Countries with Critical Health Workforce Shortages

Options Discussion Paper

Working Group 1

Code Article 5.1: In accordance with the guiding principle 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.*

Background

Adopted in 2010, the WHO Global Code of Practice ("Code") serves as the universal ethical standard with respect to the international recruitment of health workers and the strengthening of health systems. The Code is a voluntary international legal instrument that recommends rather than dictates Member State and relevant stakeholder actions. Of note, as of 2019, Code provisions have been incorporated into law, policy and international agreements in approximately 60 countries.[1]

Strengthening international cooperation between migrant source and destination countries resides at the heart of the Code. The Code places emphasis on supporting and safeguarding the health workforce and health systems of "*developing countries*", "*developing countries, economies in transition, and small island states*", "*countries particularly vulnerable to health workforce shortages and/or countries with limited capacity to implement the recommendations of this Code*", with varying use of terms.[2] In the context of assessing and discouraging active recruitment, specific focus is place on "*developing countries facing* ***critical shortages of health workers***".[3]

The Code does not identify "countries with critical health workforce shortages" or explicitly reference an associated list. Similarly, the Code does not identify "countries particularly vulnerable to health workforce shortages" or "countries with limited capacity to implement the Code". The negotiation of the Code did, however, take place at a moment of substantial

[1] See WHO EAG Background Paper 2

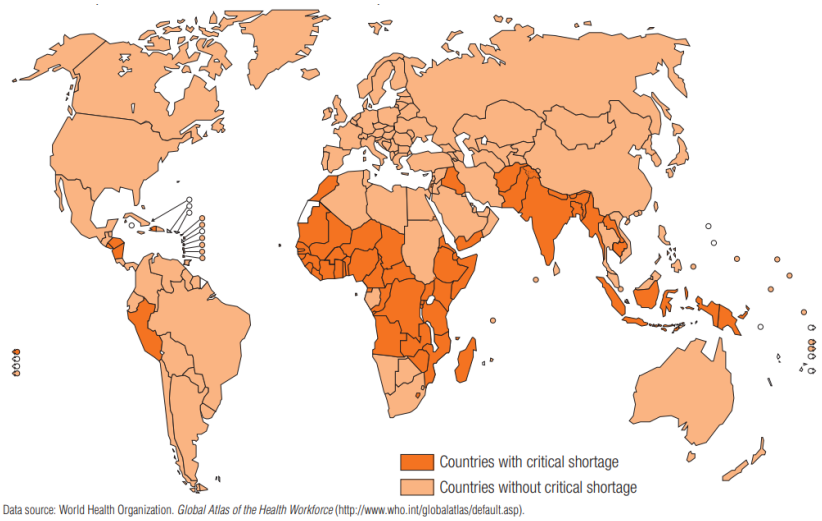
[2] See Code Articles 1.4, 2.3, 3.2, 3.3, 5.2, and 8.7.

[3] See Code Articles 5.1 and 8.7, with Article 10.2 additionally though not exclusively focused on International Organizations, International Donor Agencies, and financial and development institutions providing technical and financial support for the Code implementation and health system strengthening for "developing countries with critical health workforce shortages".

awareness and concern in the World Health Assembly on the health workforce-related situation of 57 crises countries, as made prominent in the World Health Report 2006.[4]

In the 2006 World Health Report, critical shortage countries were defined as those with less than 2.28 doctors, nurses and midwives per 1,000 population. The 2.28 density threshold was estimated in 2006 from the density of doctors, nurses and midwives required to reach a singular service delivery objective: 80% skilled birth attendance. While global monitoring was the primary objective of the density threshold, it has since resulted in important action across countries with respect to health workforce development.

