

## **Draft Evidence Brief No. 1**

# **Situating the WHO Global Code of Practice: looking back, looking forwards.**

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

*DRAFT WHO Evidence Brief prepared for WHO Expert Advisory Group meeting: The second review of relevance and effectiveness of the WHO Global code of Practice on the International Recruitment of Health Personnel. 18-20 June 2019. WHO: Geneva.*

## **Situating the WHO Global Code of Practice: looking back, looking forwards.**

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12<sup>th</sup> June 2019

**Abstract:** The conclusion of the WHO 2010 Global Code of Practice on the Ethical Recruitment of Health Personnel was a milestone in the history of international initiatives to realise universal health coverage. This Policy Brief situates the Global Code in the context of previous global policy initiatives by WHO and other policy actors to promote ethical health worker migration and recruitment. It highlights how the Global Code differed from previous and parallel initiatives and why it was so significant at the time of its conclusion. The Brief also 'looks forward' from 2010 to the present day. It assesses the changing contexts of the implementation of the WHO Global Code and the recent global initiatives bearing on it. Notable among these are the Sustainable Development Goals and UN Global Compact migration. We discuss the potential, opportunities and challenges arising from the Global Code's first decade in terms of realising universal health coverage and the health SDGs, and identify first-order priorities for action for the Global Code during the 2020s.

### Methodology

The data underpinning this Policy Brief is derived from a systematic search of official literatures of international organisations and academic research literatures. The full data is published as Nicola Yeates and Jane Pillinger (2019) *International Health Worker Migration and Recruitment: global governance, politics and policy* (Routledge).

## 1. Introduction

This Policy Brief provides a brief review of global governance relating to international health worker-migration and -recruitment. It contextualises the WHO Global Code in relation to historical and contemporary policy developments dating back to some of the earliest global initiatives in the 1950s onwards, and up to recent developments emanating from emerging new forms of global governance following the agreement for the 2030 Sustainable Development Agenda. It finishes by pointing the way forward for global governance priorities during the 2020s to which the WHO Global Code must comprehensively respond. These priorities are underpinned by a commitment to health systems sustainability, that is capable of tackling unequal development and inequalities in health between richer and poorer nations as a pre-condition for fair migration, ethical recruitment and for the achievement of ambitious goals in health, including universal health coverage (UHC).

The Policy Brief is organized around four principal sections. Section 2 outlines international governance initiatives on health worker migration and recruitment from a historical perspective, since the foundation of the UN. Section 3 highlights the strengths of the WHO Global Code in relation to knowledge and evidence from other international governance agreements regarding what works well. The discussion then identifies some key challenges for the WHO Global Code (section 4), before turning to how recent global initiatives since 2010 are bearing on the global debate about the future directions of the Global Code in the 2020s (section 5). Section 6 sets out some conclusions and recommendations.

## 2. A brief history of international governance initiatives on skilled health worker migration and recruitment: trends and actions underway up to 2010

The WHO Global Code on the Ethical Recruitment of Health Personnel (hereafter, WHO Global Code) was a milestone in a long series of international initiatives dating back to the earliest days of the UN to regulate the international recruitment of skilled health workers in the interests of universal health and social protection. Table 1 sets out a summary timeline of principal selected initiatives since 1948.

### **Box 1 Principal international governance initiatives with a bearing on health worker-migration and -recruitment, 1948-2010**

#### **WHO**

1968 Study of the Criteria for assessing the Equivalence of Medical Degrees in Different Countries (WHA21.35)

1969 Training of Medical Personnel and the “Brain Drain” (WHA22.51)

1979 Mejia et al. study on physician and nurse migration

2004 International migration of health personnel: a challenge for health systems in developing countries (WHA57.19)  
2006 International migration of health personnel: a challenge for health systems in developing countries (WHA59.18)  
2010 WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA63.16)

### **United Nations**

1948 Universal Declaration on Human Rights  
1990 International Convention for the Protection of the Rights of All Migrant workers and Members of their Families

