

The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs

Report by the Secretariat

1. The Executive Board at its 132nd session noted an earlier version of this report and requested that certain areas be expanded in the report to be considered by the Health Assembly.¹

2. In 2010 the Sixty-third World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel in resolution WHA63.16. The Code is a multilateral framework for tackling shortages in the global health workforce and addressing challenges associated with the international mobility of health workers. In 2011 the Sixty-fourth World Health Assembly adopted resolution WHA64.6 on health workforce strengthening and resolution WHA64.7 on strengthening nursing and midwifery. In the former resolution Member States were urged, inter alia, to implement the Code; in the latter, they were urged to translate into action their commitment to strengthening nursing and midwifery by, inter alia, developing the necessary action plans for nursing and midwifery as an integral part of national or subnational health plans, collaborating in the strengthening of the relevant legislation and regulatory processes, and scaling up education and training in nursing and midwifery. This report is submitted in line with the requirements of Articles 9.2 and 7.2(c) of the WHO Global Code of Practice on the International Recruitment of Health Personnel, together with the requests to report on progress contained in resolution WHA64.6 and resolution WHA64.7. In response to a Member State request, the present report also provides information on the development of the health workforce to support universal health coverage.

THE CURRENT SITUATION

3. Nearly three years after the adoption of the Code, the coverage with designated national authorities is incomplete: the great majority of country reports originate from a single WHO region. The Secretariat has been promoting the designation by each Member State of a national authority responsible for exchanging information regarding health personnel migration and the implementation of the Code. Designated national authorities have been established in 84 countries (see Table below); three quarters of those authorities are based in the ministry of health.

¹ See document EB132/23 and the summary record of the of the Executive Board at its 132nd session, fourteenth meeting, section 1.

4. The reporting countries cover more than 80% of the world's population living in destination countries, but only reflect the situation in a minority of source countries. Efforts to extend the reach of reporting continue, in order to address this discrepancy. Thirty-two countries reported having taken steps towards implementing the Code. In consultation with Member States and the relevant stakeholders, the Secretariat has been supporting the development of a national reporting instrument to serve as a country-based self-assessment tool covering the following topics: legal rights of migrants, bilateral agreements, research on health personnel mobility, statistics, and regulation of authorization to practice. This instrument is publicly available, has been provided to each designated national authority and has been further disseminated through WHO's regional offices and offices in countries, territories and areas. By 21 February 2013, the designated national authorities of 51 countries had reported on implementation of the Code using the national reporting instrument. Of the 51 reports, 36 originated from the European Region (see Table below).

Table. Number of designated national reporting authorities established, by region, and number of reports received as at 21 February 2013

WHO region	Number of designated national authorities established	Number of reports received using the national reporting instruments
Africa	13	1
The Americas	11	4
South-East Asia	4	3
Europe	42	36
Eastern Mediterranean	8	3
Western Pacific	6	4
Total	84	51

5. The main challenge is to ensure engagement of all stakeholders involved in decision-making processes on health personnel migration and international recruitment. Typically, the multitude of public and private stakeholders from different sectors complicates adherence to one core set of principles.

6. Another challenge concerns health personnel migration: there is a lack of coordinated and comprehensive data, the data that exist are usually shared among multiple agencies and entities within and among countries. More efforts and technical cooperation are needed to improve existing health information systems, including information on laws and regulations related to health personnel recruitment.

7. The Secretariat has been fostering multistakeholder collaboration involving governmental and academic institutions, as well as civil society organizations and networks, in order to support the advocacy and analytical work called for by the Code. The European Region in particular has organized a host of activities that culminated in a roadmap for implementing the Code in the European Region. Other noteworthy developments include the creation of La Red Iberoamericana de Migración de Profesionales de la Salud (Ibero-American Network on Migration of Health Professionals), a network led by the technical secretariat of the Ministry of Public Health of Uruguay and supported by the European Commission; the facilitation of national stakeholder dialogue (for example in Belgium, Germany and Italy in 2012); discussions with the Committee on Development of the European Parliament (Madrid, 2012); and the establishment of a summer school on migration and ethics in Geneva, with the Brocher Foundation, the University of Geneva and Harvard University. Civil society organizations have been increasingly active at both national and international levels in raising

awareness and bringing political attention to health workforce issues, including by promoting the dissemination and implementation of the Code. A nine-country case study¹ from the European Region has shown that civil society has also played a considerable role in monitoring health workforce migration, adopting a rights-based approach that considers both the rights of health workers along with the need for equitable and sustainable health systems.

