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Ethical Recruitment of Health Workers:

Using bilateral cooperation to fulfil the World Health Organization's Global Code of Practice

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Using bilateral cooperation to fulfil the World Health Organization's Code of Practice

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Introduction

Doctors, midwives, and nurses ('health workers') are moving overseas in large numbers. 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.[1] Many of them left countries that do not have enough health workers to provide critical services. This has raised questions about whether actively facilitating international health worker migration is ethical. On one hand, it may be unethical to promote the movement of people from countries with overburdened health systems. On the other hand, it may be unethical to restrict the migration choice of people, purely because they are health workers. In addition, would blocking their movement even translate into improved health outcomes?

Almost a decade ago, the world gained a clear, universal standard to judge the ethics of facilitating health worker migration. The World Health Organization (WHO) adopted its *Global Code of Practice on the International Recruitment of Health Personnel* in May 2010 ('Code').[2] One sentence of the Code discourages active recruitment from a list of 57 countries where the WHO had identified a "critical shortage" of health workers. This sentence has been interpreted by some to mean that *any* recruitment of health workers from those countries is unethical.

But the Code does not recommend any such ban. In fact, both the WHO, and the researchers who created its definition of "critical shortage", specifically warned that it should *not* be used in this way. For recruitment from these countries to be ethical, it needs to occur under government-to-government agreements that rightly give substantial influence to the Ministry of Health. There may well be settings where health worker recruitment is not in the best interests of the migrant country of origin. But they are best placed to decide whether any specific partnership agreement brings overall benefits that outweigh the costs.

To fulfill the Code, therefore, we should *not* unilaterally ban health worker migration from countries with "critical shortages", but should ensure a seat at the bilateral table for the government officials most affected. This brief begins by reviewing the meaning of the Code and of "critical shortages", and concludes by discussing forms of health worker recruitment that can fulfill both the 2018 Global Compact for Migration and the Code.

What the Code says: In countries with a "critical shortage", only recruit in partnership

The Code does not recommend unilateral bans on cooperation with shortage countries, as long as those countries believe they would benefit from broad forms of bilateral cooperation that include some recruitment. Article 5.1 of the Code states:

> "*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 the above passage has sometimes been interpreted, in isolation from its nuanced context, as recommending a unilateral ban on any recruitment of health workers from "critical shortage" countries. For example, the German Employment Ordinance of 2013 prohibited the active recruitment or private placement of any health workers from those countries.[3]

But this Article, in context, is a call for sensible bilateral cooperation, not unilateral paternalism. It does not state that migrant countries of destination should ban recruitment of any kind from a shortage country, *even if that country has agreed that it would be beneficial in the context of a broader agreement*. What this Article "*discourages*" is unregulated recruitment from shortage countries without an offsetting obligation for the country of destination to "*collaborate … to sustain and promote health human resource development and training*". An absolute ban would prevent even forms of collaboration that the migrant country of origin might desire.

Furthermore, Article 5.1 states that countries should "*discourage*" active recruitment from shortage countries "*in accordance with the guiding principle[s] as stated in Article 3*". Those guiding principles state: "*International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed*" (3.2). That is also true, the Code emphasizes, in shortage countries. In countries "*particularly vulnerable to health workforce shortages*", the Code says, developed countries should "*provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development*" (3.3).

This "*guiding principle*" requires, logically, that migrant countries of origin be able to agree to cooperative, mutually beneficial agreements about recruitment and migration if they wish. If the drafters of the Code intended that no recruitment would occur from shortage countries, then the recommendation of "*technical and financial assistance*" for "*particularly vulnerable*" countries would be out of place. Instead, the "*guiding principles*" for Article 5.1 simply and reasonably state that "*Member States should take the Code into account when developing their national health policies and cooperating with each other*" (3.1).