### **ILO**

1949 Migration for Employment Recommendation (Revised) (R086)  
1952 Social Security (Minimum Standards) Convention (C102)  
1958 Discrimination (Employment and Occupation) Convention (C111)  
1962 Equality of Treatment (Social Security) Convention (C118)  
1975 Migrant Workers (Supplementary Provisions) Convention (C143)  
1975 Migrant Workers Recommendation (R151)  
1977 Nursing Personnel Convention (C149)  
1977 Nursing Personnel Recommendation (R157)  
1997 Private Employment Agencies Convention (C181)  
1997 Private Employment Agencies Recommendation (R188)  
1998 ILO Declaration on Fundamental Principles and Rights at Work (R188)  
1997 ILO Tripartite Declaration of Principles concerning Multinational Enterprises & Social Policy  
2005 ILO Multilateral Framework on Labour Migration: Non-binding principles and guidelines for a rights-based approach to labour migration

Source: compiled by the authors

The impetus for such UN action arose during the construction of a post-war international liberal economic and social order, to which the freedom to emigrate was a central principle. ILO's Convention on Migration for Employment (1949) was a key instrument embodying this principle, which was followed through in further ILO social policy instruments in the 1950s and 1960s, copper-fastening the principle of equal treatment and non-discrimination on the basis of national origin in a wide range of employment and social security matters.

These early global initiatives encountered the long-term legacies of uneven development internationally, including in relation to health services. In the 1950s WHO medical Fellowships scheme revealed the extent to which severe health sector staff shortages were entangled with international migration dynamics as well as with the uneven distribution of

medical education facilities worldwide. The First UN Development Decade (1960-1969) was an opportunity to highlight the complex relationship between the development of skilled workforces (whether 'at home' or abroad), labour conditions in source countries, international migration and wider economic development. This developmentalist framing of the issues enabled the elaboration of global policy approaches to health worker recruitment and migration that were squarely aimed at redressing the economic and social costs to source countries of the systemic depletion of their national development resources and their transfer to richer countries without corresponding developing gains 'at home'. Many of the ideas we see in today's global policy debate were in fact developed at this time. The dominant concept was 'brain drain' (or, as UNCTAD framed it, 'reverse transfer of technology') and it underpinned international governance initiatives by UNESCO, UNCTAD and ILO at this time. A key focus of UN initiatives was capacity-building for developing countries so that they could educate and train sufficient numbers of their own health personnel.

It was not until the late 1960s however that WHO started to engage with the issue of severe health and medical labour shortages. One strand of this involved enhancing the comparability (equivalence) of medical curricula and qualifications internationally so that domestically-trained health personnel could move more freely internationally to practise. A second strand of WHO work took the form of a comprehensive study of international migration among health personnel (Mejia *et al.* 1979). This set the first international baseline and synthesised key international dynamics. Notably, it highlighted disjunctures between global human rights, equality and development objectives, and the lack of a coherent global governance to realise these. However, the recommendations for action were not addressed to major recruiting countries; rather, they highlighted the need for better health workforce planning, management and retention strategies principally in source countries.

The principal locus of international governance initiatives on health worker recruitment and migration throughout the 1970s was at ILO. Its wide-ranging actions on gender equality, employment and international migration shaped health sector-specific actions, in particular the first multilateral instrument on international health worker migration: ILO Nursing Personnel Recommendation (1977) (Box 2). This brought together various UN principles developed over the decades into a single framework and reaffirmed the longest-held UN principle that international migration should be voluntary and freely chosen.

## **Box 2: ILO Nursing Personnel Recommendation (R157): recruitment and migration principles**

The Recommendation:

- acknowledged the positive impacts of organised exchanges of nursing personnel for professional development;
- promoted initiatives on mutual recognition of qualifications; and
- affirmed ILO international labour standards in respect of nursing personnel exchanges and migration.

The ILO migration framework that set out the need to avoid adverse human and wider social consequences of excessive or uncontrolled increases in international migration (ILO 1976) was applied as the principle that countries '*should not rely on overseas nursing personnel to staff their health services.*' Article 67 set out two conditions under which international recruitment *would* be permissible:

- if there is a lack of qualified personnel for the posts to be filled in the country of employment, and/or
- if there is no shortage of nursing personnel with the qualifications sought in the source country.