8. Several Member States also indicated that there is a lack of information on the scale of migration (from source countries) and evidence of its impact on health personnel planning (in destination countries).

9. The reports of the designated national authorities provide further detail on the situation of the migrant workforce in terms of their legal rights, recruitment and regulation of practice (see the Figure below). The information provided by statistical records, and the authorizations granted to foreign-trained personnel to practice, mainly covers doctors, nurses and midwives only.

10. Additional information is available from a joint review by WHO and the Migration Policy Institute.² Just four OECD member countries together account for 72% of foreign-born nurses and 69% of foreign-born doctors working in the member countries of that organization: Australia, Canada, the United States of America and the United Kingdom of Great Britain and Northern Ireland. The trends in health worker inflows vary among the four countries. The ways in which the destination countries handle professional registration and recertification are also changing.

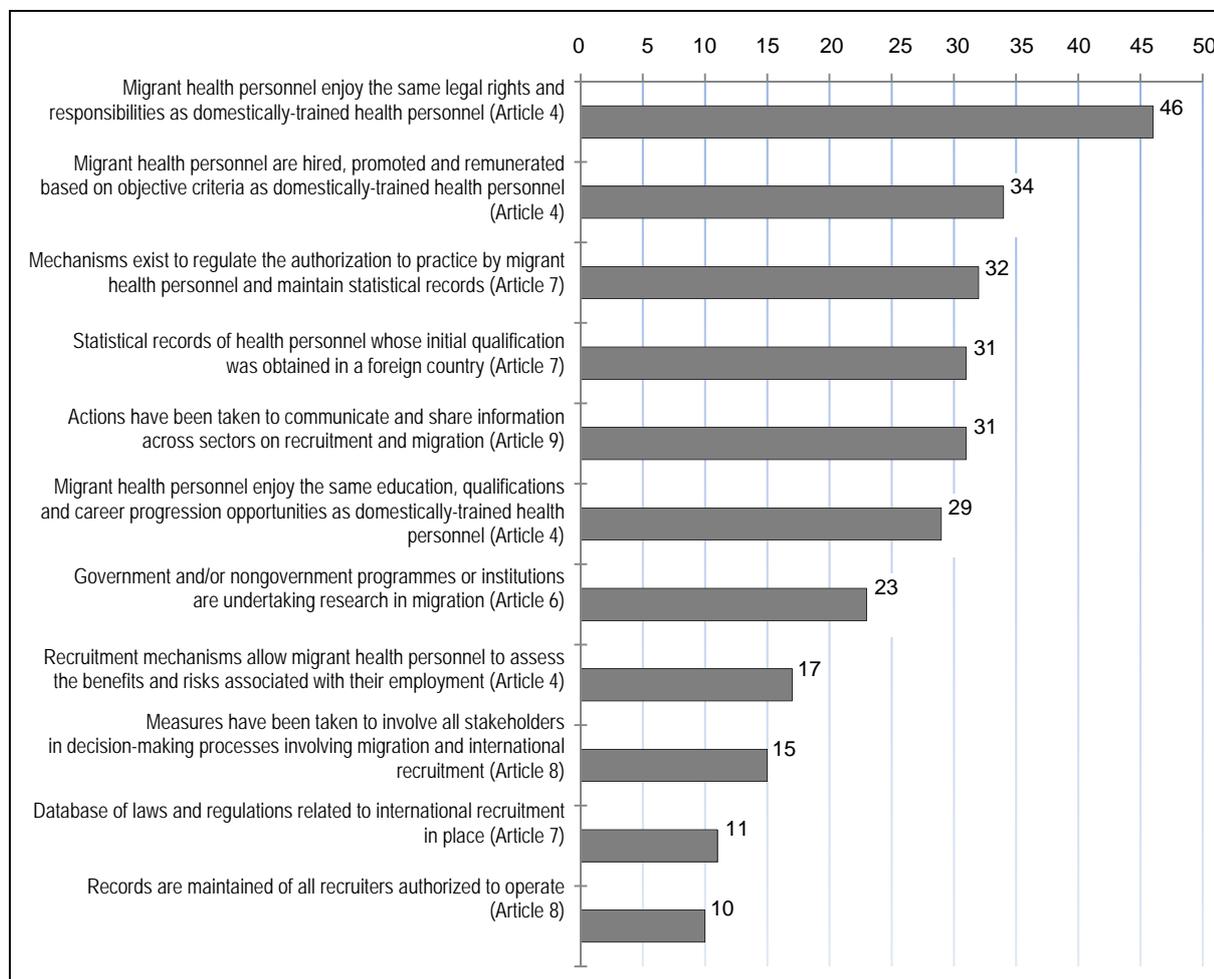
11. Since the adoption of the Code, civil society organizations have reported³ on emerging challenges such as the economic austerity measures that are affecting national health systems; the shift in focus towards internal European Union health workforce distribution imbalances; and the insufficient interaction between development nongovernmental organizations and other civil society actors, including patient federations, labour unions and professional associations that have a stake in health workforce development.