Therefore, the Code does not ban, and was never intended to ban, shortage countries from engaging in bilateral agreements that would benefit them, simply because one component of those agreements involves health worker mobility of some kind. Categorical bans on such cooperative agreements do not implement the Code, but run counter to it. The Code mentions "*cooperation*", "*collaboration*", and "*bilateral agreements*" 16 times in its slim 12 pages. The Code is clearly not a call for unilateral bans, but for careful and respectful intergovernmental cooperation.

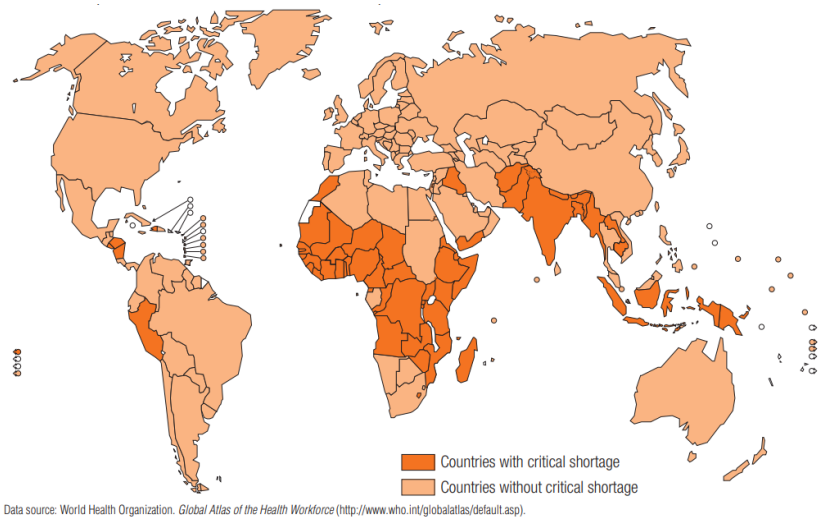
How a "critical shortage" is determined

To understand why the Code's researchers warned against misinterpreting it as a rigid ban on recruitment, we must explore how the countries with 'critical shortages' were identified. . The WHO definition of "critical shortage"—less than 2.28 health workers per thousand population—arises from a simple calculation:

1. Firstly, researchers estimated the positive relationship, on average across all countries, between health worker density and the percentage of births attended by skilled health personnel. Broadly, countries with higher health worker density have a larger fraction of births attended.
2. Secondly, the researchers selected a minimal acceptable level of skilled birth attendance: 80 percent of births.
3. Finally, they found that the average relationship between health worker density and skilled birth attendance means that an average country reaches 80 percent skilled birth attendance level at a health worker density that, with 95 percent statistical confidence, lies somewhere between 2.02 and 2.54. The middle of that range is 2.28.[4]

Based on this definition, in 2006 the WHO's flagship *World Health Report* determined that 57 countries were in "critical shortage" (figure 1).[5]

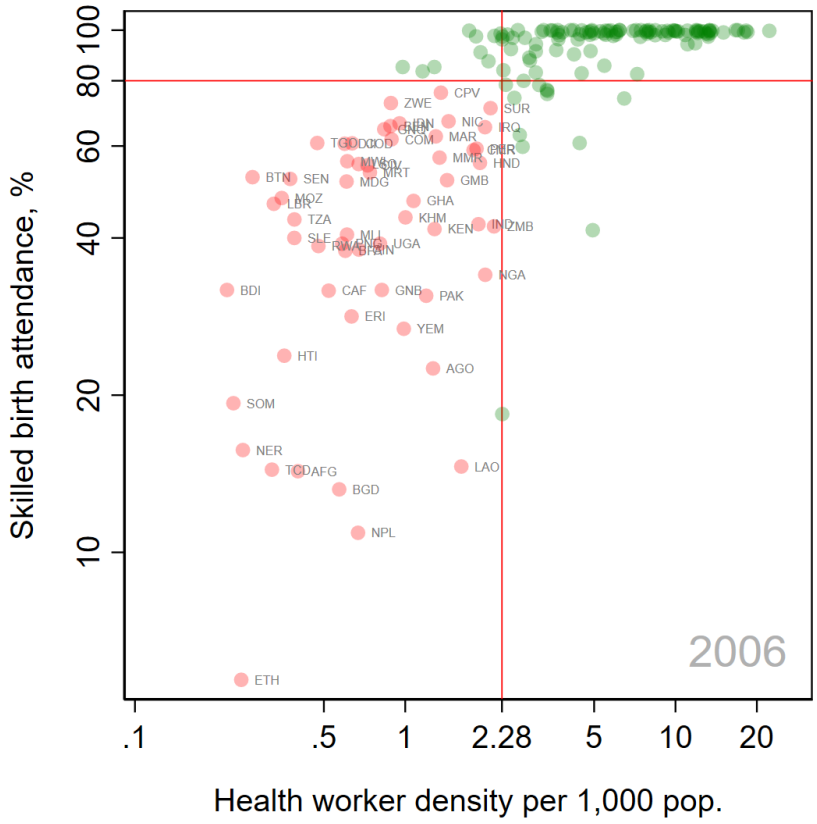
Figure 1. Countries originally designated by the WHO, in 2006, as having a "critical shortage" of health workers