The Recommendation's conditions under which recruitment could occur were *more* stringent than those set out in the WHO Global Code, which simply referred to the avoidance of recruitment from countries suffering from serious health personnel shortages. The ILO Recommendation also inscribed a conditional element into the principle of international migration, namely Article 64.2 stipulates that financial aid provided to nursing personnel for education or training abroad 'may be made dependent on an undertaking to return to their country within a reasonable time and to work there for a specified minimum period'. This reflected thinking that temporary periods of professional development overseas all-too-often turned into permanent emigration. Lamentably, the implementation of the ILO Nursing Personnel Recommendation (or its recruitment and migration provisions) was not monitored by ILO.

Three decades elapsed before further positive international governance initiatives on international health worker-migration and -recruitment instituted. The context for initiatives during the 2000s was markedly different from the 19760s and 1970s, but a principal spur to a new global agreement was the Millennium Development Goals and the increasing activity

by the UN in elaborating an international governance framework on international migration. These wider pressures conditioned the work of WHO in this area during the first decade of the 2000s. Calls for action were thus borne of a combination of sector-specific and more general developments, which raised the issue as a priority matter for the WHO to address through a new global agreement at that time. WHO was helped in this by being able to build on a raft of voluntary ethical recruitment codes and frameworks that were broadly concerned with the conditions under which overseas-trained health workers could be recruited (Yeates and Pillinger 2019). These initiatives were instituted by major recruiting countries in higher-income countries and negotiated outside of the UN system. Voluntary 'ethical' codes of practice developed through multi-stakeholder negotiations have been one route where 'the voices of employers, recruiters, unions, and migrants themselves' have been involved (PSI 2012: 2). During the course of the decade, the major trend was the multilateralization of unilateral initiatives - increasingly becoming multilateral ones involving an ever-greater number of signatory governments and culminating in the WHO Global Code (2010).

Despite the limitations of ethical recruitment initiatives (Willems and Martineau 2004, Yeates and Pillinger 2013, Bourgeault et al. 2016) they were important stepping stones towards a Global Code of Practice that *all* WHO member states could support. They helped kickstart a 'new' global policy dynamic and trajectory by forging a pathway for voluntary initiatives to take hold, and they galvanised attention on recruitment practises (Dhillon, Clark and Kapp 2010). In this, they helped reframe the policy debate such that the responsibilities to sustain health workforces were not only 'source' countries', but, crucially, also those of countries seeking to recruit overseas health personnel as a health workforce planning option. From a wider historical perspective, this helped refocus attention back to earlier concerns with health worker recruitment, which were clearly encoded in ILO Nursing Personnel Recommendation (1977) and other 'fair recruitment' initiatives.

### **3. Strengths of the WHO 2010 Global Code**

The strengths of the WHO Global Code lie in its ethical norms and legal and institutional arrangements for national and multilateral cooperation, alongside a strong focus on developing sustainable health systems, protecting migrant health workers' human rights and the need to support through technical and financial assistance health systems in low- and middle-income countries. From the perspective of wider international governance, the WHO Global Code stands out in three particular respects.

First, is the Global Code's **inclusive approach to consultation** which is vital to sustaining on-going support for its objectives. The negotiating process during the Code reflected an

extensively consultative method and this method is also built in to the implementation monitoring mechanism through the ISRI process. Inclusive approaches to consultation reflect multi-stakeholderist policy development processes and they are important because the most successful multilateral agreements not only enshrine a codified set of global aspirations at any one moment in time but continue to demonstrate their relevance over time. By calling upon diverse stakeholders to collaborate around good practice approaches to health workforce issues generally and to international recruitment specifically, the Global Code underpins continued multi-stakeholder participation in implementing and monitoring processes. By extension, it fosters participatory policy making which is a key hallmark of democratic governance.

