill Partnership is a bilateral agreement between equal partners. The country of destination agrees to provide technology and finance to train potential migrants with targeted skills in the country of origin, prior to migration, and ultimately welcomes migrants with precisely the skills they need to best integrate and contribute upon arrival. The country of origin agrees to provide that training and gets support for the training of non-migrants too – increasing rather than draining human capital, with a key role for the WHO to provide information on the health labor market. One hundred and fifty-two countries have endorsed this type of agreement, by name, in the *Global Compact for Safe, Regular, and Orderly Migration* (Objective 18).[33] The model can and should be used to build the global stock of health workers.

A well-designed Global Skill Partnership could lead to a variety of positive improvements in health workforce development and, ultimately, health outcomes. Evidence from the Philippines shows that even the presence of migration opportunities induced ten times more nurses to qualify under existing training programs.[34] In addition to this incentive, the Global Skill Partnership could directly train more health workers (under the "home" track) who would contribute to health systems in their countries of origin, thereby reducing "brain drain."

Investing in health systems

Yet merely increasing the supply of health workers in migrant countries of origin is too simplistic. If countries of origin are unable to employ newly qualified workers, especially within the public system, this will merely create more emigration pressure and dissatisfaction. Instead, countries of destination should interrogate the reasons why more qualified workers are not trained and employed, and tackle these. As the WHO has mentioned, "the policy prescription should therefore focus on treating the underlying causes (in terms of improving the work environment, support systems and remuneration), rather than attempting to address in isolation the migratory phenomenon."[35]

Investment would include improving and expanding the training infrastructure, such as providing equipment and facilities and improving the capacity of trainers. Investment could also be channeled to supporting the ministry of health itself, improving reporting under the WHO Code to the NHWA, and developing a Health Workforce Migration Strategy and

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[32] Michael A. Clemens (2015) "Global Skill Partnerships: A proposal for technical training in a mobile world," *IZA Journal of Labor Policy*, 4:2. https://doi.org/10.1186/s40173-014-0028-z

[33] The Global Compact for Safe, Orderly, and Regular Migration, Objective 18(e) reads, "*Build global skills partnerships among countries that strengthen training capacities of national authorities and relevant stakeholders, including the private sector and trade unions, and foster skills development of workers in countries of origin and migrants in countries of destination with a view to preparing trainees for employability in the labour markets of all participating countries*" See Global Compact for Safe, Orderly, and Regular Migration, UN General Assembly A/CONF.231/3. https://undocs.org/en/A/CONF.231/3. One hundred and fifty-two countries voted to endorse the Global Compact on December 19, 2018. See *General Assembly Endorses First-Ever Global Compact on Migration, Urging Cooperation among Member States in Protecting Migrants*, GA/12113. https://www.un.org/press/en/2018/ga12113.doc.htm

[34] Paolo Abarcar and Caroline Theoharides (2020) "Medical Worker Migration and Origin-Country Human Capital: Evidence from U.S. Visa Policy," https://www.amherst.edu/system/files/Abarcar_Theoharides_2020_July_FINAL.pdf

[35] WHO (2020) *State of the World's Nursing Report – 2020,* WHO: Geneva. https://www.who.int/publications-detail-redirect/9789240003279

Health Workforce Development Strategy. Finally, it could be used to better incentivize the retention of health workers by increasing wages and working conditions, supporting further professional development, and improving the attractiveness of the sector to other potential trainees. All the above could be measured and evaluated, to provide useful lessons for practitioners far beyond the migration sector.

While nothing like a Global Skill Partnership currently exists within the health sector, related experience shows that such interventions can be developed. Germany has been cooperating on nursing and eldercare projects with countries of origin for over a decade, many of which included some language and cultural training in the country of origin.[36] The UK has government-to-government health worker agreements with the Philippines and some Indian states, while also promoting health systems strengthening through Health Education England (HEE) and the Tropical Health Education Trust (THET). Israel and Canada bring in care workers, and Japan cooperates with the Philippines to promote health worker migration. In addition, pilots of the Global Skill Partnership model *exist in other sectors*, including in hospitality between Australia and the Pacific Islands,[37] and between Belgium and Morocco in ICT.[38] These pioneers have solved many problems of cooperation, skill recognition, language skill, and several others.

But it is time to get to work. Both the WHO Code and the *Global Compact for Safe, Orderly, and Regular Migration* were carefully built, in exhaustive collaboration with countries of origin, to address real and legitimate concerns they have about the emigration of health professionals and other skilled workers. Global Skill Partnerships are one way among many to do that. Agreements of this type fulfill the requirements of the WHO Code: they help individual health workers move to countries of destination, they increase the number of skilled workers and improve health systems in countries of origin, and they manage migration in an ethical and sustainable way. They deserve to be piloted, tested, appropriately modified, and scaled.

[36] Michael Clemens, Helen Dempster, and Kate Gough (2019) "Maximizing the Shared Benefits of Legal Migration Pathways: Lessons from Germany's Skills Partnerships," CGD Policy Paper 150. Washington, DC: Center for Global Development (CGD). https://www.cgdev.org/publication/maximizing-shared-benefits-legal-migration-pathways

[37] Australia Pacific Training Coalition (APTC) https://www.aptc.edu.au/

[38] Enabel, "Pilot Project Addressing Labour shortages through Innovative labour migration Models (PALIM)," BEL180741T. Brussels: Enabel—Belgian Development Agency. https://open.enabel.be/en/BEL/2337/updates/pilot-project-addressing-labour-shortages-through-innovative-labour-migration-models.html