World Health Organization

Draft Evidence Brief No. 2

The WHO Global Code of Practice on the International Recruitment of Health Personnel: Reporting, Compliance and Effect (2010-2019)

WHO Health Workforce Department

Prepared for the 2nd Review of Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel

The WHO Global Code of Practice

on the International Recruitment of Health Personnel:

Reporting, Compliance and Effect (2010 -2019)

Abstract

The year 2020 marks the tenth anniversary of the WHO Global Code. This paper summarizes progress related to Code reporting, compliance, and effect. WHO Member States and relevant stakeholders are increasingly aware of and engaged with the Code. Strengthened Member State reporting has contributed to improved global data and information on international health worker mobility. Member States are also increasingly complying with and implementing the Code, with evidence of strengthening legal and behavioral effectiveness. Despite clear areas of success, engagement of a number of countries most in need remains limited. The period forward must seek to broaden and deepen Code effect. The ILO, OECD, WHO International Platform on Health Worker Mobility, through mobilization of additional resources and new partnerships, provides an important avenue to broaden and deepen Code effect.

Background

The international mobility and migration of health workers is accelerating. Over the last decade, the number of migrant doctors and nurses working within OECD countries increased by 60 per cent.[1] The patterns of international health worker migration and mobility are also growing in complexity, with substantial intra-regional, South-South, and North-to-South movement, alongside better understood movement of health workers from the Global South to the Global North.[2] Driven by demographic, economic and epidemiological transitions, future projections point to further acceleration of international health worker mobility.[3]

The need for national action and international cooperation to better manage health worker mobility has risen in importance both within and outside the health sector. Across WHO Member State health systems, improved management of the inflow and outflow of health workers is today intimately tied to the achievement of Universal Health Coverage. Outside the health sector, improved management of international health worker mobility is increasingly viewed as fundamental to achievement of various goals of sustainable development: decent work and employment, inclusive economic growth, safe, orderly and regular migration, and trade.

---

[1] OECD, International Migration Outlook 2015 (2015). Accessed at https://www.oecd-ilibrary.org/social-issues-migration-health/international-migration-outlook-2015_migr_outlook-2015-en

[2] World Health Organization, "A dynamic understanding of health worker migration." (2017). Accessed at http://www.who.int/hrh/HWF17002_Brochure.pdf.

[3] Liu et al, Global Health Workforce Labour Projections for 2030, Human Resources for Health, 2017. Available at https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0187-2.

In 2010, WHO Member States unanimously adopted the WHO Global Code of Practice on Practice on the International Recruitment of Health Personnel ("WHO Global Code") to advance coherent action and cooperation with respect to international health worker mobility (WHA 63.16). Upon its adoption the WHO Director-General hailed the WHO Global Code as "a real gift to public health everywhere.[4]"

The WHO Global Code is the broadest articulation of the ethical principles and practices to better manage international health worker mobility. The WHO Global Code's substantive articles call for national action and international cooperation with respect to ensuring ethical recruitment practices and rights of migrant health workers (Article 4), to support health workforce development and sustainability (Article 5), to strengthen data gathering and research (Article 6), and to support information exchange (Article 7). the Code provides special attention to the health systems of developing countries, economies in transition and of small island states. In addition to its substantive articles, the WHO Global Code contains a strong monitoring process, including both a reporting and review process (Articles 7, 8, and 9).

The WHO Global Code is not binding on WHO Member States. The WHO Global Code does however contain a robust implementation, monitoring and effectiveness review mechanism. It is worth emphasizing that such mechanisms are rare in binding international agreements and, until recently, highly uncommon in non-binding international agreements.[5] With respect to the former, a review of 10 multilateral environmental agreements[6] identified that over half did not have either an implementation or effectiveness review mechanism.[7] Alongside the Codex Alimentarius, the WHO Framework Convention on Tobacco Control, the International Code of Marketing of Breast Milk Substitutes, and the International Health Regulations, the WHO Global Code is one of a handful of international legal instruments under the stewardship of WHO. As such, the WHO Legal Office submits regular reports on Code developments to the annual UN Juridical Review.