Second, **regular monitoring** is decisive in the prospects for full implementation of multilateral agreements. The Global code's inclusion of a monitoring mechanism is therefore a crucial provision. Regular monitoring is one part of an array of possible follow-up mechanisms which can include periodic reviews and forums. These permit questions to be raised and the observance of the instrument to be discussed. Follow up is even stronger if a dedicated body has been established with a mandate to clarify issues that arise under the agreement and if periodic review points are built in (Sauvant 2015). This is because such provisions facilitate the upgrading of the implementation mechanism over time. This was the case for OECD MNE guidelines while the active work of ILO and UNCTAD secretariats also helped make the implementation mechanisms relatively effective by, for example, establishing forums for discussion, creating institutional homes and self-interest on the part of the organisations involved, which extended to promoting the use of the respective instruments among their constituent networks (Sauvant 2015).

In this regard, the WHO Global Code's inclusion of detailed legal, institutional and data sharing mechanisms (Articles 7 and 8) and implementation (Article 9) are significant. Their inclusion is all the more significant because WHO agreements are not supported by any WHO-wide monitoring and implementation governance mechanisms. One of the lessons of the ILO 1977 Nursing Personnel Recommendation is that even where there are such mechanisms, commitment is needed to activate and sustain them. This is a matter of resourcing as well as institutional priorities within the organisation responsible for the agreement.

Third, **direct accessibility** by all key stakeholders and 'natural constituencies' is a major principle of accountability which is necessary to hold all signatory parties to account for the effectiveness of the agreement. It is not just the strength of monitoring and review mechanisms, but also their availability which is crucial to making an international governance



instrument effective (Sauvant 2015). In this regard, the WHO Global Code's ISRI process is a vital mechanism for ensuring the Global Code's provisions are available to – and directly accessible by -- all stakeholders. However, this presupposes that those stakeholders have sufficient capacity and resources to meaningfully participate in such participation and accountability mechanisms. It also requires that WHO is sufficiently resourced for the functioning of those mechanisms to be meaningful and that it (and its membership) prioritises accessibility and availability.

#### 4. Challenges for the WHO Global Code

Despite the many strengths of the WHO Global Code, challenges arise from its content and the implementation.

First, the voluntarist nature of the Code places limitations on it being a transformational global instrument and is a reflection of how far Member States were prepared to engage in institution-building and regulation of their practices. Still, the Global Compact on Migration was also voluntary, as was the Paris Climate Change agreement and they have strong monitoring processes attached to them. The voluntarist nature of these international instruments reflects the recognition that **encouraging** governments, organisations and populations to change their behaviour and to participate in an agreed process binding all parties **may be** a more effective approach than mandatory measures.

Second, it sanctions the continuation of substantial overseas health worker-recruitment, so long as source countries are not identified as having a critical health worker shortage (the Global Code also calls for particular attention to the health systems of developing countries and small island states). In this, it arguably prioritises the continuation of overseas recruitment at the expense of an emphasis on self-sufficiency. This speaks to the **need for strengthened health workforce sustainability measures in the Global Code**.

Third, there are a number of major gaps in the Global Code, such as not directly obliging private enterprises and private employers to comply with its provisions, unless required by national law to do so. This omission is of direct relevance to the burgeoning and largely unregulated private recruitment industry. **There is significant potential for the Global Code's provisions to engage more directly and actively with the private recruitment industry.**

Fourth, the absence of a precise operational definition of 'ethical recruitment' hampers the achievement of coherence across other policy instruments (such as bilateral/regional labour agreements and trade agreements) in achieving the same goals. There is also a lack clarity

in the Global Code regarding countries facing critical shortages in that it asks Member States only to ‘...observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel’ (Article 8.7), without explicitly calling for active support for developing countries in doing so beyond the general level of support for health systems strengthening. This speaks to **the need for greater support for countries to strengthen their health systems with particular reference to health workforce retention.**

Fifth, there is an apparent disjuncture in global governance on health worker-migration and -recruitment between global migration and labour rights regimes. This affects the clarity given to issues such as equality of treatment under Article 4.5, whereby migrant health personnel enjoy the same legal rights and responsibilities as domestically trained health workforce in terms and conditions of employment. This disjuncture is attributable to the limited ‘lateral linkages’ in the Global Code to global policies embedded in the UN normative framework, such as the UN and ILO Conventions on migration and fundamental rights at work. There is accordingly **a need to strengthen the embeddedness of the WHO Code in the wider social policy measures of the UN normative system.**

