Overview of health system vulnerabilities from international health worker mobility during the COVID-19 pandemic - Update of WHO Support and Safeguards List

Member States information session-
19 September 2022

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Director WHO HWF

World Health Organization

WHO Code of Practice on International Recruitment of Health Personnel ("the Code")

2010 — 63rd WHA Adoption of the WHO Global Code of Practice

2012 — First round of Code reporting

2013 — WHO DG report to the WHA on the first round

2015 — First review of Code Relevance & Effectiveness

Second round of Code reporting

2016 — WHO DG report to the WHA on the Second round

2018 — Third round of Code reporting

2019 — Second review of Code Relevance & Effectiveness

WHO DG report to the WHA on the third round

2020 — WHO DG Report of the 10 Year Review of the Code

Health Workforce Support and Safeguards List, 2020

Fourth round of Code reporting

2021 — WHO DG report to the WHA on the fourth round

2022

COVID-19 pandemic

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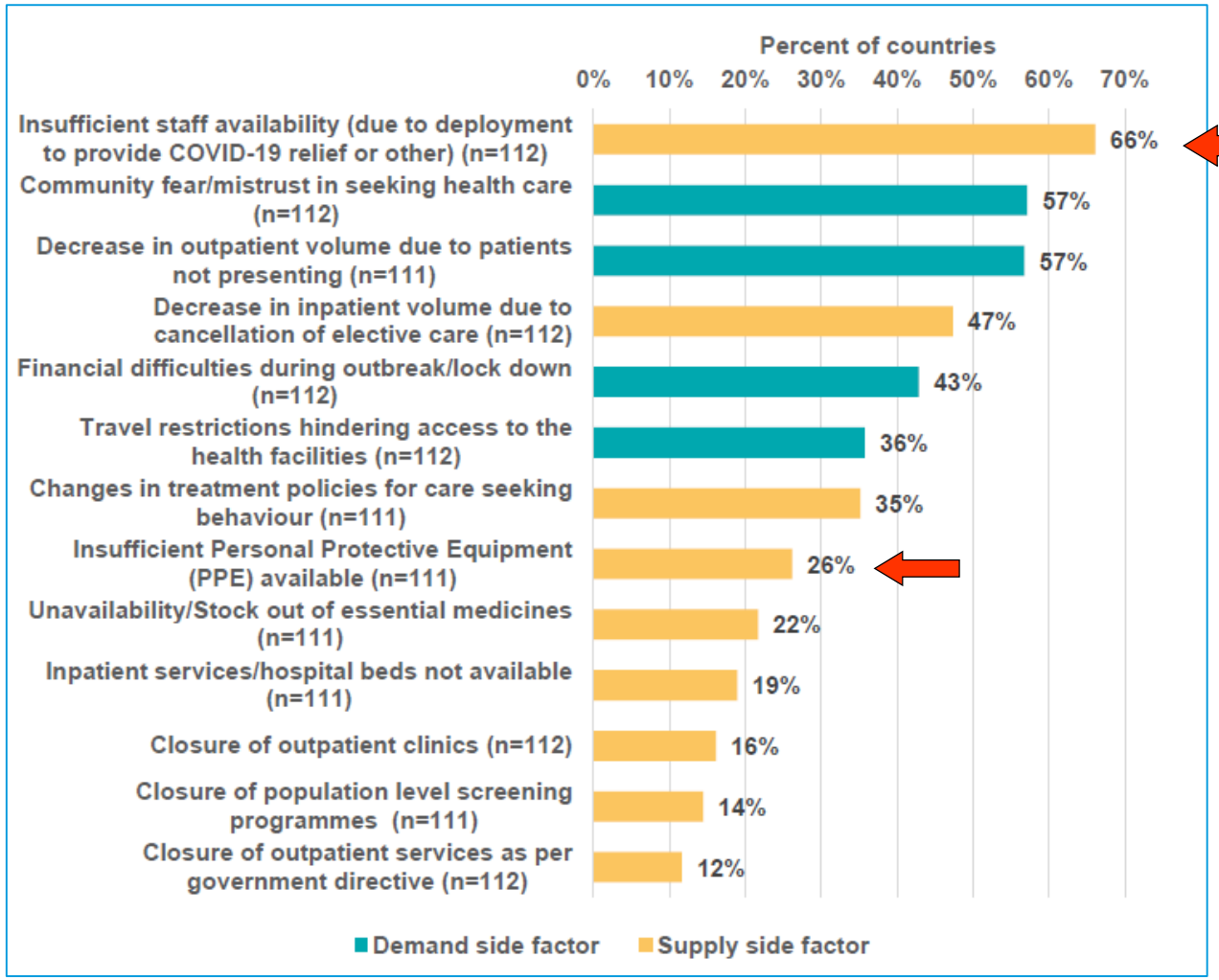
Essential health service disruptions: Human resource challenges

