PMAC | PRINCE MAHIDOL AWARD CONFERENCE 2024

Geopolitics, human security and health equity in an era of polycrises

Human resource for health migration through the lens of decolonization

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"To fill the gaps created by resignations and migration of nurses, the TELS quota for Bachelor of Nursing will be increased to 350." - Attorney...

32 new healthcare roles added to immigration fast-track scheme

By Felix Desmarais, Political Reporter | Tue, Apr 11

Concern over Albania losing doctors to Germany highlighted as leaders meet

By Tirana Times
March 9, 2023 10:15

Philippines to hire unlicensed nurses as shortages bite

Many with nursing qualifications take jobs abroad for higher salaries

'There won't be enough people left': Africa struggles to stop brain drain of doctors and nurses

The exodus of healthcare workers from Nigeria, Ghana and Zimbabwe continues, despite the WHO red list and a range of laws to keep them at home

Rich countries are importing a solution to their nursing shortages—and poor countries are paying the price

As US healthcare workers quit in droves, record numbers of migrant nurses from the Philippines and elsewhere are filling the void

As Canada grapples with a doctor shortage, Ottawa announces immigration stream for health workers

Home / Sri Lanka's healthcare in distress as doctors leave for Middle East, other countries

Sri Lanka's healthcare in distress as doctors leave for Middle East, other countries

NHS hiring more doctors from outside UK and EEA than inside for first time

Jeremy Hunt questions 'morally dubious' recruitment as thousands hired from poorer countries

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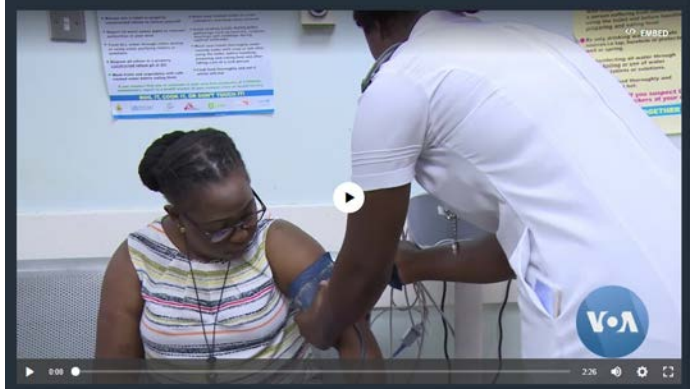
Advancing the Global Health Workforce

International Medical Graduates (IMGs) Are Critical to Addressing U.S. Physician Shortages

Exodus of Doctors, Nurses Threatens Universal Health Coverage in Zimbabwe



Short of doctors, Senegal faces a brain drain to France

France recently presented a law that could make it easier for foreign doctors to come to the country.

German envoy: Hiring health workers part of agreement with Philippines, not 'piracy'

Kaycee Valmonte - Philstar.com
January 17, 2023 | 1:35pm

New Law Allows International Medical Graduates to Bypass US Residency

Alicia Gallegos
June 26, 2023

Mass emigration is leaving huge gaps in Africa's health sector

By Pelumi Salako // 15 June 2023

UK risks becoming reliant on overseas care workers, report warns

Analysis suggests demand for foreign staff has left care homes and NHS open to 'vulnerabilities'

Labour schemes drawing nurses from across Pacific to lower-qualified aged care jobs in Australia, New Zealand