Figure 1. Countries identified as having a "critical shortage" of health workers



Source: WHO (2006) World Health Report

The global community's adoption of the SDG and UHC agendas has given rise to an updated health workforce density threshold. In 2016, the *WHO Global Strategy on Human Resources for Health* (GSHRH)[5] identified an indicative threshold of 4.45 doctors, nurses and midwives per 1,000 population based on a composite SDG index (service coverage across 12 indicators: 5 related to infection diseases, 3 with respect to maternal, newborn and child health, and 4 for non-communicable diseases). Following establishment of the updated need-based density threshold and country commitment to implementation of the GSHRH, health workforce data availability and timeliness has improved substantially (including in the areas of stock, distribution, education, and mobility).

Explicitly linked to Code Article 5.1, the list of countries with critical health workforce shortages has been used, modified and expanded upon by important destination nations, to limit their

[4] See World Health Report 2006, Working Together for Health. Available at https://www.who.int/whr/2006/en/.
[5] See Global Strategy on Human Resources for Health: Workforce 2030. Available at https://www.who.int/hrh/resources/globstrathrh-2030/en/.

active recruitment from relevant countries.[6] In recent years, there have been requests for removal from the list from a few WHO Member States. Some Member States have also expressed concern related to the ineffective role of the Code due to limited protection from active recruitment.

The 2nd Review of Code Relevance and Effectiveness is an important opportunity to review the list of countries with critical shortage. As evidenced and discussed in the first meeting of the Expert Advisory Group, the list of countries with critical health workforce shortages is outdated and the underlying methodology for its calculation requires updating. Perhaps more fundamentally, the review of the list, as part of the 2nd Review of Code Relevance and Effectiveness, presents an opportunity to advance the overarching purpose of the Code, including but not limited to the final sentence of Article 5.1.

The review and revision of the list benefits from an improved evidence base and a strengthened understanding of the dynamics of international health worker mobility. It also presents an opportunity, as called for by the Code and the Global Strategy on Human Resources for Health, to account comprehensively for the multiplicity of factors that influence health workforce development, sustainability and vulnerability.

Methodological Options for List Revision (for Working Group 1 input)

Discussions in the first EAG meeting, internal review by the WHO Secretariat, and input from EAG members has resulted in the following set of options for potential revision of the methods and list of countries with critical shortage. Moreover, the presented options seek to move away from a simplistic dichotomous approach that restricts recruitment from "critical shortage" countries, to one where particularly vulnerable countries are prioritized for health workforce-related support and recruitment-related safeguards.

A description of various approaches, with advantages and disadvantages is presented as follows:

Option O: No change

Description: Maintain the list as it currently exists.

Advantages: 1. Highly limited.

Disadvantages: 1. Data utilized is over fifteen years old 2. Limits analysis of the spectrum of health workers to doctors, nurses and midwives. 3. Methodological limitation with the threshold including link to MDGs and use of data available at the time 3. Is currently compromising Code legitimacy, relevance and effectiveness.

[6] Germany, South Africa, United Kingdom as example.

Option 1: Self-selection

Description: Establishment of a methodology and dynamic approach by WHO to enable countries to opt-in and opt-out of an established list, including potentially occupation by occupation and on sub-regional basis. Countries that self-select to be on the list to benefit from support and safeguards (e.g. the approach to bilateral agreements piloted by Germany B.A and WHO). Able to be applied on its own or in concert with Options 2, 3 and 4.

Advantages: 1. Balances evidentiary and methodological challenges related to country classification.

Disadvantages: 1. Governance process requires further clarification 2. Open question as to whether individual or national perspective will be advanced 3. Result may not be consistent with the Code articles or interest of those seeking to uphold the Code 4. Identification by several WHO EAG members that cross-country comparisons are a core function of international organizations and are required to achieve the full benefits articulated in the Code.