Interim report: 22 April 2021



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Health workforce issues represent the biggest barriers to access to COVID-19 tools

Community demand challenges (including due to acceptance and affordability) is greatest challenge to scaling up COVID-19 vaccination

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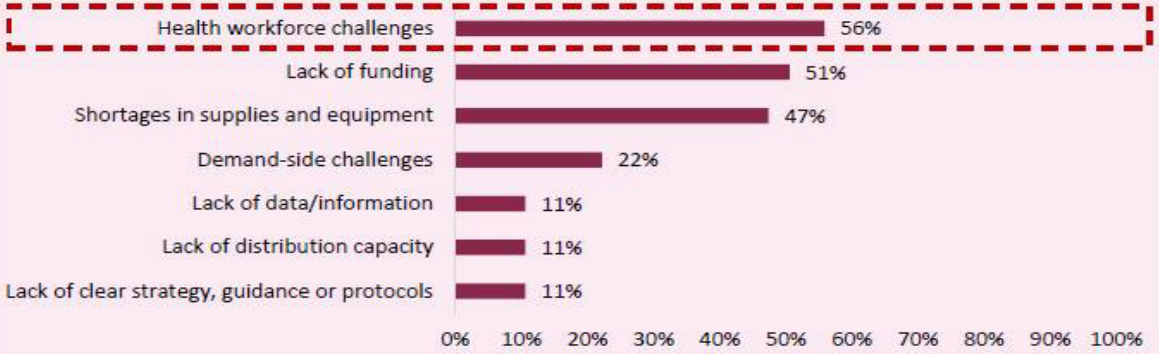
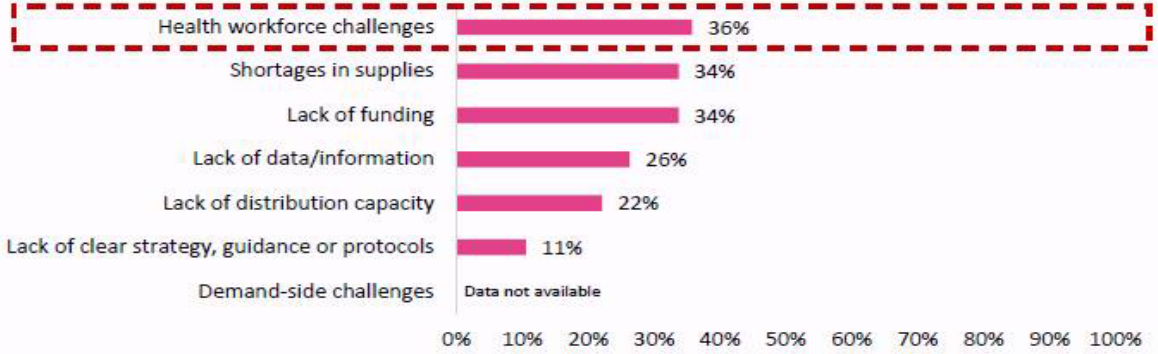
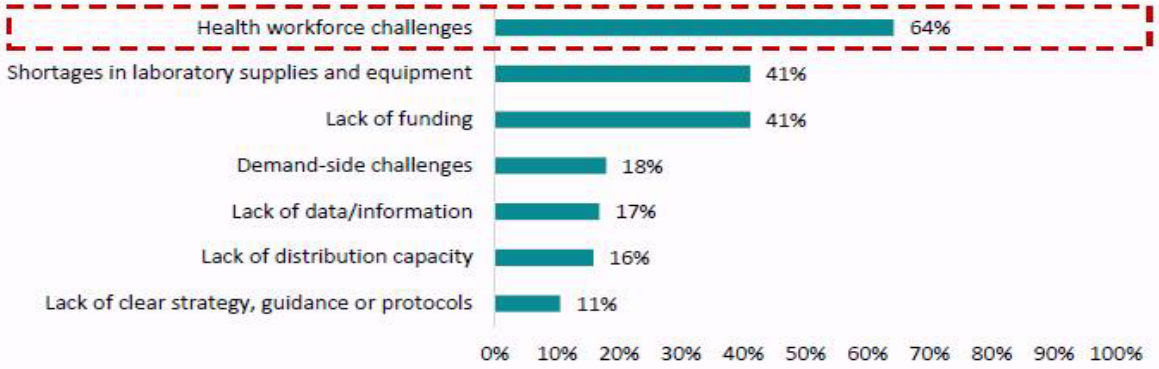
Bottlenecks for COVID-19 diagnostic and testing (n=95)



