# Covid-19 highlights the global health workforce crisis

## Francis Omaswa explores the health worker migration problem and possible ways forward

*'Health workers for all and all for health workers'*
*The slogan of First Global Forum on Human Resources for Health, March 2008, Kampala, Uganda*

The Covid-19 pandemic has exposed and shone a torch on the global health workforce (HWF) crisis that is characterised by widespread shortages, maldistribution and poor working conditions. This HWF crisis was documented by the report of the Joint Learning Initiative on Human Resources for Health in 2004.[1] The global HWF shortages have resulted in a scramble among richer countries to recruit health workers from poor countries and is precipitated by the urgent need to fill skills gaps in the scaled-up Covid-19 responses and to address long-standing HWF shortages.

International Recruitment Agencies are advertising to recruit health workers from Africa, Asia and the Caribbean, all of whom are needed more in their home countries. Rich countries, including the UK, Japan and USA, have eased visa and migration requirements for health workers to facilitate the ongoing urgent recruitment. Significantly, some African and Caribbean countries have formally protested to the WHO against these clandestine recruitments but have been ignored. Source countries have now been left to appeal to the patriotism of their HWF to mitigate an exodus that would cripple health systems. In July 2020, a charted airplane from the UK was prevented by Nigerian immigration authorities from flying 58 doctors out of Nigeria.[2]

This piracy of health workers, left uncontrolled, carries a public health threat to all countries of the world and is untenable. The pivotal role played by the HWF in public health and health emergencies, exposed by the Covid-19 pandemic, is sufficient to classify health workers as a Global Public Health Good on a par with or ahead of vaccines and drugs. The G20 leaders met recently with the WHO and agreed to collaborate in urgently in developing and equitably sharing new technologies including vaccines and therapies for Covid-19. They should have included HWF in these discussions and it is regrettable that global support for the HWF agenda has declined.

### The problem

Evidence from the UN High Level Commission on Health Employment and Economic Growth[3] shows that between 2000 and 2010 there was 60% increase in migrant doctors and nurses working in OECD countries and the increase was 84% for those who migrated to OECD from countries previously identified by WHO with critical HWF shortages.

Even worse, there are disturbing stories of these migrant health workers being treated differently from local colleagues in destination countries and are impoverished and dying disproportionately from Covid-19. Some them have to pay heavily to enable their families to access essential social services, including health, for which they were recruited to provide.

### Drivers of migration

The need for HWF migration within the global HWF labour market dynamics are driven by demographic, epidemiological, economic and socio-political forces. The demographic and epidemiological realities of ageing populations in the rich countries who require increasing health services and social care which cannot be met by the local labour market is a major driver of migration of health workers. The World Bank Global Monitoring Report 2015/16[4] and the UN Population Prospects 2019 Data booklet[5] show declining working age populations in rich countries and the fact that half of worldwide population growth between 2019 and 2050 will come from sub-Saharan Africa.

The economic drivers of HWF migration are rooted in poverty and poor working conditions in the source countries and the ability to pay of the destination countries. The Global HWF strategy 2030[6] estimates a global shortage of 18 million health workers. It points out that in the face of these demographic realities, rich countries will afford to import the health workers that they need while the poorer countries will not. Health workers in source countries, in general, want to stay at home and serve their people, but their aspirations for supportive working conditions and the future of their children are not being met when they do so. On top of this, in some countries social injustice and political instability serve as push factors for decisions to migrate. This situation leaves global health security in perilous state that is not acceptable.

### The solution

The WHO Code on the International Recruitment of Health Personnel[7] was adopted by the World Health Assembly in 2010 following acrimonious debates between health ministers from rich and poor countries over unregulated recruitment practices. The Code took six years to negotiate and is comprehensive. The objective is to

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*Screenshot from a recruitment video from a UK nursing agency.*

scale up training and share a global HWF pool guided by the Code using voluntary ethical practices, taking into account the rights, obligations and expectations of source and destination countries and above all of the migrant health personnel. The goal is that countries will use the code to negotiate mutually supportive binding agreements for sharing and upholding the rights of all health personnel.

## Strengths of the code

Although the Code is well known to member states of the WHO and the UN and 80% of them are complying with the required reporting, there are not enough bilateral agreements based on the Code that have been signed over the last ten years. The OECD Office Migration in Paris is committed to implementing the Code[8] but is constrained by the limited adoption and institutionalisation in both source and destination countries.

The Code is widely recognised as the universal ethical framework that links the international recruitment of health workers and the strengthening of health systems. It is one of a number of international legal instruments under WHO's stewardship. Others include the Codex Alimentarius, the Framework Convention on Tobacco Control, the International Health Regulations, and the WHO/Unicef International Code on the Marketing of Breast-milk Substitutes.[9]

As a non-binding international legal instrument, the Code benefits from embedded robust implementation, monitoring, regular reporting and effectiveness review mechanism which is rare in both non-binding and binding international legal instruments.

To date, the procedural elements of Code have resulted in three rounds of national reporting as well as an independent Member State-led review of its relevance and effectiveness (A 68/32 Add.1). Findings from the reporting and review have been discussed and actions taken by respective World Health Assemblies.