The year 2020 marks the ten-year anniversary of the WHO Global Code. Building on the WHO Global Code's monitoring process and to contribute to its review process, this paper outlines the progress made with respect to reporting, compliance and effectiveness of the WHO Global Code.

Methods

[4] Taylor et al, The WHO Global Code of Practice on the International Recruitment of Health Personnel: The Evolution of Global Health Diplomacy, Georgetown University Law Center, 2011. Available at https://pdfs.semanticscholar.org/a869/0b339749389e49c4c2c24b720e826b1a81bf.pdf.

[5] Recent adoption of both the Paris Agreement on Climate Change and the Global Compact on Safe, Orderly and Regular Migration evidence the value of non-binding international agreements with strong implementation and monitoring mechanisms.

[6] MEAs reviewed include: Ramsar Convention of Wetlands, World Heritage Convention, Convention on the International Trade in Endangered Species, Convention on Migratory Species, Law of the Sea Convention, Montreal Protocol, Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal, Framework Convention on Climate Change and the Kyoto Protocol, Convention of Biological Diversity, and the Convention to Combat Desertification.

[7] Raustiala, K, Reporting and Review Institutions in 10 Multilateral Environmental Agreements, United Nations Environment Program, 2001. Available at https://www.peacepalacelibrary.nl/ebooks/files/C08-0025-Raustiala-Reporting.pdf.

Process

This paper consolidates information received across three rounds of national reporting on the WHO Global Code: 1st round (2012-2013), 2nd round (2015-2016), and 3rd round (2018-2019).

Following a review by Member States and Regional Offices, the National Reporting Instrument (NRI), a national self-assessment reporting tool on the implementation of the Code, was updated in 2018 to reduce the reporting burden on Member State governments while maintaining consistency with previous iterations. Data elements were harmonized with the system of National Health Workforce Accounts, as recommended by the World Health Assembly in resolution WHA69.19(2016).

Time-series analysis is presented across the three rounds in selected areas of Code implementation, with emphasis provided to the 2nd and 3rd rounds.

While non-state actors are fundamental to implementation and effectiveness of the WHO Global Code, this brief focuses primarily on Member State actions. Complementary briefs are being produced to fully capture practice and perspectives from relevant stakeholders, including synthesis of 14 Independent Stakeholder reports submitted during the 3rd round of Code reporting.

Theory

Assessing the effectiveness of international agreements is a priority concern for international legal scholarship and practice. This is an area where there has been tremendous scholarship and contestation, with philosophical and methodological challenges across varying approaches.

This paper will consider both the legal and behavioral effectiveness of the WHO Global Code, while cognizant of the interaction between the two.[8] Legal Effectiveness can be understood as the extent to which Member State behavior conforms with Code principles and recommendations, with national reporting utilized as a key indicator of compliance. Behavioral effectiveness, harder to assess, seeks to identify the extent to which Codes has resulted in an observable, desired change in Member State behavior. In this respect, Member State efforts to implement Code norms into practice (e.g. dissemination, legislative action, policy and institutional reform, and incorporation into international agreements) are taken into consideration.

Moreover, the analysis provided in this brief adopts a normative understanding of why Member States comply and implement international commitments. Under such understanding, it is the legitimacy of the rules and an ***iterative process of discourse*** between the parties, treaty organization, and the wider public – not incentives or sanctions - that is fundamental to the incorporation of international norms into domestic practice.[9] Moreover, under such an understanding, an international instrument is not simply viewed as a list of norms but a mechanism through which international cooperation can be advanced; transparency fostered; transaction costs lowered; collective learning captured; and where certain actions are legitimized while other delegitimized.[10] Lack of compliance and effectiveness is in

[8] Taylor, A., Legal Definitions of Effectiveness, as prepared for the 1st Review of the Code
[9] Raustiala, K., Compliance & Effectiveness in International Regulatory Cooperation, Case Western Journal of International Law, Vol 32, No. 421, 2000.
[10] Id.

turn linked to inadequate administrative, technical or financial capacity, ambiguity and terms, and a time lag between undertaking and performance.[11]

Results

Three rounds of national reporting (2010-2019) evidence strengthening legal and behavioral effectiveness of the WHO Global Code. WHO Member States, across the six WHO Regions, are increasingly engaging with and reporting on implementation of the WHO Global Code. Evidence on international health worker mobility has strengthened considerably. Member States are also increasingly reporting implementation of the WHO Global Code, incorporation of Code principles and recommendations into national legislation and policies, as well as in international agreements.