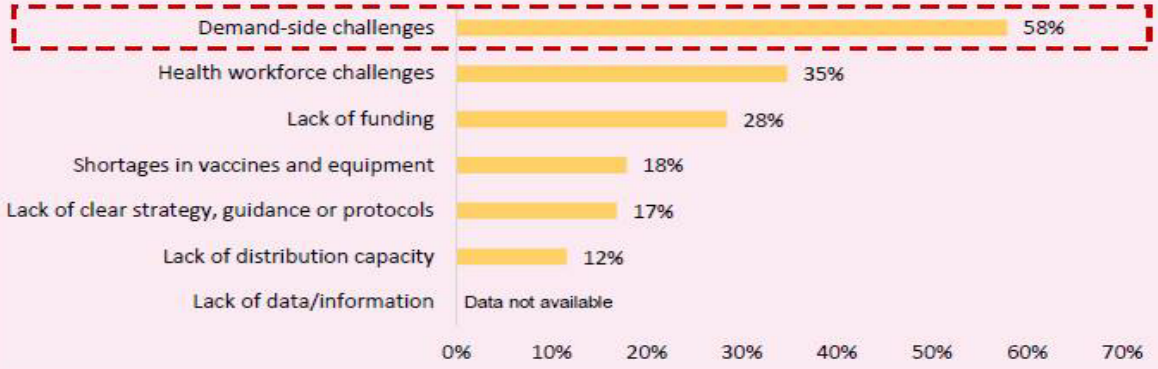
Bottlenecks for PPE distribution and use (n=95)



Bottlenecks for COVID-19 therapeutics (n=95)



Bottlenecks for COVID-19 vaccination (n=95)



Source: Round 3 Global pulse survey on continuity of essential health services, Nov-Dec 2021 (reflecting situation during previous 6 months)

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EAG Review of the Code: Recommendations

Box 2. Code implementation activities 2020–2023

Priority activities in support of Code implementation (2020–2023):

1. Provide requested technical assistance to Member States: 64 Member States requested support during the third round of Code reporting.
2. Strengthen institutional governance for the health workforce, including management of health worker mobility, across WHO Member States. Targeted support should also be provided to Member States who have not yet designated a national authority or participated in Code reporting.
3. Develop Global Guidance and Tools: Code User and Implementation Guide, Repository and Best Practices on Bilateral Agreements, Global Data Report on International Health Worker Mobility, Estimation of education costs and remittances, and Approaches to better understand and improve the lived experience of migrant health workers.
4. Strengthen the Member State reporting processes related to the fourth round of national reporting, including improved synergy with NHWA.
5. Revise the Independent Stakeholder Instrument and strengthen the reporting process to better capture input from non-State actors.
6. Engage with and support regional economic bodies and harmonization processes.
7. Strengthen engagement with private sector actors, including complementary hospital, trade union and recruiter codes.
8. Regularly update the list of countries with critical health workforce shortages, with the Secretariat encouraged to explore analysis that considers the full dynamic of the health labour market in determining health workforce vulnerability.
9. Strengthen Code advocacy efforts, including partnership with destination countries and donor and financial institutions, to drive health workforce related support to countries with greatest UHC-related health workforce vulnerability.
10. Ensure knowledge production, dissemination and lateral linkages with efforts in other sectors and with non-State actors through regular convenings and outputs of the ILO/OECD/WHO International Platform on Health Worker Mobility.

https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_9-en.pdf

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Activities undertaken 2020-2022