Sixth, is that, despite efforts within WHO, the WHO Global Code has been insufficiently integrated into the work of WHO as a whole, while greater resources for technical support are needed for the continued implementation of the Code (WHO 2015, Campbell et al. 2016, Yeates and Pillinger 2019). It is worth noting in this regard that 64 countries have requested technical support as part of the 3<sup>rd</sup> round of Global Code reporting. Aside from the ‘Brain Drain to Brain Gain’ project providing on-going support to five countries, the ability to scale-up targeted country-level assistance is hampered by resource constraints within WHO. The establishment of the International Platform on Health Worker Mobility and associated resources under the 3<sup>rd</sup> round of Code Reporting are responses to requests for country-level support. There is also **a strong case for further specific country-level support.**

A final challenge facing the implementation of the Code is the increasing engagement of organisations outside of the UN normative system in this global policy field, including the role of the private sector, non-state private corporate and philanthropic actors in global health (Martens and Seitz 2015). Their engagement may in fact be detrimental to the realisation of global goals on health worker-migration and UHC if this diverts attention towards selective health care initiatives and away from health systems sustainability and the provision of quality universal health care. These are major challenges which could undermine progress towards UHC. **Refocusing global initiatives on trade and business on the sustainability**

**of universal high quality health care systems will be essential if the Code is to have the full leverage it deserves.**

## **5. The SDG era: an impetus renewed**

The emergence of new ‘landmark’ initiatives bearing upon the globalization of health labour market and health worker-migration governance are set out in Box 3.

### **Box 3: Principal international governance initiatives with a bearing on health worker-migration and -recruitment, 2012-2018**

2012 UNGA universal support for universal health coverage (UHC)

2012 ILO Social Protection Floors Recommendation (R.202)

2015: 2030 Sustainable Development Agenda and SDGs

2016 UN High-Level Commission on Health Employment and Growth

2018 International Platform on Health Worker Mobility

2018 UN Global Compact for Safe, Orderly and Regular Migration (UN Global Compact)

2014 ILO Fair Migration Agenda

2016 ILO General Principles and Operational Guidelines for Fair Recruitment

The 2030 Sustainable Development Agenda has led to unprecedented global institutional developments and renewal of global governance with a bold commitment to ‘leave no one behind’. It has added new impetus to the WHO Global Code’s principles and goals by opening up a space for health worker-migration and -recruitment to be simultaneously addressed alongside goals for UHC and health system-strengthening. Despite this, the Sustainable Development Agenda mandates voluntarism and bilateralism, as well as a general trends towards selectivist (rather than universalistic) responses, which in turn impact on the capacity of governments (and funding for public services) to achieve sustainability and high quality public health services, adequate numbers of trained health workers essential for the achievement of UHC and other global health goals. It sends a warning signal that the WHO Global Code’s aspirations and implementation processes need vigilant monitoring as well as concerted and committed action backed by sustained levels of resourcing that are consistent with the scale and multisectoral nature of the issues to be addressed.

In parallel to these global developments is the increasingly vocal global advocacy movements promoting UHC, ethical recruitment, health as a public good and rights-based approaches to health worker migration and recruitment, along with campaigns for quality

health care. The calls for funding for quality public health care services is gaining ground, for example, as underlined by a joint OECD/WHO/World Bank report arguing that ‘high-quality, safe, people-centred healthcare is a public good that should be secured for all citizens’ (OECD/WHO/World Bank 2018: 58). Central to this is the idea that health is a fundamental human right.

A turning point in 2012 was the UNGA’s endorsement of UHC and in parallel the ILO’s Social Protection Floors Recommendation (R202), which reaffirmed calls for governments to invest in health to ensure universal access to basic health services and protection from financial hardship in doing so. Recognition that UHC can *only* be achieved with strengthened health systems and workforces has led the WHO to highlight that this depends on the availability, accessibility, and capacity of health workers to deliver quality people-centred integrated care (WHO 2016 & 2018, HEEG 2016). Linked to this is the WHO *Global Strategy on Human Resources for Health: Workforce 2030* (WHO 2016) which put health workforce planning centre stage. Driven by SDG target 3 relating to health workforces, the strategy emphasises the importance of the health workforce to realising health and development goals. Despite progress in the recognition of UHC as a core goal, there is far from a global consensus either about *how* to achieve UHC or the broader role of the public and private sectors in strengthening health systems more generally.