Source: WHO (2006) World Health Report

Figure 2 reconstructs how this list of critical shortage countries was made in 2006. The horizontal axis shows the density of health workers—the number of health workers per population—on a logarithmic scale. 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.[6]

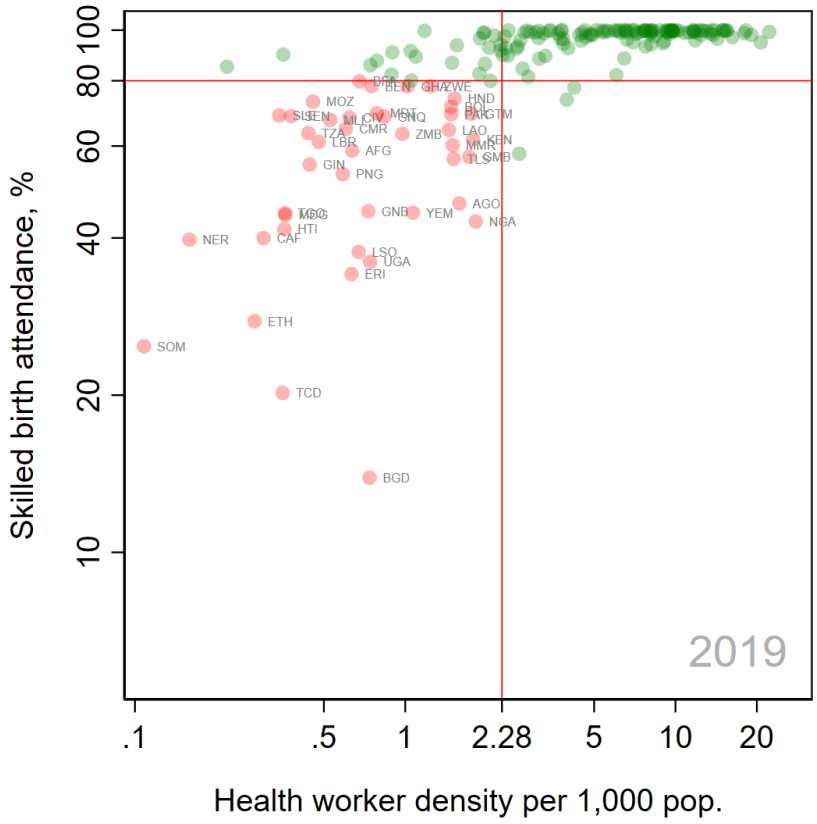
Figure 2. How 57 countries in "critical shortage" (red dots) were identified in the 2006 data