1. Technical support on Code implementation provided to 25 Member States
2. Increased to 158 (81%) the Member States with a designated national authorities, up from 122 (63%) in 2019
3. Included development of WHO Code implementation toolkit in workplan for 2022-23
4. Strengthened synergy with NHWA: 117 Member States reported data on foreign-born or -trained health personnel 2011–2020; 87 have done so in the last three years
5. Revised NRI instrument to include private recruiters reporting: 188 submitted a report in the 4th round
6. SADC and ECOWAS engaged in labour market and migration issues
7. Ongoing advocacy efforts on private sector uptake
8. Support and Safeguard List developed
9. Mainstreamed Code advocacy in dialogue with global health initiatives and funders
10. Development of WHO technical guidance on bilateral agreements in collaboration with ILO and OECD

https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_14-en.pdf

Health Workforce Support and Safeguards List, 2020 (HWSSL)

- WHR 2006 identified 57 countries with critical shortage (density lower than 2.28/1000, less than 80% coverage SBA)
- Updated methods guided by EAG identified health workforce support and safeguards list (2020)

• 47 countries with the most severe workforce vulnerabilities

➢ Prioritized for health personnel development & health system related support

➢ Provided with safeguards that discourage active international recruitment of health personnel

➢ Government-to-government agreement on health worker mobility from these countries should:

i. Be informed by health labour market analysis to **ensure adequate domestic supply in countries**
ii. Explicitly **engage health sector stakeholders**, including ministries of health
iii. Notify the WHO Secretariat