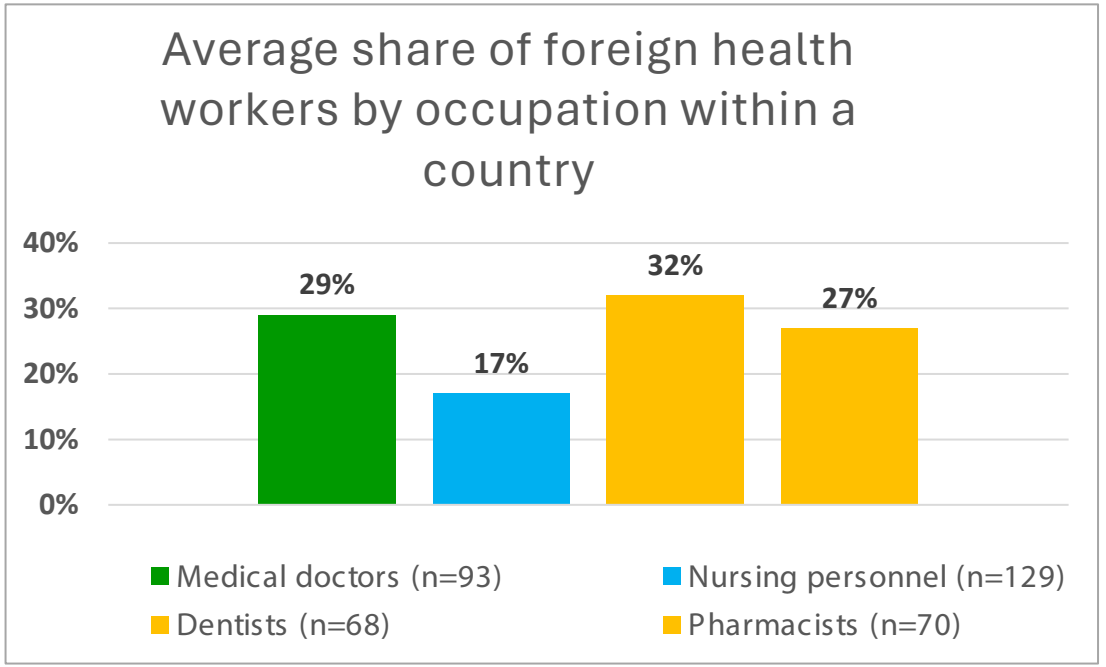
Pacific Beat / By Dubravka Voloder
Posted Wed 23 Nov 2022 at 1:48am, updated Wed 23 Nov 2022 at 6:15am

International health worker migration and mobility

Based on data from 133 countries for 4 occupations (dentists, doctors, nurses and pharmacists):

- at least 2.7 million health workers are working outside their country of birth or first professional qualification (>1 in 10)
- 63% of these are nurses
- 30% are doctors
- 10 high-income countries host 64% of migrant doctors and 46% of migrant nursing personnel

This is an underestimate of the global situation.



* WHO report on global health worker mobility. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/370938)

The COVID-19 pandemic effect

- Increasing reliance on international recruitment to meet demand in high-income countries:
  *More than 20% doctors in 37 countries (21/37 are high-income countries);**
  *More than 20% nurses in 30 countries are foreign-trained (12/30 are high-income countries).**
- Compared to the pre-COVID years:
  *31% increase in net inflow of foreign trained medical doctors in 20 OECD countries***
  *36% increase in net inflow of foreign trained nurses in 23 OECD countries***
- Broader economic and social impact of COVID-19: service disruptions, backlog, higher rates of foregone care, out-of-pocket and financial hardship.

* WHO report on global health worker mobility. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/370938)
** NHWA 2023 data release

Did/Does colonialism influence health worker migration?

- The oldest academic institutions and organizations that influenced global health policies and practices were established to advance colonial interests.[1,2]
- Models of education and health system established during the colonial era internalized ideologies, standards and culture which persisted after political independence.[3,4]
- The *push-pull* factors for migration of health workers (a highly valued resource) are rooted in socio-economic inequities which can be partly attributed to colonial history.[5]
- Migration patterns tend to follow colonial linkages.
- Contemporary forms of imbalance in power and influence in global health decision making extends beyond the historical North-South relationship.[6]

1. Hirsch LA, Martin R. LSHTM and Colonialism: A report on the Colonial History of the London School of Hygiene & Tropical Medicine (1899– c.1960). Project Report. London School of Hygiene & Tropical Medicine, London; 2022.
2. Packard RM. A history of global health: interventions into the lives of other peoples. Baltimore (MD): Johns Hopkins University Press; 2016.
3. Naidu T, Abimbola S. How medical education holds back health equity. Lancet. 2022 Aug 20;400(10352):556-557.
4. Mogaka OF, Stewart J, Bukusi E. Why and for whom are we decolonising global health? Lancet Glob Health. 2021 Oct;9(10):e1359-e1360.
5. Acemoglu D, Johnson S, Robinson JA. Reversal of fortune: geography and institutions in the making of the modern world income distribution. Q J Econ. 2002;117(4):1231-1294.
6. McCoy D, Kapilashrami A, Kumar R, Rhulea E, Khosla R. Developing an agenda for the decolonization of global health. Bulletin of the World Health Organization. Article ID: BLT.23.289949.

