World Health Organization

EXECUTIVE BOARD
132nd session
Provisional agenda item 10.4

EB132/23
14 December 2012

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

Report by the Secretariat

1. 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 request from a Member State, the present report also provides information on the development of the health workforce to support universal health coverage.

SUPPORT TO MEMBER STATES IMPLEMENTING THE CODE

2. The Secretariat has been providing support along four lines of work.

Designated national authority

3. 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 81 countries (see Table).

National reporting instrument

4. 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. 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 September 2012, the designated national authorities of 48 countries had

reported on implementation of the Code using the national reporting instrument. Of the 48 reports, 35 originated from the European Region (see Figure).

Collaboration

5. 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 study 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. In addition, the Secretariat's **collaboration with professional organizations** has led to an agreement on strategic directions for strengthening nursing and midwifery services for the period 2011–2015.[1]

Table. Designated national authorities by WHO region: number established and number that reported to the Secretariat using the national reporting instrument

WHO region	Designated national authority established	Reports received
	As at 31 September 2012	
Africa	13	1
The Americas	11	4
South-East Asia	4	3
Europe	42	35
Eastern Mediterranean	6	1
Western Pacific	5	4
Total	81	48

THE CURRENT SITUATION

6. Two and a half years after the adoption of the Code, the creation of the designated national authorities, their reporting efforts, and the research and documentation efforts of the different networks and collaborations, have enabled a more detailed picture to be generated of health workforce migration across countries.

[1] See document WHO/HRH/HPN/10.1. Available at http://www.who.int/hrh/resources/nmsd/en/index.html (accessed 16 November 2012).

Migration patterns

7. There are four OECD member countries that together account for 72% of foreign-born nurses and 69% of foreign-born doctors working in the member countries of that organization. A joint WHO and Migration Policy Institute review of the four countries concerned has shown that the inflow of doctors in the United States of America has remained stable since the mid-2000s,[1] whereas it has increased in Australia and Canada. In the United Kingdom of Great Britain and Northern Ireland, by contrast, inflows of both doctors and nurses have dropped sharply since 2008, as the Government reversed its policy of active international recruitment. India is the top country of origin for doctors in Australia, the United Kingdom and the United States, and has recently risen to second place in Canada. South Africa has also been a significant source of doctors in all countries except the United States; it is the largest country of origin in Canada. The Philippines is the top source for nurses in the United States, the United Kingdom and Canada, and the third-largest source in Australia. Substantial health workforce migration has taken place even in the absence of active recruitment initiatives of the kind that the United Kingdom undertook in the early 2000s. The economic crisis does not appear to have influenced migration patterns in a significant way.

Regulation of migration

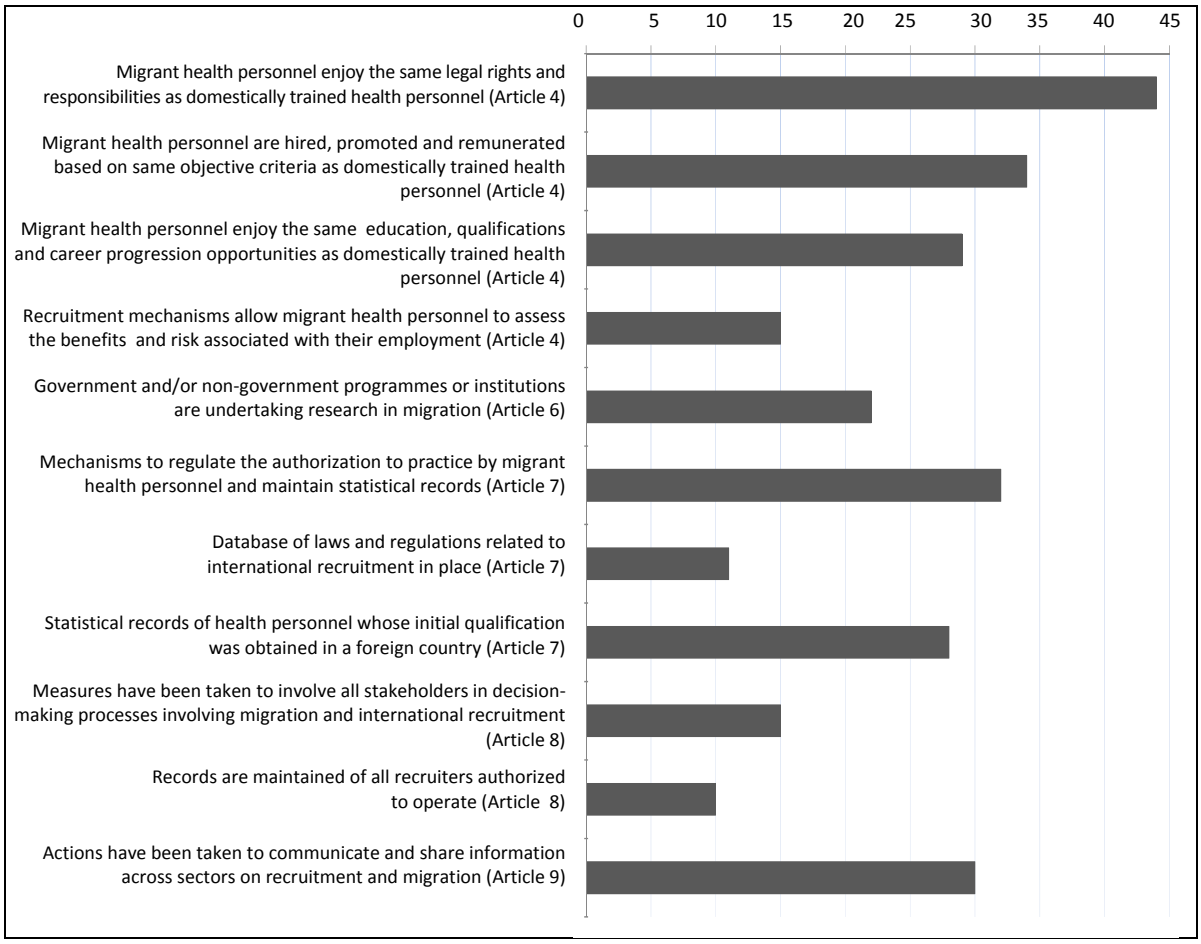
8. The way destination countries handle professional registration and recertification is changing. Australia recently liberalized professional registration requirements for international medical graduates who have been licensed to practise by "trusted" authorities in English-speaking countries. In the United Kingdom, by contrast, a policy package to stem international health workforce recruitment after a period of high inflows included the tightening of professional registration pathways and stricter visa rules. Pre-migration screening for employment-based immigration has been introduced in Australia, the United Kingdom and the United States.