Region	AFRO	EMRO	PAHO	SEARO	WPRO
Countries	33	6	1	2	5

https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5

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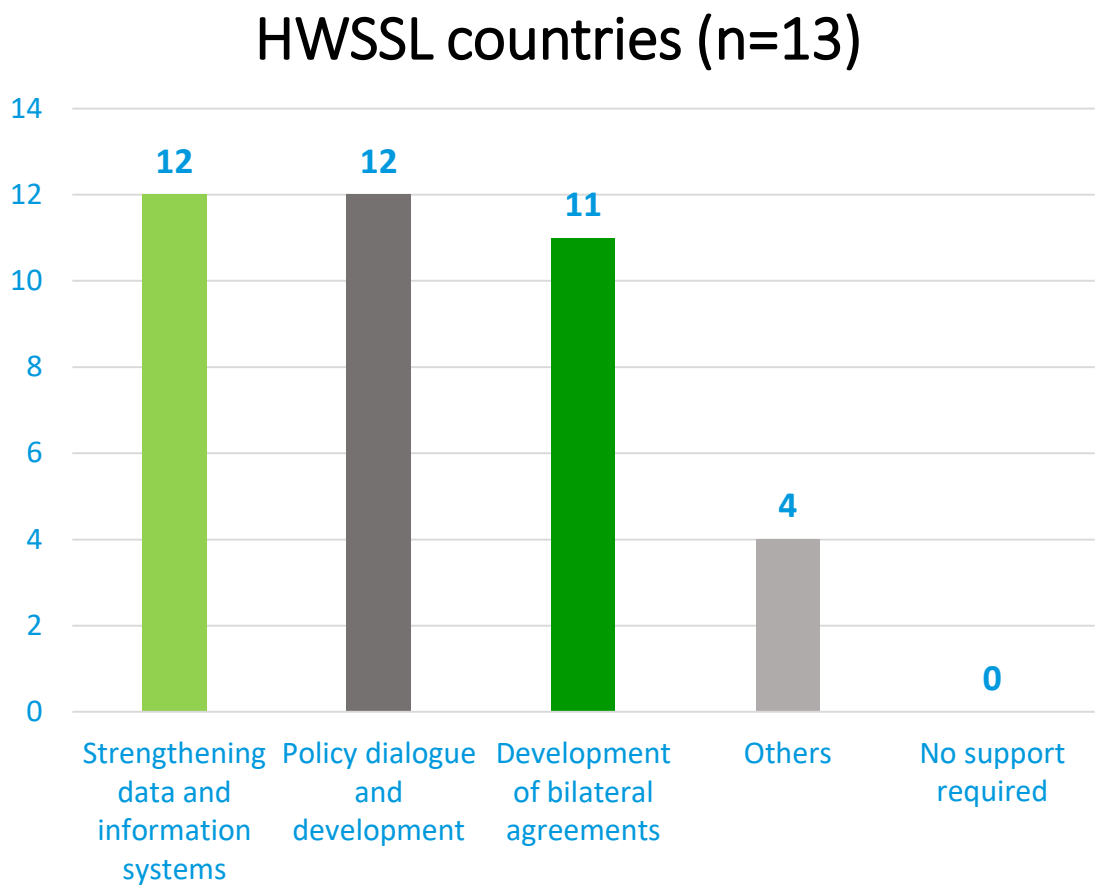
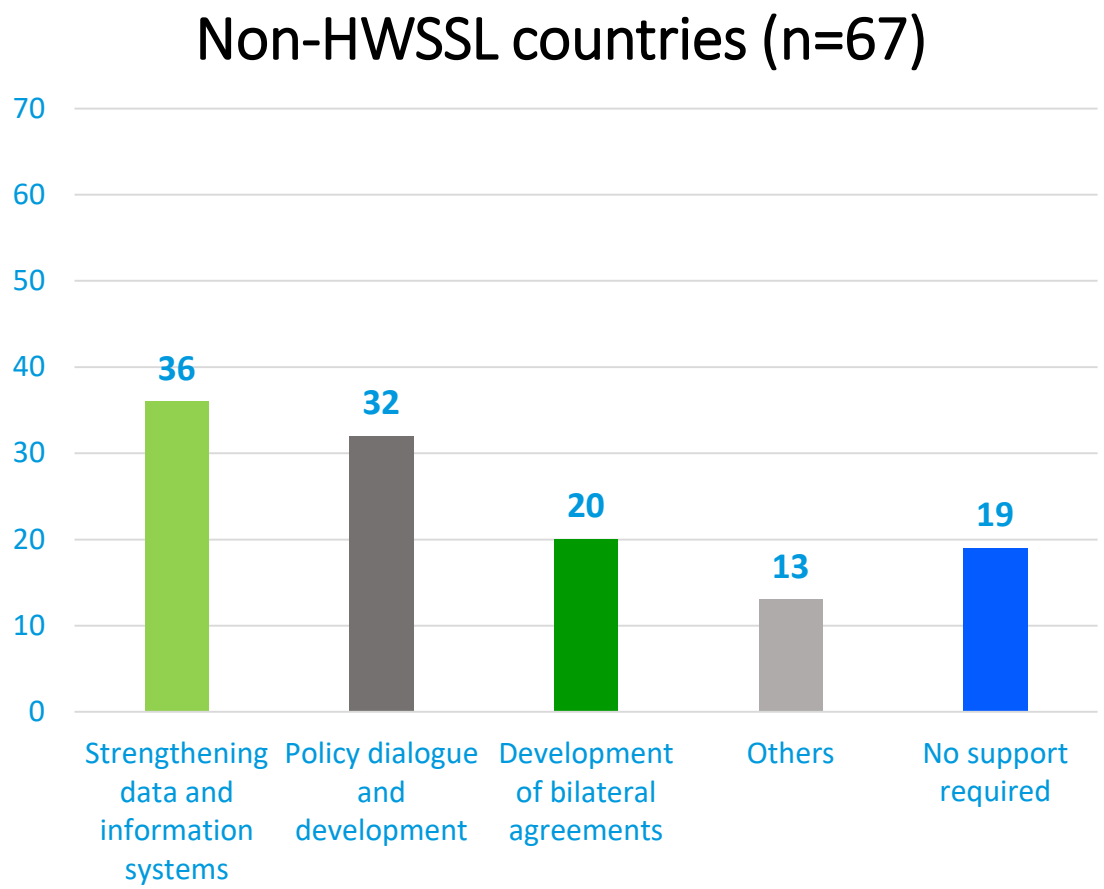
4th round of Code reporting: support required for Code implementation