Source: WHO and UNICEF

If we apply the same criteria to today's data, we can identify 43 countries in "critical shortage" (figure 3). Between 2006 and 2019, therefore, the world has seen a great deal of progress. While Ethiopia remains in "critical shortage", it has improved from 6 percent skilled birth attendance in 2006 to 28 percent today. 17 countries that were in critical shortage in 2006 are not there anymore—including India, Morocco, and Indonesia. Three countries, unfortunately, are in critical shortage now but were not in 2006—including Bolivia.[7]

Figure 3. Today, using the same method, 43 countries are in "critical shortage" (red dots)



Source: WHO and UNICEF

Why the Code's designers warned against misinterpreting it as a rigid ban

Both the authors of the "critical shortage" definition used in relation to the 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*."[8] The WHO agreed: "*These estimates … are not a substitute for specific country assessments of sufficiency*."[9]

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 WHO analysis, 14 countries lay within this uncertainty interval.[10]

- **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* which chooses that level as an arbitrary round number to summarize the data in one of its figures.[11] 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 show.[12]

- **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.[13] 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.[14]

- **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.[15] 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 19 percent, Chile 100 percent).

- **There is currently no published evidence that limits on recruitment have affected staffing levels or health outcomes in migrant countries of origin.** Eighteen years ago, the United Kingdom began banning the National Health Service from recruiting health professionals from certain countries deemed to have health worker shortages, using a different definition of 'shortage' than that used by the WHO. Currently the UK list covers 152 countries—almost the entire developing world.[16] 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.[17]

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".

Partnerships to fulfill the Code in vulnerable countries

So what form of recruitment could fulfill the Code in all countries? The Code makes this clear: it is fulfilled by recruitment agreements that require migrant countries of destination "*to collaborate with source countries 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).

That is, recruitment is ethical under the Code in "shortage" countries only if it meets a critical condition: it must be part of an intergovernmental agreement which also includes collaboration with, and assistance to, the country of origin Ministry of Health and other institutions. The net effect of that agreement, in the view of the country of origin, must be that of *strengthening* health systems and personnel development.

How can this happen? One specific form of such an agreement is the Global Skill Partnership model (GSP).[18] 152 countries have endorsed this type of agreement, by name, in the Global Compact for Migration (Objective 18).[19] A GSP 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 gets migrants with precisely the skills they need to integrate and contribute best 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. The model can be applied to health workers certainly, but to other types of workers as well. A well-designed GSP could, for example, support the training of more nurses in a country of origin than the number of nurses recruited to migrate under the agreement.[20]

If this collaboration were sufficient for the country of origin to voluntarily enter the agreement, it would fulfill the Code as an ethical form of recruitment. A GSP could help to strengthen health systems and human resources for health in any migrant-origin country, *especially* countries designated as experiencing critical shortages, *in fulfillment of the Code*.

The great challenge of GSPs is building a new institution representing the interests and abilities of everyone involved. A GSP that fulfills the Code must directly involve the Ministry of Health of the country of origin. Transferring decision-making power is the only way to ensure tangible benefits from such an agreement. Beyond this, a successful GSP requires coordination among several ministries in the country of destination, including ministries of foreign affairs, labor, immigration, and development, as well as labor unions, employees' associations and, crucially, employers. All of this is difficult; in many countries there is no formal mechanism for this kind of coordination, again suggesting a potential role for organizations such as the WHO.

Nothing exactly like a GSP exists currently in the health sector, but related experience shows that these challenges can be overcome. Germany supports the training of nurses in Vietnam for placement into eldercare in Germany.[21] Australia subsidizes the training of hospitality workers in Papua New Guinea with qualifications recognized in Australia. Belgium and Morocco are testing the GSP model in the Information Technology sector.[22] 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 of Practice and the Global Compact for 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, implement the Code as they implement the Global Compact for Migration. They deserve to be piloted, tested, appropriately modified, and scaled.

[1] The fraction of nurses foreign-trained is 7 percent in Western Europe and in the US and Canada collectively; in Australia and New Zealand collectively it is 19 percent. From: OECD (2019), *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, OECD Publishing, Paris, https://doi.org/10.1787/5571ef48-en. Tables 1.3 and 1.4.