¹ Civil society contribution and advocacy for implementing the WHO global code in the European Region: country case studies. Geneva, World Health Organization, in press.

² *Immigration and the healthcare workforce since the global economic crisis: report for the World Health Organization*. Washington, DC, Migration Policy Institute, in press. See also International Migration Outlook: SOPEMI 2007 Edition.

³ Civil society contribution and advocacy for implementing the WHO global code in the European Region: country case studies. Geneva, World Health Organization, in press.

Figure. Highlights of the information obtained from 51 designated national authorities using the national reporting instrument (by Article in the Code)



Agreements

12. A clearer picture is also emerging in respect of the bilateral, multilateral and regional agreements on the recruitment of health personnel. Most of these preceded the Code; however, some have been developed or refined in the two and a half years since the Code was adopted. Examples include agreements between neighbouring countries such as Cyprus and Greece; and Denmark, Finland, Iceland, Norway and Sweden; Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan and Uzbekistan; as well as between countries of different income levels such as Italy and Tunisia; and Croatia and Germany. Multilateral agreements include “Mobility Partnerships”, which are non-legally binding frameworks for well-managed movements of people between the European Union and individual countries. European Union member States join the Partnerships on a voluntary basis. Prominent regional agreements include those between Brunei Darussalam, Cambodia, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, Philippines, Thailand and Viet Nam. Agreements cover doctors and nurses and, in a few cases, midwives. Many agreements were concluded at national level, others at subnational level.

Cooperation beyond migration

13. Cooperation on health workforce development in the context of the Code tends to go beyond purely migration-related issues. Member States reported on a range of broader financial and technical cooperation agreements, including: the agreements within the Ibero-American Network on Migration of Health Professionals; the agreement between the Governments of Cuba, Egypt, Nigeria and Rwanda; the Triple Win pilot project involving Albania, Bosnia and Herzegovina, Germany and Viet Nam; and the Indonesia–Japan collaboration on enhancement of nursing competency through in-service training.

14. WHO is collaborating with the European Union in the development of an action plan for the health workforce designed to bring Member States together in response to key challenges facing the health workforce in the medium- to longer-term, with the aim of promoting a sustainable workforce in Europe. The focus of this core work will be threefold: forecasting workforce needs and improving workforce planning methodologies; anticipating future skills needs in the health professions; and sharing good practice on effective recruitment and retention strategies for health professionals.