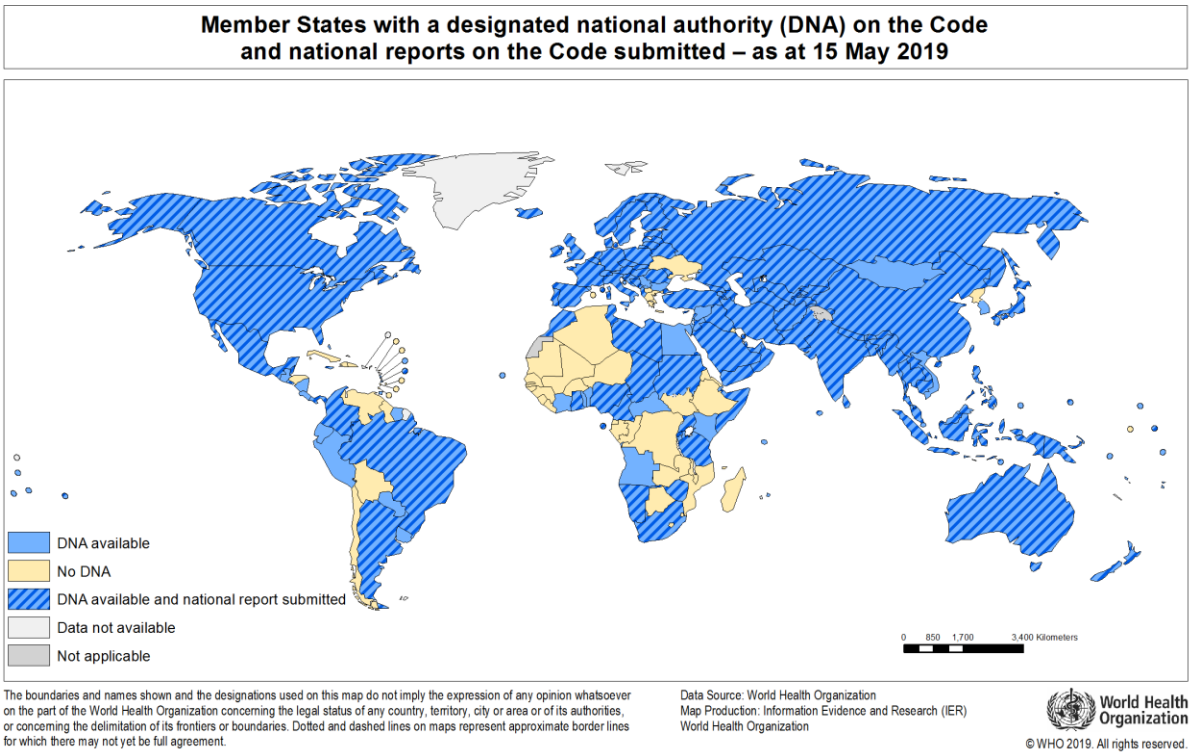
Legal Effectiveness

The designation of a national authority to support exchange of information and Code implementation is a critical first step towards Code compliance and implementation (Article 7.3). As of May 2019, **three-quarters of WHO Member States** (146 out of 194) have designated a national authority to exchange information and support Code implementation. Twenty-nine Member States did so for the first time in 2019.

Furthermore, **110 of all 194 WHO Member States,** have now submitted a complete national report to the Secretariat (Article 7.2) (See Figure 1). These Member States represent over 80% of the world population. As comparison, this figure is higher than that for the set of binding Multilateral Environmental Agreements reviewed, with most MEAs evidencing (when available) less than 50% reporting **by ratifying parties**.[12] In contrast, WHO's Framework Convention on Tobacco Control has been widely recognized as one of the most rapidly embraced and successful international treaties in the UN system. In 2018, for the very first time all 181 Parties to the Convention had formally submitted at least one implementation report.