Further impetus to strengthen the WHO Global Code has come from the UN High-Level Commission on Health Employment and Economic Growth (HEEG) (HEEG 2016) which acknowledged the need to upscale efforts to meet the SDG targets and for an integrated and strategic focus to health worker migration as an economic investment (Addati et al. 2018). Realising these objectives would depend, it argued, on expanding, transforming and creating a sustainable health workforce, to guide the creation of 40 million new jobs anticipated in health and social care especially in the upper middle and high-income countries (HEEG 2016). Revised health workforce densities required to implement UHC also identified a predicted needs-based shortfall of 18 million health workers by 2030 (HEEG 2016). With health worker migration and recruitment predicted to continue to grow in response to this growing need for a larger health (and social care) workforce, HEEG suggests responsible recruitment practices and the safeguarding of migrant workers’ rights, along with the potential for ‘transnational standards’ and an ‘updated broader international agreement on the health workforce, including provisions to maximize mutuality of benefit from socially responsible health worker migration.’ (HEEG 2016: 49-50). The ensuing Five-Year Action Plan (WHO 2018) set out an agenda firmly located within the existing global policy framework characterised by non-binding agreements reached through policy dialogue and

mutual learning, to be carried out through the International Platform on Health Worker Mobility. Absent from the Plan was HEEG's original recommendation for 'an updated broader international agreement on the health workforce' (HEEG 2016: 50).

A further significant development in global governance is the UN Global Compact for Safe, Orderly and Regular Migration (UN Global Compact) as it recognises the need for a comprehensive approach to human mobility and enhanced cooperation at the global level, in line with SDG target 10.7 and to improve coordination and cooperation on global migration governance. It incorporates 23 objectives addressing amongst others, ethical recruitment, decent work, labour rights, social protection for migrants, social security portability, access to services, skills recognition and skills partnerships, and vulnerabilities related to migration. Past developments in the global governance of health worker migration and recruitment attest to the likely future importance of the Global Compact in this area.

The recent developments outlined above point to ways to ensure further alignment of WHO's work with ILO campaigns and instruments on fair recruitment and decent work, as well as with others in the fields of human rights, trade and business governance. For ILO in its centenary year, the SDGs and the UN Global Compact have given additional leverage to the importance of fair recruitment across all sectors including health care, at a time of concern about increasing levels of precarious and non-standard work (ILO 2017, 2018, 2019). The ILO Tripartite Meeting on Improving Employment and Working Conditions in Health Services (ILO 2017), for example, set out ways to improve employment and working conditions in health services, including protection from unethical and unfair recruitment and employment practices in international migration, stressing the importance of 'ensuring the sustainability of the health workforce in source countries' (ILO 2017:4).

## **6. Conclusions**

This Policy Brief has given some brief insights based our review of 70 years of global debate and action on global governance on health worker migration-migration and -recruitment. Skilled health worker migration is now much closer to the centre of global debates on health and social protection than it was when the Global Code was concluded. Building health system sustainability and providing good quality health care are now widely accepted as foundational to achieving good health outcomes for all and to the goal of 'leave no-one behind'. These developments alone show a 'mainstreaming' of health worker-migration and recruitment into global policy in ways that have spurred efforts to strengthen the implementation of the WHO Global Code and diverse ILO instruments regarding decent work, gender equality, social protection, fair recruitment and migration.

These diverse initiatives have brought international organisations into constructive dialogues and thinking about global policy responses, and in the SDGs of the role of multistakeholder responses and multisectoral partnerships and their role in planning, sustainable financing and institutional strengthening. They bring to the fore new possibilities for accountability in domestic and global spheres of governance for quality health care services under UHC and the importance of global solidarity for health as a public good. This has potentially far-reaching consequences for strengthening the labour components of health systems and for achieving goals on human rights, health, social protection, decent work and equality. While these developments mark significant progress in global governance, global health goals will remain aspirational unless these instruments are rigorously implemented.

