Assessing the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel

Evidence & Reflection

The WHO Global Code of Practice on the International Recruitment of Health Personnel (hereafter “the Code”) was unanimously adopted at the 63rd World Health Assembly in 2010. Much celebrated, the Code was hailed by the WHO Director General as a “real gift to public health everywhere” (Taylor and Dhillon). A review of the Code, mandated by its procedural requirements, provides an important early opportunity to assess its relevance and to strengthen its effectiveness. The ultimate success of the Code is not limited to advancing equitable health outcomes; it stands also a measure of the continuing place of moral expression and restraint in current international relations.

Relevance

Powerful, well-documented, demographic, economic, and epidemiological trends continue to drive global health personnel shortages and mal-distribution. Relevant trends include population growth; ageing populations in high-income states; an ageing health workforce in high and many low and middle income nations; urbanization; increasing liberalization of rules related to skilled migration; as well as constrained fiscal space and poor working environments in many low and middle income states.

Despite an increase in the production of health personnel worldwide, recent evidence suggests that the reliance on foreign health workers remains strong in OECD countries, growing in many (Dumont). In the US, reliance on physicians graduating from Sub-

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2 Dumont J.C., Recent Trends in International Migration of Medical Workers (including data from forthcoming OECD International Migration Outlook 2015), as presented at the 1st Expert Advisory Group, March 2015.
Ibadat Dhillon

Saharan African medical schools increased by almost 11% between 2011 and 2013 (Akhenaten et al\(^3\)).

The overall magnitude of skilled migration has remained largely protected from the effects of the financial crisis (Siyam and Dal Poz\(^4\), Buchan et al\(^5\)). However, much as in the case of low and middle income countries in the past, austerity measures have resulted in new South-North flows within the EU to add to continuing East-West migration patterns (Buchan et al\(^6\)). Moreover, previous destination countries are now facing new challenges in attracting foreign health workers (e.g. significant declines in registration of foreign health workers in Italy, Siyam and Dal Poz\(^7\)).

Long term and predictable support to least developed countries seems to be wavering. The OECD recently reported that Bilateral Overseas Development Assistance to the poorest countries continued to fall in 2014, with a 16% decline in real terms from the previous year (OECD\(^8\)). Aid through General Budget Support/Sector Budget Support, key mechanisms to support recurrent costs in low and middle countries, also seems to be declining. As illustration, General Budget Support/Sector Budget Support constituted 20% of DFID’s budget in 2008/2009, but only 10% of its budget in 2012/13 (a 40% decline in absolute terms, IDC, House of Commons, UK\(^9\)). Moreover, there remain fundamental challenges to quantifying the amount and character of HRH-related aid provided to low- and middle-income countries (Campbell et al\(^10\)).

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\(^6\) Id.

\(^7\) Supra note 4.


Abuses in international recruitment practices persist, with recent evidence suggesting that those educated in low-income nations and those recruited through staffing agencies are most likely to face unequal treatment in the host country (Pittman et al\textsuperscript{11}).

The need for coordinated and coherent policy action, from the sub-national to the global level, remains urgent. The Code assessed through focus on its specific articles remains as relevant today as in 2010 (See Chart: WHO Global Code Recommendations & Policy Drivers). The following areas deserve additional attention during the review:

1. Policy development in the regional fora, as related to the Code, deserves special attention (especially as related to Article 3.1). The increasing economic integration amongst nations (European Union, ASEAN, Mercosur) and the sharing of competencies related to movement of skilled workers present new opportunities and challenges.

2. Throughout the code, but especially in terms of ethical recruitment and employment practices, gender deserves specific attention (Articles 3.5, 4.3 – 4.6). Gender deserves particular attention in terms of “brain waste” (e.g. 44% of foreign educated caregivers in Canada served as registered nurses in their country of origin, Schilz and Rijks\textsuperscript{12}). The recent creation of UN Women presents a potential new institutional partner.

3. Nowhere does the Code explicitly call for support from developed countries for sustaining and retaining health workers in low/middle income countries (the Code calls for such support for Health System Strengthening generally, and for health personnel production). More specificity in this area would bring in essential discussions around fiscal space, budgetary priority, and character of bilateral/multi-lateral aid.