[11] Id.
[12] Supra note 7.

Figure 1. Member State DNAs and National Reports, as at May 2019



The quantity and diversity of national reporting has improved consistently across the three rounds of Code reporting. In striking contrast to the first round, the third round of Code reporting saw strong reporting in three of WHO's six regions. Despite clear progress, national reporting remains constrained in some of the regions and sub-regions where the challenges from international health worker mobility are most pronounced (See Table 1). Twenty-nine Member States submitted national reports across all three round of Code reporting.

Table1. National reports submitted to the Secretariat, by WHO region

	National Reports, 1st Round (2012-2013)	**National Reports, 2rd Round (2015-2016)**	**National Reports, 3nd round (2018-2019)**
AFRO (47 MS)	2	9	7
AMRO (35 MS)	4	9	8
SEARO (11 MS)	3	6	9
EURO (53 MS)	40	31	31
EMRO (21 MS)	3	7	15
WPRO (27 MS)	4	12	10
Total Count	**56**	**74**	**80**

The quality of national reports has also strengthened over the last nine years. Improvements are evident in both the data and information provided to the Secretariat.

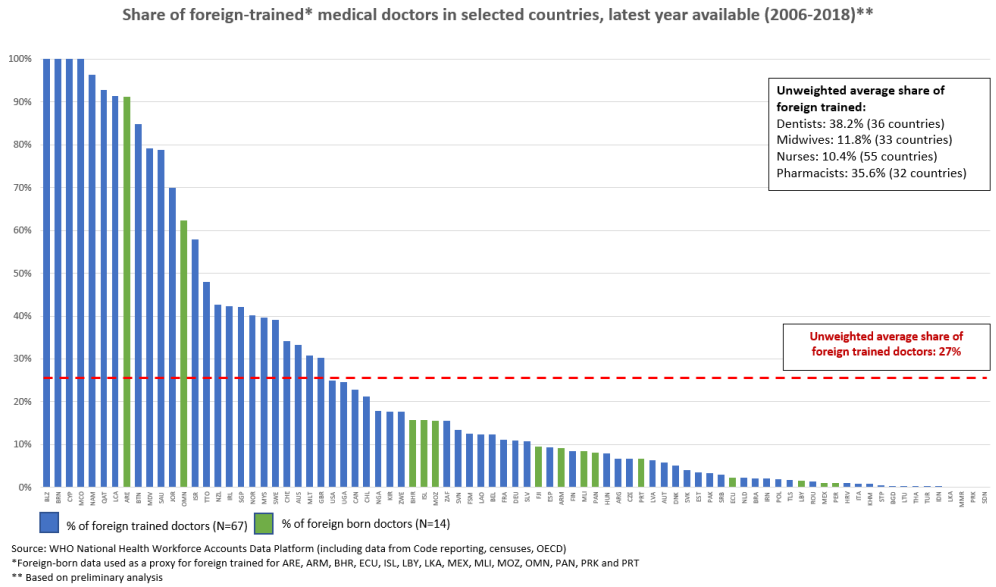
The negotiation of the WHO Global Code was hindered due a paucity of data on international health worker mobility. As such, strengthening national and global evidence on international health worker mobility was included as a core substantive (Article 6) and procedural (Articles 7 and 9) element of the Code. Improvements in Code reporting, particularly evident during the 3rd round, have considerably strengthened global data on international health worker mobility (See Table 2).

Table 2. Member State reporting on the share of foreign-trained/ foreign-born health workers, as at May 2019.

	National Reports, 1st Round (2012-2013)	**National Reports, 2rd Round (2015-2016))**	**National Reports, 3nd round (2018-2019)**
Physicians	0	24	51
Nurses	0	13	44
Midwifery	0	0	36
Dentists	0	0	40
Pharmacists	0	0	38

Improvements in data reporting via the Code has enabled further consolidation and triangulation through the system of National Health Workforce Accounts. For the first time a global picture of international health worker mobility is available, with information for over 80 countries and across five major health professions: dentists, midwives, nurses, pharmacists and physicians (See Figure 3). Foreign-born data is utilized when foreign-trained is not available.