Recent data confirm substantial and growing reliance on migrant health workers moving permanently or temporarily for employment; across WHO Member States of all income groups. Yet, for some source countries, WHO Member States, the escalating and unmanaged international health worker migration threatens achievement of Universal Health Coverage (UHC).

Improved management of international health worker mobility is increasingly viewed as essential to achievement of various other sustainable development-related goals: decent work and economic growth; gender; human capital development; international trade; and safe, orderly and regular migration which ensures mutual benefit between source and destination countries.

## Weaknesses of the code

Evidence presented to the EAG points to a growth in government to government bilateral agreements related to international recruitment of health worker have made use of the principles of the Code. However, agreements notified to the WHO Secretariat also make clear that Ministries of Health and health stakeholders are not regularly engaged in the negotiation and implementation of these agreements. Further, few countries have streamlined the code into national legal and policy instruments and a significant number of WHO Member States have not participated in national reporting across three consecutive rounds of national reporting.

## The Global Compact

The Global Compact on Safe, Orderly and Regular Migration ('Global Compact'),[10] adopted in 2018 by 154 UN Member States as a non-binding international legal instrument with a strong monitoring process, is the first WHO-led international agreement to comprehensively address the overall challenges of international migration. It has strengthened the implementation of the Code by:

1. Supporting data collection and utilisation, health workforce density and distribution for evidence-based policy has been identified by the United

Nation Secretary General's Report on International Migration and Development (A/RES/71/159) as one of 6 tier 1 migration-related data indicators.

2. International recognition of qualifications which is central to facilitating mobility, ensuring employment and addressing demographic-related global labour market challenges. As example, Germany's presentation to the EAG showed that over a third of the applications in 2018 for recognition and licensing of foreign qualifications was from health personnel.
3. Promoting the creation of global partnerships to invest in skills development in countries of origin to better meet global labour demand.

The limited Official Development Assistance (ODA) support to health workforce activities contrasts starkly to the estimated UHC-related investments required, with health workforce education and employment accounting for the largest cost component to deliver UHC across low and middle-income countries.

## Escalating interest

The health sector is today recognised as both a leading economic and employment sector. As such, facilitating international health workers mobility has been key priority across sectors and international stakeholders. This includes the International Organization of Migration and the priorities of the UN Network on Migration related to Global Compact implementation; ILO's Care Work, Decent Work Across Borders, and Fair Recruitment Programmes; the World Bank's Human Capital Development Agenda; and the World Trade Organizations' efforts related to advancing Trade in Services and Regional Economic Harmonization.

## Irregular migration

A study on irregular migration from Africa to the EU by the UNDP[11] found that contrary to expectation 85% of irregular migrants came from urban centres, 57% had secondary education and jobs, 77% were not happy with their home governments and all were supported by their families to make the hazardous trip to Europe across desert and the Mediterranean sea and would take the risk again. Most had found unskilled jobs as cleaners and fruit pickers. This study highlighted similarities between irregular migration and skilled health workers; namely that both groups were looking for better lives and their services were needed in destination countries. Indeed the migration both groups should be synchronised as health services in destination countries need them all.

## Way forward

In the first place, urgent advocacy is needed as part of the response to Covid-19 and the post Covid world, to recognise and appreciate the need and mutuality of the benefits for managed international migration in strengthening health systems and achieving all SDGs. In many ODA countries where skilled and unskilled migrants are needed, the issue is generally presented as if it is an invasion and a threat to those countries.

Accordingly, the Code and the Compact on Safe, Orderly and Regular Migration should be publicised and popularised in order to increase awareness of the benefits and acceptability of labour migration among the general populations in source and destination countries. Researchers at the University of Washington's Institute for Health Metrics and Evaluation showed the global fertility rate nearly halved to 2.4 in 2017 – and their study, published in the Lancet,[12] projects it will fall below 1.7 by 2100. 'We will go from the period where it's a choice to open borders, or not, to frank competition for migrants, as there won't be enough,' argues Prof Murray in a BBC interview.[13]

With population awareness and acceptance, countries should be able to incorporate the Code into national laws and policies to facilitate its implementation in routine HWF planning in all countries.

Priority should be given to promotion and establishment of international partnerships in education and training that enable accreditation of training programs and recognition of qualifications for a pool of portable global health professionals. Strengthen professional association in all countries and at global level to promote the highest standards of professionalism and ethics among the HWF.

HWF information systems and databases are needed in all countries and at global level (by WHO) to track demand and supply and other relevant labour market issues. This database should include registration, licensing and monitoring of recruitment agencies to ensure compliance with ethical practices.

Finally, we should work to create a global movement and global solidarity that will make this happen. A new effort and leadership is needed at global level to refocus our attention on the global health workforce crisis to the levels that enabled the establishment of the Global Health workforce Alliance and the adoption of the WHO Code. This provides the only solution to move from conflict to collaboration in our quest to provide a skilled, motivated and supported health worker for every person in every village everywhere.

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