[2] WHO (2010), *The WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva: WHO.

[3] OECD (2016), *OECD Health Policy Studies Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places*, Paris: OECD, p. 120.

[4] 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 Chen et al. *op. cit.*

[5] WHO (2006). *World Health Report 2006*. Geneva: WHO. Table 1.3, page 13.

[6] Data sources: 1) Skilled Birth Attendance from: *UNICEF/WHO joint database on SDG 3.1.2 Skilled Attendance at Birth*, https://data.unicef.org/topic/maternal-health/delivery-care/ Accessed Sep. 24, 2019. 2) Skilled health professionals density (per population): Original 2006 data: From *World Health Report 2006*, Annex 4, https://www.who.int/whr/2006/en, Accessed Sep. 24, 2019. Updated data: *Skilled health personnel, Data by country*, 'Last updated: 2018-02-07', https://apps.who.int/gho/data/node.main.HWF10?lang=en Accessed Sep. 24, 2019

[7] The countries in critical shortage in 2006 but not in 2019 are: Bhutan, Burundi, Cambodia, Cape Verde, Comoros, Dem. Rep. of the Congo, Djibouti, India, Indonesia, Iraq, Malawi, Morocco, Nepal, Nicaragua, Peru, Rwanda, and Suriname. The countries in critical shortage in 2019 but not in 2006 are: Bolivia, Guatemala, and Timor-Leste.

[8] Chen L, Evans T, Anand S, Boufford JI, Brown H, Chowdhury M et al. (2004): "Human resources for health: overcoming the crisis." *Lancet*, 364:1984–1990. (http://www.who.int/hrh/documents/JLi_hrh_report.pdf)

[9] WHO 2006 *op. cit.* pages 12–13.

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

[11] Chen et al. *op. cit.*

[12] 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.*

[13] 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) (M.R. Dal Poz, Y. Kinfu, S. Dräger and T. Kunjumen. 2006. "Counting health workers: definitions, data, methods and global results". Background paper for the *Global Health Report 2006*. Geneva: WHO). (http://www.geopsy.com/memoires_theses/counting_health_workers.pdf)

[14] Ummuro Adano. 2008. "The health worker recruitment and deployment process in Kenya: an emergency hiring program". *Human Resources for Health*. 6:19, doi:10.1186/1478-4491-6-19 (http://www.human-resources-health.com/content/6/1/19)

[15] 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. (https://extranet.who.int/iris/restricted/handle/10665/43432)

[16] Buchan, "International Recruitment of Nurses: Policy and Practice in the United Kingdom", (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955378/). Current country ban list: https://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/list-of-developing-countries, accessed Oct. 2, 2019. Two countries on the UK list are only partially banned: certain states of India, and certain health occupations of the Philippines.

[17] See e.g. 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.

[18] Clemens, Michael A. (2015), "Global Skill Partnerships: A proposal for technical training in a mobile world", *IZA Journal of Labor Policy*, 4:2.

[19] The Global Compact for 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*" (Global Compact for Safe, Orderly and Regular Migration, UN General Assembly A/CONF.231/3). 152 countries voted to endorse the Global Compact on December 19, 2018 ("General Assembly Endorses First-Ever Global Compact on Migration, Urging Cooperation among Member States in Protecting Migrants", GA/12113)

[20] Anderson, Michael, Caitlin McKee, and Theodore Talbot. "Investing UK aid in a global skills partnership: Better health at home and abroad." CGD Policy Paper 106. Washington, DC: Center for Global Development (2017).

[21] Michael Clemens , Helen Dempster and Kate Gough, "Maximizing the Shared Benefits of Legal Migration Pathways: Lessons from Germany's Skills Partnerships", CGD Policy Paper 150. Washington, DC: Center for Global Development (2019).

[22] Enabel, "Pilot Project Addressing Labour shortages through Innovative labour migration Models (PALIM)", BEL180741T. Brussels: Enabel—Belgian Development Agency.