Figure 2. Share of Foreign-trained and/or Foreign-born health medical doctors in select WHO Member States, latest year available, as at May 2019



Source: WHO National Health Workforce Accounts Data Platform (including data from Code reporting, censuses, OECD)
*Foreign-born data used as a proxy for foreign trained for ARE, ARM, BHR, ECU, ISL, LBY, LKA, MEX, MLI, MOZ, OMN, PAN, PRK and PRT
** Based on preliminary analysis

Based on preliminary analysis, the evidence suggests substantial reliance on foreign-trained health workers across countries of varying income classification and health professions. Disaggregated data provided via Code reporting further evidences complex patterns of international mobility that vary by country and profession. The data suggests that a simplistic binary narrative of source/destination or sending/receiving country is outdated. It also emphasizes the importance of enacting policies across countries to better manage both the in-flow and out-flow of health workers.

Alongside improving information on data (Article 6), information on the development of bilateral agreements (Objective 3), information on responsibilities, rights and recruitment practices (Article 4), health workforce development and health system sustainability (Article 5) have also strengthened. As illustration, **120 separate bilateral agreements** were notified to the Secretariat during the 2nd and 3rd round of national reporting, with 30 texts of agreements made available. The WHO secretariat is in the process of analyzing and preparing guidance with respect to health worker mobility-related bilateral agreements.

Approximately 90% of Member States who reported during the second and third round, identified that they had taken measure to education, retain and sustain their health workforce as called for by the Code (Article 5.3). A similarly high proportion identified respecting labour rights of migrant health workers (Article 4.%). The general nature and applicability of these recommendations are likely a significant contributing factor to the high compliance reported.

Considered together, the analysis above suggests legal effectiveness of the WHO Global Code with respect to a large proportion of the 110 Member States that provided national reports, albeit to varying degrees.

Behavioural Effectiveness

The assessment of behavioral effectiveness for international agreements is a more challenging endeavor than that for legal effectiveness. A causal relationship or pathway between the suggested rule and the observed, desired behaviour is required for the assessment of the former.

The robust implementation and monitoring arrangements contained in the WHO Global Code, complemented by improved Member State reporting during the 2nd and 3rd rounds, allows for an assessment of behavioral effectiveness. Article 8 of the WHO Global Code is particularly useful as it suggests a set of practical measures to help translate Code principles and recommendations into desired behavior (See Box 1).

Box 1. Select Code Implementation Measures (Article 8)

Member States are encouraged to:
8.1: Publicize the Code
8.2: Incorporate the Code into law and policy
8.3: Consult all relevant stakeholders

8.5: Maintain a record of all recruiters authorized to operate within jurisdiction

8.6: Encourage good practice by only using agencies that comply with Code general principles

8.7: Observe and assess magnitude of active international recruitment of health personnel from countries facing critical shortages

Article 8.1: Over thirty countries have reported taking steps to publicize the Code in each of the three rounds of reporting: thirty-one in round 1, thirty-nine in round 2, and thirty-nine in round 3. In addition to the 6 UN languages, the Code has been translated into Catalan, Dutch, Farsi, Finish, German, Hungarian, Indonesian, Italian, Japanese, Polish, Romanian, and Thai.

Article 8.2: Forty WHO Member States identified the incorporation of the Code **into national law and policy** as part of the last two rounds of national reporting.[13] Four additional WHO Member State pointed to ongoing or envisaged policy development.[14]

These active Member State measures taken include incorporation of Code recommendations into national law (e.g. Bahrain, El Salvador, Indonesia, Germany); into National Strategic Plans (e.g. Bangladesh, Cameroon, Dominican Republic, eSwatini, Ireland, Jordan, Myanmar, Sierra Leon, South Africa); in the development and/or incorporation into recruitment and migration polices (e.g. Canada – Saskatchewan Code, Finland, Sudan, South Africa, Switzerland, Trinidad and Tobago, UK - England and Scotland Codes); and the creation of new administrative and coordination functions (e.g. Nigeria, Norway, South Africa, Sudan, USA).