Situation of migrating health workers

9. A more detailed picture of the situation of migrant workforce at country level is emerging from the reports of the designated national authorities (see Figure). The information provided by the reports is more detailed than the data available in the period leading up to the adoption of the Code; however, it has so far been limited by the fact that coverage with designated national authorities is not yet complete with the great majority of country reports originating from a single WHO region. Efforts to extend the reach of reporting are continuing.

[1] *Immigration and the healthcare workforce since the global economic crisis: report for the World Health Organization.* Migration Policy Institute, 2012, in press.

Figure. Highlights of the information obtained by 48 designated national authorities using the national reporting instrument (by Article in the Code).



Agreements

10. 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

11. Cooperation on health workforce development in the context of the Code tends to go beyond purely migration-related issues. Member States have 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.

12. In the European Union, work to develop an action plan for the health workforce is bringing Member States together in response to the 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.

13. Progress has also been made in some of the key results areas defined by the strategic directions for strengthening nursing and midwifery services for the period 2011–2015, agreed upon with the professional organizations. Intensive consultations resulted in regional and country action plans in the Region of the Americas, the European Region and the Eastern Mediterranean Region. Joint planning led to strengthened regulatory frameworks in six countries in the African Region. The development of standards and networks for midwifery education and practice was accelerated with an emphasis on country experience, particularly in the African Region and the European Region. Twenty-eight nursing networks were set up in the Region of the Americas. Research on enhancing the various roles of community health nursing was launched in 18 countries.

CHALLENGES FOR THE FUTURE

14. Efforts to implement resolutions WHA63.16 and WHA64.7 will need to respond to various challenges, a number of which are set out below.

15. Data on health workforce migration are scarce and are often fragmented among multiple agencies and entities. In many countries this problem is illustrated by the lack of data on the health workforce in general.

16. Implementation of the resolutions is hampered by 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.

17. The complexity of engaging the multiple stakeholders who are involved in decisions that affect health workforce migration and international recruitment has constituted an obstacle to progress. This concerns the health workforce in general and nursing and midwifery in particular.

18. These problems are more difficult to deal with in countries where the capacity for governing and managing the health workforce is still weak, as efforts to support institutional and individual capacity for planning and the creation of human resources for health observatories take time to produce visible effects, particularly since the political commitment to tackle the health workforce crisis has only partially been matched with corresponding investments.

A changing health workforce landscape

19. Implementation of the resolutions has also had to be adjusted to the fact that it has been taking place in a context of marked and rapid change in the way the human resources for health are dealt with across countries.

20. In marked contrast to the situation that prevailed even in the recent past, policy-makers at both global and at country levels are now well aware of the urgent need to deal with the health workforce crisis. There has been a shift away from a need for intensive advocacy towards a need for matching awareness of the crisis with investment.

21. The political imperative of moving towards universal coverage provides opportunities that must be seized for much greater integration between health workforce planning on the one hand and policy-making and overall efforts at strengthening health systems on the other. It also calls for the establishment of linkages with other sectors, civil society and the political establishment. These changes are under way in a number of countries; in some of the countries concerned they are part of the aid effectiveness work being undertaken through the IHP+ mechanism.

22. To date, the current global economic crisis and the rising unemployment levels it has provoked have not been significant drivers either of health workforce migration or of substantial lay-offs among health personnel. However, there are disquieting signals suggesting that in some countries pressure on public finances is starting to have a negative impact on health workforce production, distribution and performance. This could have implications for implementation of the resolutions.

23. In this rapidly changing context, there is a need for close monitoring. The reporting system set up though the Code can contribute to this, as can the national and regional networks of human resources for health observatories, which are well positioned to facilitate the monitoring and anticipation of emerging trends.

24. In the recent past, much attention has been given to the most acute manifestations of the health workforce crisis, namely: the 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 truly global and a multidimensional challenge. It therefore requires a far more 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 coverage.

ACTION BY THE EXECUTIVE BOARD

25. The Board is requested to take note of this report.

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