\textsuperscript{12}Schultz, C. and Rijks B., \textit{Mobility of Health Professionals to, from and within the European Union}, IOM Migration Research Series No. 48, IOM, 2014.
Ibadat Dhillon

The European Commission’s *Action Plan for the EU Health Workforce* sounds the following warning related to austerity measures in the EU, that is perhaps even more applicable to the long-standing challenge faced by low/middle income countries: “There is recent and worrying evidence that the cost-containment measures to reduce public expenditure is profoundly affecting the recruitment and retention of health care staff and in particular nurses, the largest health profession, in almost half of EU 28.” (Buchan et al\(^\text{13}\)).

**Effectiveness of the WHO Global Code**

*Some Theory*

In seeking to assess the impact of the Code, as Taylor rightfully cautions, it is imperative to understand the distinction and inter-play between the concepts of compliance and effectiveness. Moreover, especially in the context of strengthening the Code’s effectiveness, it is useful to appreciate theoretical approaches as to why nation states act upon internationally defined rules and standards. This is an area where there has been tremendous international legal, political, and philosophical scholarship, as well as contestation.

Referencing back to Taylor’s definitions, compliance speaks to when an actor’s behavior complies to specific rules or standards (*Raustiala*\(^\text{14}\)). A modest definition of effectiveness in contrast seeks to identify an observable desired change in behavior. Notably, compliance by a state or regulatory party can be independent of action (with practice already in place; akin to Buchan’s ‘ticking the box’), while the assessment of effectiveness requires a link to causation (*Raustiala*\(^\text{15}\)). Following is an excerpt from an informant in Malawi that speaks to the above distinction:

> *In all honesty, we have not done anything directly related to the Code. But when looking at the Code you can see we have done things expected by the Code... the*

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\(^{13}\) Supra Note 5.

\(^{14}\) *Raustiala, Kal, Compliance & Effectiveness in International Regulatory Cooperation, Case Western Journal of International Law, Vol 32, No. 421, 2000.*

\(^{15}\) Id.
Ibadat Dhillon

discussion on support for training, our strategic direction on HR, all those are in
the spirit of the Code. Yeah but not because of the Code perhaps.

- (Dambisya et al.16)

Much has been written on why parties comply or do not comply with international
agreements, including rationalist, norm-based, and liberal understandings. The approach
taken in this paper is a normative one. For those ascribing to this theory, the legitimacy
surrounding the process of international rule creation is itself perceived as a central factor
to ensuring compliance (Raustiala17). As noted by a leading scholar in this area, it is the
complex process of nations interacting - not incentives or sanctions - that over time leads
to the internalization of international norms into domestic legislation and politics
(Raustiala18). Chayes and Chayes, eminent scholars in the area, go further to note that
“the fundamental instrument for maintaining compliance with treaties at an acceptable
level is an iterative process of discourse among the parties, the treaty organization, and
the wider public” (Chayes and Chayes19). A key function of the treaty regime here is to
serve as an interpreter of treaty norms. Lack of compliance under this approach is often
associated with ambiguity in terms; inadequate administrative, technical, or financial
capacity; and a time lag between undertaking and performance (Chayes and Chayes20).
Finally, an international instrument, under this perspective, is not simply a list of norms
but a mechanism through which international cooperation can be advanced; transparency
fostered; transaction costs lowered; collective learning captured; and which is able to
legitimize certain policy actions while delegitimizing others (Raustiala21). Even a quick
read of the WHO Global Code points to a conscious effort on the part of the drafters to
advance such a normative framework; with strong procedural mechanisms residing at its
core.

16 Dambisya et al, The engagement of East and Southern African countries on the WHO Code of Practice
on the International Recruitment of Health Personnel and its implementation, Regional Network for
Equity in Health in East and Southern Africa Discussion Paper No.103, June 2014.
17 Supra note 14.
18 Id.
20 Id.
21 Supra note 14.
Compliance and Effectiveness

An article-by-article assessment of the Code’s effectiveness is, in many ways, premature, with findings likely to be unsatisfactory. This is due in part by the inevitable time lag between instrument adoption and policy action, as well as that between policy action and resulting impact. Moreover, fundamental gaps related to the “iterative process of discourse”, as discussed below, first need to be rectified before effectiveness can be properly assessed.