Moreover, forty-four Member States also identified incorporation of Code principles in relevant bilateral agreements related to health worker mobility (e.g. Germany, Ireland, Saudi Arabia, Sudan, Philippines).

In sum, over the last two rounds, **sixty-eight WHO Member** States identified incorporation of the Code into law and policy, at national and international levels.

Article 8.3: Member State engagement of relevant stakeholders has increased markedly over the three round of Code reporting. Fifteen countries reported engaging stakeholders in the first round. The numbers increased substantially in the second and third rounds: with 27 and 34 respectively. Canada, Indonesia, Norway, and the United States each provide positive examples of engagement with stakeholders.

Article 8.5: The number of Member States that maintain a record of all recruiters authorized to operate within their jurisdiction similarly grew from 15 during the 1st round, to 27 during the second round, and to 34 during the third round.

[13] Australia, Austria, Bahrain, Bangladesh, Belgium, Cameroon, Canada, Dominica, El Salvador, eSwatini, Finland, Germany, Indonesia, Iraq, Ireland, Jordan, Latvia, Malta, Moldova, Myanmar, Namibia, Nigeria, Norway, Oman, Panama, Philippines, Qatar, Saudi Arabia, Sierra Leone, Slovakia, Slovenia, South Africa, Spain, Sudan, Sweden, Switzerland, Trinidad and Tobago, UAE, United Kingdom, and USA.

[14] India, Moldova, Uganda, and Zimbabwe

Article 8.6: Member State limiting utilization of recruitment agencies to only those that comply with the guiding principles of the Code showed the biggest increase between the 2nd and 3rd rounds. The first and second rounds of national reporting saw 10 and 13 Member States, respectively, implementing such practice. The figure jumped dramatically in the third round where 28 Member States identified only utilizing recruitment agencies that comply with the Code. The UK reported example of monthly review of recruitment agency lists and regular audits of recruitment agencies to ensure compliance with the WHO Global Code and England/Scotland Code's is an important practice.

Article 8.7: Limited information was shared by Member States on the magnitude of recruitment from countries with critical shortages or the impact of circular migration. Secretariat review and relevant stakeholder reporting are important mechanisms to fill this gap.

There is, of course, synergy across the various implementation steps identified above. The following example from Indonesia speaks to the value of continuous engagement with and implementation of the Code (See Box 2)

Box 2. Continuity of Code Implementation: Indonesia

2012: Ministry of Health translated the Code into Bhasa Indonesian, held public hearing and distributed translated text across relevant Ministries: Ministry of Manpower, Ministry of Trade, National Board for the Placement and Protection of Overseas Indonesian Workers, Indonesian Medical Council, Directorate of Referral Health Services, and the private agency for Indonesian Overseas Placement.

2013: Code recommendations adopted into MoH Regulation on Utilization of Foreign Health Workers (No. 67/2013 and No. 27/2015) adopted in national Adoption Continued dissemination at Central Level. Adoption of regulation included potential to engage in the development of bilateral agreements. Code incorporated in Economic Partnership Agreement between Japan and Indonesia, including support through JICA for nurse education in Indonesia. Code benefits promoted in ASEAN and regional discussions.

2014: Code distributed at provincial levels, with expectation that "all relevant stakeholders adopt Code principles."

2015: National Report Compiled and submitted to WHO.

2016: Code distributed at Central Level.

2017: Compilation of country information initiated.

2018: National report submitted to WHO. Code promoted in discussion on the Global Compact on Safe, Orderly and Regular Migration.

The evidence consolidated above suggests an observable, desired change in behavior across a substantial number of Member States, attributable at least partly to the WHO Global Code.

The impact from the observed and desired changes in behaviour is likely to vary considerably across countries and needs further examination. There is also significant potential to ensure deeper penetration of national law and policy through closer interaction with other international actors and non-state stakeholders.

International and Non-State Actors: Awareness, Code Implementation, Iterative Discourse

There is widespread and growing recognition of the WHO Global Code of Practice amongst international institutions, civil society, and academia.