‘Decolonization’ in global health

includes:

- Acknowledging historical injustices, exploitation, and inequalities that have resulted from colonialism and imperialism.
- Addressing power imbalances.
- Promoting representation in global health leadership and decision-making, equitable research practice and redistribution of resources to address public health challenges.
- Adapting health professions’ education and promoting institutional capacity to develop systems that are appropriate for the specific national context.

Is the WHO Global Code of Practice an example of 'decolonization'? (*in theory*)

History

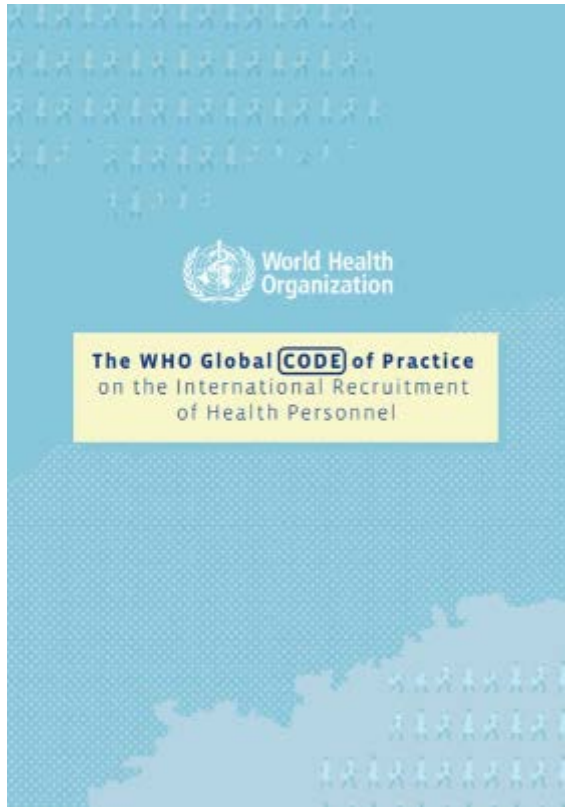
- A vacuum in global governance
- Long standing and growing concern
- Six-year negotiation process (first resolution in 2004)
- Adopted in 2010 at 63rd World Health Assembly
  - Only the second instrument of its kind from the WHO

Process of the Code

- Acknowledged inequalities
- Recognized 'brain drain'
- Co-developed by governments and experts from South and North
- Member State negotiations chaired by Thailand
- Principles and practices for ethical international recruitment
- Included focus on 'mutual benefits' for countries

WHO Global Code of Practice: Key highlights

- Ethical principles and practices in international recruitment.
- Right to health of populations and rights of health personnel.
- Health system sustainability in developing countries.
- Reducing reliance on international health workers.
- Technical and financial assistance from high-income countries.
- Promotion of bilateral agreements.
- Promotion of circular migration.
- Transparency in health workforce data.
- Voluntary document with robust implementation monitoring.
- Dynamic document to be updated to meet stated objectives.