Option 2: Update list based on established density benchmarks

Description: Health workforce density data has improved significantly over the last decade. The list of countries with shortages could be updated based on current densities through the application of benchmark values of 2.28 (published in 2006) and/or 4.45 (published in 2016) doctors, nurses midwifes per 1,000 population. Both values could be used, with countries with less than 4.45 health workers per 1,000 population being identified as relevant for support and safeguards, and countries with less than 2.28 health workers per 1,000 population being identified as requiring additional and special consideration (e.g. extension of WHO-German B.A. cooperation requiring engagement with health stakeholders and health system concerns).

Advantages: 1. Uses established benchmark values already available in existing WHO reports and through WHO governance processes. 2. Takes advantage of significantly improved health workforce stock data 3. Allows prioritization of varying levels of support and protection based upon classification of countries either below 4.45 health workers per 1000 population or below 2.28 health workers per 1000 populations.

Disadvantages: 1. The benchmarks values reflect the underlying workforce densities of the period when computed 2. As recognized in the relevant WHO documents, methodological challenges exist with the computation of these benchmark values, especially rationale for the determination of the proportion of service coverage or SDG index for deriving the workforce density 3. The benchmark values prioritize doctors, midwives, and nurses and would not necessarily be representative of the health workforce situation in countries with strong reliance on other health occupation. 4. The values do not include other relevant health workforce characteristics (e.g. distribution, demographics, production).

Option 3: Use new benchmark values linked to the UHC Service Coverage Index and health workforce density

Description: The UHC Service Coverage Index, composed of 14 tracer indicators, is the official measure for SDG indicator 3.8.1. The 2019 UHC Monitoring Report[7] calculates a UHC SCI index score for all countries. Like previous efforts, updated health workforce density data for doctors, midwives and nurses can be analyzed with respect to country achievement of the UHC SCI. Countries from lower groupings could be targeted to benefit from support and safeguards related to the WHO Global Code.

Advantages: 1. Builds on the methodology of the UHC Index, developed and adopted by five UN agencies 2. Explicitly links WHO Global Code processes to the UHC agenda

Disadvantages: 1. Similar methodological challenges as identified for Option 2, particularly with respect to the determination of benchmark values 2. Limited connection to broader health workforce and health labour market characteristics (e.g. production, demographics, occupations).

Should the above options be found unsatisfactory, the Secretariat could also consider the following forward-looking option to maximize the use of available health workforce data.

Option 4: Classification of countries based on analysis that accounts for core health workforce, health system and health coverage data

Description: Various factors underpin a countries health workforce-related vulnerability. As such, analysis[8] can be conducted across several indicators related to the health workforce (e.g. density across multiple occupations, direction and rate of change in density, distribution, demographics including age and share of foreign-trained/born, and production), health systems (e.g. financing, facility/bed availability), and health service coverage indices (e.g. UHC index). The multi-dimensional analysis would enable the classification of all countries, with identification of five groups based on health workforce-related sustainability and/or vulnerability. The same approach of support and safeguards could be provided to those most vulnerable.

Advantages: 1. The primary advantage is that the classification moves away from an approach that requires the identification of benchmark values. 2. The approach makes full use of available and relevant health workforce data, acknowledging as described in the GSHRH, the need to account for several factors beyond doctors, nurses, and midwifery density to properly capture health workforce challenges. 2. Allows incorporation of data on occupations additional

[7] See Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report, WHO. Available at https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf.

[8] Path analysis is the application of structural equation modelling without latent variables. One of the advantages of path analysis is inclusion of relationships among variables that serve as predictors in one single model.

to doctors, nurses and midwives, as well as and on relevant health systems/coverage indicators 3. No fixed values are used as threshold, classification would be updated regularly and dynamically in line with the progressive availability of health workforce data. 4. Not limited to a list of a few countries, with ability to ensure reflection across all countries with respect to key Code principles, while also identifying countries requiring priority support and safeguards. 5. Essential data requirements and regularity of update would encourage countries to report their data at global level and further improved evidence-based and timely classification.

Disadvantages: 1. Requires additional time and resources for development of the full methodology. 2. Given the sophistication in methodology, requires an appropriate communication and sensitization strategy.