It is worth highlighting up front that the period since Code adoption has generated significant criticism of the Code and its implementation (Akhenaten et al\textsuperscript{22}, Yeats and Pillinger\textsuperscript{23}, Edge and Hoffman\textsuperscript{24}, Dambisya et al\textsuperscript{25}). Commentators have in turn pointed to the Code’s voluntary “soft-law” nature; failures in dissemination and the lack of knowledge surrounding the Code; lack of in-country preparedness for implementation; little publicity on the progress of Code implementation; high turnover of key personnel; ambiguity in terms and the need for complementary guidelines; lack of prioritization and problems of internal coherence; and the lack of sustained resources to support Code implementation (Akhenaten et al\textsuperscript{26}, Yeats and Pillinger\textsuperscript{27}, Edge and Hoffman\textsuperscript{28}, Dambisya et al\textsuperscript{29}). Much of this criticism is valid.

A central challenge identified across the various studies has been the weak leadership by the WHO secretariat and the associated lack of awareness of the Code by key stakeholders. Studies focusing on US, Australia, Canada, and the UK, as well as in Sub-

\textsuperscript{22} Supra note 3.
\textsuperscript{23} Yeats, N, and Pillinger J. Human Resources for Health Migration: Global policy responses, initiatives, and emerging issues”, The Open University, November 2013.
\textsuperscript{25} Supra note 16.
\textsuperscript{26} Supra note 3.
\textsuperscript{27} Supra note 23.
\textsuperscript{28} Supra note 24.
\textsuperscript{29} Supra note 16.
Ibadat Dhillon

Saharan Africa, evidence basic gaps in knowledge of the Code amongst key stakeholders, including within relevant governmental departments and HRH Technical Working Groups (Edge and Hoffman\textsuperscript{30}, Dambisya et al\textsuperscript{31}). Moreover, commentators have specifically pointed to the negative effect of WHO reforms and its impact on Code dissemination and implementation (Yeats and Pillinger\textsuperscript{32}, Dambisya et al\textsuperscript{33}). A recent criticism related to the lack of transparency, advanced during the First Expert Advisory Group meeting, is of additional concern given the importance of the iterative discursive process to the success of the Code.

In spite of well-recognized challenges, there have been successes in terms of compliance and effectiveness that are all the more notable given the complexity, sensitivity, and lack of historical action in this area. The high response rate to the National Reporting Instrument amongst OECD nations, including from the largest recipient countries, is one clear point of success (Siyam et al\textsuperscript{34}). The identification of national designated authorities and responses to WHO’s National Reporting Instrument provides important legitimacy to the Code. The legitimacy of the Code, especially with respect to its innovative reporting and monitoring provisions, was not guaranteed and serves as an important foundation for the future.

The Code’s implementation in Europe goes further to evidence that in addition to compliance, an iterative process of discourse has been initiated that can over time, and is already, embedding Code norms into domestic, as well as regional, legislation and policy. In part due to the construct of the European Union, funding from the European Commission, and the leadership of WHO EURO, a level of institutionalization of the Code has emerged in the region that is deeper than seen elsewhere.

\textsuperscript{30} Supra note 24.
\textsuperscript{31} Supra note 16.
\textsuperscript{32} Supra note 23.
\textsuperscript{33} Supra note 16.
Fourty countries in the WHO EURO region reported through the National Reporting Instrument; with 26 identifying that they had taken steps to implement the Code (Siyam et al\textsuperscript{35}). In addition to member states translating and publicizing the Code in local languages (e.g. Finland, Norway, Netherlands), and instituting inter-ministerial and cross-sectoral dialogue around the Code (e.g. Belgium, Italy, Ireland, Norway, Switzerland), the Code through its process of negotiation and adoption has galvanized meaningful action at the regional and national level (Siyam and Roberto Dal Poz\textsuperscript{36}, European Migration Network\textsuperscript{37}). Following are some examples:

- EU Blue Card Directive exemption, as related to recruitment of health workers from countries with critical health workforce shortages (adopted in 2009 in the context of high profile discussions around the WHO Global Code; however still limited in use).
- EU Joint Action Health Workforce on Planning and Forecasting was initiated in 2013, including 30 European and 53 collaborating partners, as a means to support member state collaboration and exchange; with a significant work stream related to implementation of the Code (Joint Action Health Workforce Planning and Forecasting\textsuperscript{38}). Workshops of the Joint Action Health Workforce on Planning and Forecasting have advanced awareness and shared understanding around the Code; opened channels for dialogue and information exchange; and identified early Member State best practices in implementing the Code.
- The German Employment Regulation was amended in 2013, placing a ban on the recruitment of nurses and caregivers by private recruitment companies from 57 countries with critical health workforce shortages; commitment by the German

\textsuperscript{35} Id.
\textsuperscript{36} Supra note 4.
\textsuperscript{38} Available at http://www.euhwforce.eu/.
Federal Agency for Health to also not conduct such recruitment in compliance with the WHO Global Code (*European Migration Network*).[39]

- Norwegian strategies have been developed aimed at improving domestic health workforce capacity and improving domestic health workforce. Norway also reports supporting health worker performance internationally (*Siyam and Dal Poz*).[40] While the strategy development occurred prior to the adoption of the Code, they were very much linked to ongoing discussions and negotiations towards Code adoption. The causal link between international support to health personnel performance and the Code is however uncertain.

- Finnish National Development Programme for Social Welfare and Health Care (“Kaste Programme”) 2012-2015, prioritizes self-sufficiency and clarifies practices related to the international recruitment of health personnel. The Ministry of Employment and Economy initiated a pilot project in 2012 in order to develop an ethical recruitment process model for those recruited outside the EU area (*Ailasmaa*).[41]

- Ireland engaged with the Esther Alliance in 2012, as one mechanism to strengthen the health personnel capacity in low and middle-income countries through institutional twinning partnerships (*Siyam et al.*)[42]

- The European Commission and WHO Euro provided technical and capacity-related support to Moldova with specific respect to implementation of the Code, including Euro 2 Million project, 2012-2014, to better manage health professional migration between Moldova and EU health institutions. Moldova has also developed a draft Intergovernmental Framework Agreement as a means to seek and undertake bilateral agreements, as recommended in the Code.

Finally, the emergence of a coordinated civil society serving as champions for Code implementation, with action in 8 EU countries through the EC-supported Health Workers

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[39] Supra note 37.
[40] Supra note 4.
[42] Supra note 34.
Ibadat Dhillon

for All Project (HW4All\textsuperscript{43}), is both an important product of the Code development process an important means for advancing its principles.

Outside the European region, evidence of early compliance from the United States has laid the foundation for potential Code impact. The United States has the greatest reliance, in terms of numbers, on foreign health workers. Code implementation in the United States is thus fundamental to ensuring meaningful Code effectiveness. The US submission through the National Reporting Instrument adds important legitimacy to the Code (HRSA\textsuperscript{44}). The US has appointed an inter-governmental working group to guide US implementation of the Code; submitted national designated authorities from both domestic and global health departments; and held an open public meeting in December 2011 to highlight and discuss US efforts towards Code implementation. Moreover, in its submission the US specifically pointed to efforts to both improve health workforce planning domestically, as part of the Affordable Care Act, and to support health systems and personnel development in low and middle income countries (e.g PEPFAR and MEPI/NEPI initiatives) (HRSA\textsuperscript{45}). While neither of the above efforts can themselves be attributed to the Code (are limited to compliance), the appointment of an inter-governmental working group and associated interaction amongst agencies and senior government officials opens the potential for more explicit linkages in the future between domestic health workforce planning and international development assistance.

Compliance with the Code’s reporting process and efforts to implement the Code have been most limited in low and middle-income countries: the very countries that presumably have the most to gain. Much of this can be explained by limited capacity at the country level, with little technical, financial or institutional support for dissemination and implementation. The specific lack of reporting amongst member states in the WHO AFRO region has been attributed by some to the fact that much of the negotiation took place as part of an African regional position, with little mechanism to provide feedback to

\textsuperscript{43} Project website available at http://www.healthworkers4all.eu/gb/project/.