Our research points to the urgent need to strengthen global governance for a shared global responsibility in health, with scope for outstanding global leadership that can solve the global health and social inequalities that the SDGs are tasked to address. The complexity of health workforce challenges and the adverse impacts of inequitably distributed health workers globally raise added urgency to implement sustainable health systems capable of tackling health inequalities that arise from, and are exacerbated by, health worker-migration and -recruitment.

Our recommendations call for strengthened a global governance in addressing international migration and recruitment of health workers alongside and integrated with the fight to end global inequalities in health and achieve UHC. These are pressing global issues which require a strong set of global responses. This requires a step change in global financing through concrete long-term programmes of action based on multi-dimensional, multi-scale, intersectoral strategies to ensure that source countries with the weakest health care systems can achieve UHC. In that vein, we highlight three sets of priorities:

*1. Strengthening the implementation of existing mechanisms*

There is a strong case for strengthening the WHO Global Code and with greater resources and robust mechanisms underpinning its implementation at country level. Priorities include i strengthened provisions to promote health systems sustainability, and to ensure training and retention opportunities for skilled health workers in countries facing critical shortages of health workers. Promoting global social responsibility to improve access to quality health care, tackling staff workloads, salaries and career opportunities and improving resources for quality patient care have never been more pertinent and urgent. To achieve this, WHO can actively exercise its mandate, working with countries and other global partners, to ensure:

- All WHO Member States fully engage with the Global Code's provisions - in the letter and in spirit), to actively implement and regularly report on all aspects of implementation of the Global Code under the monitoring mechanisms;
- greater integration between health sector policies with wider global social policies of the UN normative system.
- provision of comparable data in all source and destination/recruiting countries for effective mapping of patterns of health worker migration, including the proliferation of circular and temporary migration and its impacts, the gendered nature and consequences of skilled health worker migration, and the living and working conditions of health workers (whether presently migrant or not).

## 2. *Global health governance renewal: new instruments*

Ensuring that health worker migration and recruitment is mutually beneficial for source and destination countries requires new global governance instruments. This means that WHO and other global organisations have a key responsibility to shift from 'aid' and 'charity' models currently embedded in global health towards a model of shared responsibility in global health governance where health is viewed as a public good and implemented through a new partnership for global health.

- building on the SDGs, multilateral organisations have a critically important role to play in advocating for and working with governments and other partners to achieve a strengthened commitment to social justice, socially-equitable health care provision, underpinned by the right to health;
- WHO's leadership, normative role and resources in global health that it has begun to develop with greater confidence and authority in recent years needs on-going support to underpin the effectiveness and impacts of this global agreement.
- Greater investment in health workforces (including education and training systems) would underpin a new partnership for global health, and give tangible expression to the commitments expressed in the Global Code. Reinvigorating the principles of global health equity and social justice based on shared global responsibility are part of this investment. . These principles and investments could also helpfully be linked to socially-progressive trade agendas and to countering the view that UHC can only be achieved through commercial health care and public-private partnerships. Support for public-public partnerships to support health systems strengthening and quality public

health care services would be a vital expression of the global commitment to realising UHC.

### *3. Fair treatment, decent work and fundamental labour rights of migrant health workers*

Achieving an equitable distribution of health workers across the world to meet the SDGs on health, and particularly UHC, requires new thinking about investments in health care and to mitigating the factors that lead many health workers to migrate and the need to fully implement existing labour and migration rights. This means:

- ensuring full implementation of existing instruments on fundamental rights at work, fair migration and ethical recruitment, and better monitoring of their implementation, including them as part of the obligations on signatories to the WHO Global Code;
- ethical recruitment initiatives and bilateral agreements are benchmarked against 'best practice' standards and norms on recruitment, labour standards and protection against exploitation, recognition of skills, portability of social security, access to social protection, and support for reintegration when a migrant health worker returns to their home country;
- rigorous monitoring of global and regional trade negotiations, trade and economic partnership agreements and regional integration processes where these refer to cross-border migration of skilled health workers – a model for which has already been established under the WHO Global Code.



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