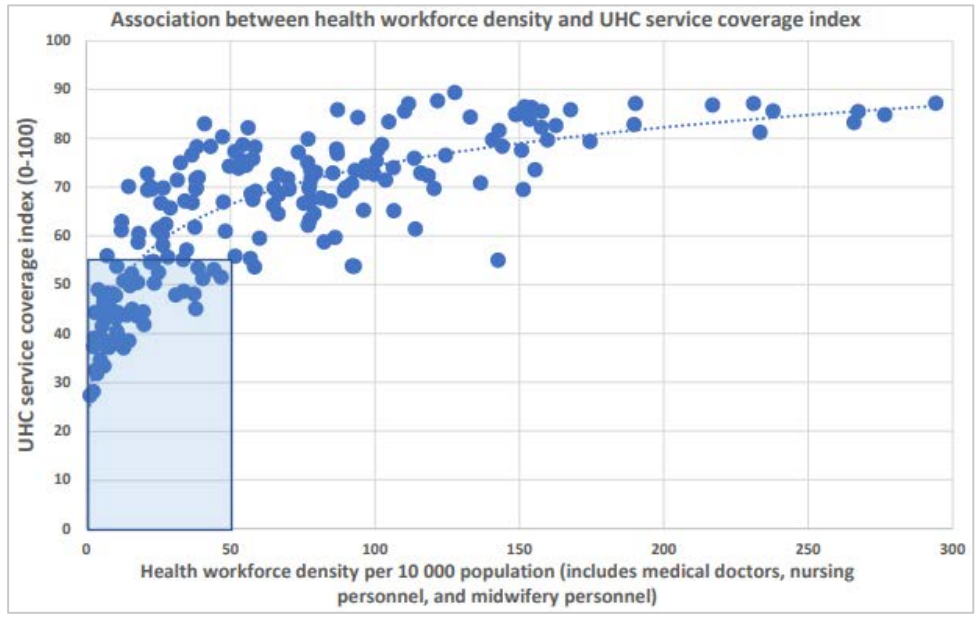
WHO Health Workforce Support and Safeguards List (2023)

55 countries with the most severe health workforce vulnerabilities

- Prioritized for health personnel development & health system related support
- Provided with safeguards that discourage active international recruitment of health personnel

Recruitment under government-to-government agreements**:**

- informed by a health labour market analysis and provisions to **ensure adequate domestic supply**;
- engage health sector stakeholders including **ministries of health**, in the dialogue and negotiation;
- specify that are proportional to that **health system benefit to source countries** accruing to destination countries;
- **notify** the WHO Secretariat.



https://www.who.int/publications/i/item/9789240069787

Region	AFR	AMR	EMR	SEA	WPR
Countries	37	1	6	3	8

Recommendations can be extended to other low-and-middle income countries.

Is the WHO Global Code of Practice an example of 'decolonization'? (*in practice*)

- **Health workforce data:** strengthened data; trends show increasing movement from low- and middle-income countries to high income countries AND substantial regional and South-South movements
- **Fair and transparent recruitment practices:** improvement in rights and welfare of migrant health workers
- **Reporting compliance:** 126 Member States (65%) participated at least once in four rounds
- **Bilateral agreements on health worker mobility:** greater transparency in agreements but less data on their implementation; no evidence on benefits to source country health systems; alternative mobility routes
- **Countries with workforce vulnerabilities:** still exposed to passive recruitment
- **Private recruitment agencies:** few adopt the WHO health workforce support and safeguards list and very few countries require certification of ethical recruitment practices
- **External investment in health workforce of low- and middle-income countries**: limited evidence
- **Circular migration:** limited evidence

The Code related activities (2024/25)

- **5th round of national reporting** on the Code implementation, including reporting from independent stakeholders and private recruitment agencies.
- **Third review of the Code relevance and effectiveness** by Member State led expert advisory group.
- Technical **review of trends, challenges and solutions** by WHO Secretariat to inform the review.
- **Convening the top 10 high-income destination countries** to discuss strengthening domestic health workforce policies and international development strategies to align with the Code principles.
- Co-hosting dialogues on contemporary, mutually beneficial solutions in the education, employment and international migration of health and care workers.

WHO / OECD Guidance on Bilateral Agreements

All bilateral agreements should:

Contribute to **workforce sustainability, universal health coverage and health security** in countries of origin and destination.

Specify how the partnership will **strengthen health systems** of both countries.

Include additional **safeguards and support** to countries with workforce vulnerabilities.

Ensure **equal treatment** of domestic and foreign-trained health workers.

Plan and address **gender needs** of health workers.

Include **monitoring and evaluation** mechanism with **operational feedback** loop.

Report on the agreement arrangements and implementation to WHO.

Source: Bilateral agreements on health worker migration and mobility (forthcoming)

https://www.who.int/teams/health-workforce/migration

WHOGlobalCode@who.int