\textsuperscript{44} US Health Resources and Services Administration, National Center for Health Workforce Analysis, International Recruitment of Health Personnel Webpage, available at http://bhpr.hrsa.gov/healthworkforce/data/international/index.html.

\textsuperscript{45} Id.
Ibadat Dhillon

individual member states (*Dambisya et al*\(^{46}\)). It is also possible, as suggested by the Philippines, that the NRI might need to be adapted for those countries that primarily serve as the source of health workers (*Siyam and Dal Poz*\(^{47}\)).

There have been efforts in the Philippines, Kenya, and Thailand, which speak to early effectiveness of the Code (*Siyam and Dal Poz*\(^{48}\), *Dambisya et al*\(^{49}\)). All three have held inter-governmental meetings following Code adoption. Notably, all three also played an active role in the Code negotiation process. The Philippines in particular stands as a strong example of involving the private sector, including trade unions, employers organizations, professional organizations, and recruiting agencies, in dialogue and decision making (*Siyam and Dal Poz*\(^{50}\)).

**Discussion**

The case for the continuing relevance of the Code is strong. The Code’s ethical and normative frame has been provided additional legitimacy through the strong reporting compliance by OECD nations. The Code’s potential for effectiveness, however, remains fragile and calls for greater support.

A review of the five-year period following the Code’s adoption points to areas of the Code’s success. The WHO EURO region evidences that, with associated resources, a systematic process towards Code implementation, as well as meaningful action in the area, is indeed possible. Evidence of the Code’s implementation outside the European Region is patchy, with knowledge of the Code and efforts towards its implementation often dependent upon personality (and presence during Code negotiations) rather than systematic. Overall, the period post adoption has been marked by poor dissemination of the Code; limited support to Code implementation in low-income countries; and a lack of leadership from the WHO secretariat. Basic perquisites for the Code to have effect have

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\(^{46}\) Supra note 16.

\(^{47}\) Supra note 4.

\(^{48}\) Id.

\(^{49}\) Supra note 16.

\(^{50}\) Supra note 4.
not been present, constraining the utility of an instrument that is otherwise uniquely powerful.

In light of a normative managerial approach to giving effect to the Code (Chayes and Chayes\textsuperscript{51}), it was the withdrawal of foundational resources from the WHO secretariat that perhaps most negatively impacted Code implementation. First, it diminished the WHO secretariat’s capacity to support the dissemination and associated “iterative process of discourse”. Second, progress towards advancing Code norms itself requires that the secretariat play an active and vocal role, with an important interpretive and coordination role. The withdrawal of funds, in addition to limiting capacity, likely also muted secretariat voice and agency. Finally, the WHO HQ’s commitment to the Code itself came under question from those aware of the cuts in resources to the secretariat (with WHO HQ perceived as being satisfied in having responded to Member State concerns through Code adoption; with little focus on implementation).

The Code has provided important foundation for action in a complex, sensitive, and previously contentious area. Serious reflection is now needed, both within WHO and amongst WHO Member States, whether implementation of the Code is to stand as one of the priorities in the global health arena. If so, financial resources, an empowered secretariat, and a more inclusive and transparent process are critical to delivering on the promise of the Code.

If deemed a priority, the WHO secretariat, through consultation, must prioritize those amongst the Code’s norms deemed most important, issue clarifying guidance, and work towards their meaningful advancement (much as WHO EURO is currently doing). One opportunity is to ensure that the Code plays an important role in better capturing the quantity and character of bilateral and multilateral HRH support to low and middle-income countries (a gap highlighted by Campbell et al\textsuperscript{52}). If enabled, the Code holds with

\textsuperscript{51} Supra note 19.

\textsuperscript{52} Supra note 10.
it real possibility, in the relatively near term, of adding moral dimension and weight to ongoing domestic and global debates around the amount and type of HSS/HRH support.

The mandated review of the Code brings with it a renewed opportunity to mobilize support behind the Code, without which the Code is unlike to realize its intended effect.