Strengthening nursing and midwifery

15. In the document *Strategic directions for strengthening nursing and midwifery services 2011–2015*, WHO emphasizes universal health coverage and people-centred care within the context of primary health care.¹ Prevention and control of noncommunicable diseases is one of the priority components. In collaboration with the International Council of Nurses and the International Confederation of Midwives, a global forum of chief nursing and midwifery officers was held on noncommunicable diseases with the participation of 70 countries. The resulting forum statement on the role of nurses and midwives demonstrated a clear commitment to advancing the agenda on noncommunicable diseases. The forum was followed by the tripartite meeting involving 74 chief nursing and midwifery officers, representatives of national nursing and midwifery associations, and nursing and midwifery regulatory bodies. Issues critical to the development of the nursing and midwifery professions, the provision of quality nursing and midwifery care and effective regulation of these professions were addressed. In support of this work, a document entitled “*Enhancing nursing and midwifery capacity to contribute to the prevention, treatment and management of noncommunicable diseases*” has been published. Other global events to implement the strategic directions included a meeting of 60 experts, policy-makers and global partners that was convened on the issue of faculty development for midwifery and benchmarks for midwifery services.² A study has been completed in 22 countries on community health nursing, aiming to identify factors that influence community health nursing. The study included factors related to: education and training, regulation, practice, roles, policy trends and feasible strategies to optimize their contribution to primary health care, in particular, people-centred care and universal health coverage.

16. In the Eastern Mediterranean Region, a strategy for strengthening nursing and midwifery (2012–2020) was developed as the basis for supporting countries to develop their respective plans. Nursing and midwifery councils were established in three Member States. In the European Region, strategic directions for nursing and midwifery (2011–2015) and an action plan were developed. In the Region of the Americas, 28 nursing networks were established with workplans on education, practice and research with emphasis on the Millennium Development Goals and primary health care. A plan for nursing development from Central America was approved by the ministries of health of nine countries and subregional committees. In the African Region, regional prototype competency-based

¹ Document WHO/HRH/HPN/10.1. is available at <http://www.who.int/hrh/resources/nmsd/en/index.html> (accessed 19 March 2013).

² Global consultation on producing and developing an appropriate midwifery workforce for low- and middle- income countries, Geneva, 4–6 December 2012.

curricula for pre-service nursing and midwifery education programmes as well as the professional regulatory framework were developed. These aim at supporting the improvement of the quality of education programmes in Member States. New activities include the establishment of a community mental health programme for nurses and midwives in Sri Lanka, South-East Asia Region, the launch of a patient safety curriculum for health professionals, and further development of nursing education with emphasis on primary health care in the Western Pacific Region.

CHALLENGES FOR THE FUTURE

17. Efforts to implement resolutions WHA63.16 and WHA64.7 need to respond to various challenges, including the lack of a shared understanding of the nature of the connections, at country level, between workforce migration, current and future health workforce needs, and short- and long-term workforce planning. In addition, many countries have only limited capacity to anticipate future health workforce trends.

18. Political commitment is essential in order to tackle the health workforce crisis; such commitment must be matched with corresponding investments. Efforts to support institutional and individual capacity for planning and the creation of human resources for health observatories require time to produce significant effects.

19. In order for the resolutions to be implemented, there is an urgent need to expand regional and national observatories on the health workforce. Through such a mechanism, the principles of the Code can be promoted through various capacity building and policy development interventions to improve the understanding of elements including production, recruitment, deployment, retention and mobility, all of which are relevant to the health workforce.

20. WHO will build on the foundation established to support strengthening nursing and midwifery globally in the areas of policy, management, education, regulation and practice and pursue multilateral negotiations under the Code.

21. The current global economic crisis and the related rising unemployment levels have not been significant drivers either of health workforce migration or of substantial lay-offs among health personnel. However, in some countries, it appears that pressure on public finances is starting to have a negative impact on health workforce production, distribution and performance.

22. In the recent past, much attention has been given to the most acute manifestations of the health workforce crisis, namely, the health workforce shortages in the so-called “crisis countries” and migration. However, there is now increasing awareness that the crisis cannot be reduced to these two dimensions, important though they are. The health workforce crisis is a global, multidimensional challenge. It requires a comprehensive global strategy to transform the production of health workers, encompassing labour market analysis as well as the transformation of education and training of the health workforce, at national and transnational levels. It is essential that countries wanting to improve access to health care meet the challenge posed by shortages in the health workforce. Renewed approaches to the health workforce crisis will therefore be critical for moving towards universal health coverage.

ACTION BY THE HEALTH ASSEMBLY

23. The Health Assembly is requested to take note of this report.

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