At the UN level, the UN High Level Commission on Health Employment and Economic Growth identified the WHO Global Code as a key global governance instrument for health worker mobility, with a call to further support to its implementation through establishment of the *International Platform on Health Worker Mobility*. Establish of the International Platform on Health Worker Mobility has, in turn, significantly expanded the Secretariat's discourse with both Member States, other International Agencies (IOM, World Bank, WTO) and civil society organizations, including representatives from trade unions, employers' associations, national regulatory bodies, and international credential verification agencies.[15]

The importance of the WHO Global Code and health workforce density and distribution data to the broader migration agenda was further emphasized in the UN Secretary-General's Report on International Migration and Development (A/RES/71/159).

The European Union's Global Approach to Migration and Mobility (GAMM), the EU's overarching extra-EU migration policy, explicitly recognizes that support to the Code is important to mitigating brain drain and the role of the Code in facilitating legal migration and mobility and to maximizing its' development impact of migration and mobility. Incorporation of the WHO Global Code in the EU GAMM enabled support to the EU Brain Drain Project. This in turn enabled WHO to provide country-level Code implementation support to five countries[16]. Support from the EC has been fundamentally important to strengthening the Secretariat's administrative, technical, and financial capacity to support Code implementation and effect. With the WHO Framework Convention on Tobacco Control as the goal standard, it should be recognized that Secretarial capacity to fully support Code implementation across the countries requesting support remains relatively constrained.[17]

The EPSU – HOSPEEM Code of Conduct and the Alliance Code for Ethical International Recruitment Practices, targeted respectively to employers/trade unions and private recruitment agencies, both explicitly link to the WHO Global Code. There is substantial opportunity to further advance complementarity between a largely Member State-led process and ethical processes that are employer, health worker, and recruiter-oriented.

The Health Workers for All Coalition, with WEMOS as its secretariat, is additionally playing a fundamentally important role in advancing Code dissemination and implementation, including targeted support to national and non-sate actors in both European and Developing countries.

[15] See https://www.who.int/hrh/migration/platform-meeting-h-w-mobility/en/.
[16] India, Ireland, Nigeria, South Africa and Uganda
[17] The FCTC is supported by both a WHO Secretariat and the Tobacco Free Initiative, with the annual budget for the two approximately USD 20 million. The secretariat for the WHO Global

Since its adoption, the WHO Global Code had diffused widely in academia. A Google Scholar citations search, with the chrome extension "Scholar H-Index Calculator for Google Chrome", was conducted for the key words "WHA56.1" (WHO Framework Convention on Tobacco Control, 2005), "WHA 34.22" (WHO/UNICEF International Code of Marketing of Breast Milk Substitutes, 1981), and for "WHA 63.16" (WHO Global Code of Practice on the International Recruitment of Health Personnel, 2010): 11,435 citations were retrieved for FCTC, 2005; 4,081 citations were retrieved for the Breastmilk Substitutes Code, 1981; and 4,031 citations were retrieved for the WHO Global Code, 2010. The academic diffusion of the WHO Global Code thus compares favorably with two well recognized WHO-stewarded international instruments.[18]

Conclusion

The WHO Global Code of Practice has matured over the last nine years. WHO Member States and relevant stakeholders are increasingly aware of and engaging with the instrument. Strengthened Member State reporting on the WHO Global Code has contributed to improved global data and information on international health worker mobility. Member States are also increasingly complying with and implementing the Code, with evidence of both legal and behavioral effectiveness across several countries.

At the same time, the accelerating volume and growing complexity of health worker mobility is challenging national health systems. Many of the countries most affected are the least engaged with the WHO Global Code. It is an imperative to broaden and deepen Code implementation and effectiveness. The ILO, OECD, WHO International Platform on Health Worker Mobility provides an important avenue to mobilize both the resources and partnerships required to further strengthen the Code's relevance and effectiveness.

[18] Two recent books with focus on the WHO Global Code have also been published recently: 1. Richter, J "Soft Law in International Health Law – the Case of the WHO's Global Code of Practice on the International Recruitment of Health Personnel", 2018, and Yates and Pillinger, "International Health Worker Migration and Recruitment", 2019.