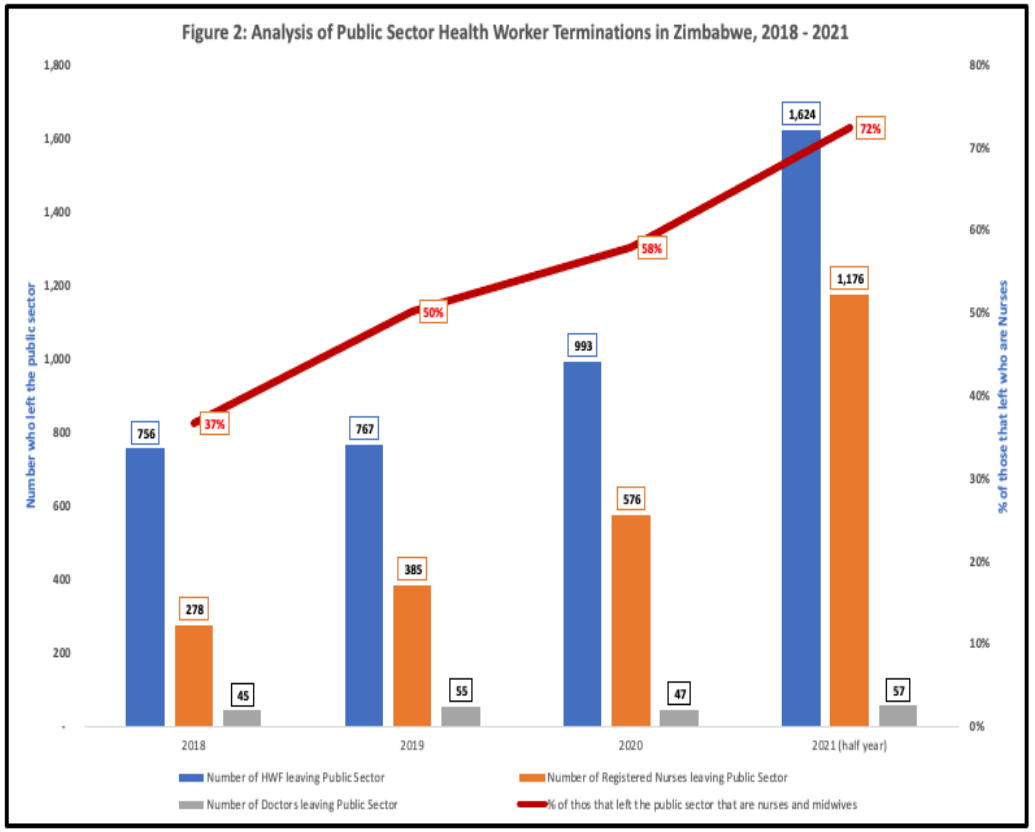




Non-HWSSL countries are also vulnerable

Zimbabwe UHC service coverage index: 54
HW density: 21 per 10,000 population

- **At least 20% of the active stock of medical doctors and 30% of nursing personnel in Zimbabwe are working abroad**. Between 2019 and 2020, out-migration of nurses increased by 44% and pharmacists by 68%.
- ZWD depreciation has caused erosion of salaries of public sector nurses from USD 400–500 to ~ USD 60–200 per month. Government is **unable to meet workers' expectations as the fiscal space is delicate**.
- **Between January and July 2021, at least 1,624 health workers, primarily nurses (1,176) terminated their services in Zimbabwe and potentially emigrated.**
- **Between Sept. 2019 to Sept. 2021, the number of Zimbabwean nurses/midwives registered in the UK rose by 819 (33% increase).** This data excludes the number of Zimbabwean nurses that may have taken employment in adult social care.
- Health facilities in Zimbabwe have **lost several nurses and midwives, especially those with specialized skills and tutors. This could compromise the ability to scale up the production** of nurses and midwives.



Public sector health worker termination in Zimbabwe 2018 - 2021

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A new context

- Increasing reports of international health personnel mobility in 2021/22.
- Concerns on the economic and social impact of COVID-19 that have increased health system vulnerabilities within countries.
- Expert Advisory Group on Relevance and Effectiveness of the Code reconvened to support process to assess implications of health personnel emigration in the context of increasing vulnerabilities brought about by the pandemic.

A/74-14
WHO Global Code of Practice on the International Recruitment of Health Personnel: fourth round of national reporting
Report by the Director-General

CONCLUSION AND WAY FORWARD

17. During the COVID-19 pandemic, countries have taken measures to maintain essential health services and respond to successive waves of infection and operationalize national vaccination programmes; this has tested the capacity of health systems and health personnel worldwide. The fact that many countries are once again turning to international recruitment to rapidly increase domestic capacity is likely to accelerate global migration and mobility of health personnel.

18. The negative health, economic and social impact of COVID-19, combined with the potential acceleration of international migration, may lead to increasing vulnerabilities within countries already suffering from low health workforce densities. The Secretariat will therefore establish a process, engaging expertise from Member States, for assessing implications of the emigration of health personnel in this context.

19. The Expert Advisory Group on the Relevance and Effectiveness of WHO's Global Code of Practice on the International Recruitment of Health Personnel will be re-convened to support this process. The Expert Advisory Group will review all countries with low health workforce density, including but not limited to those named in the Health Workforce Support and Safeguards List (2020), and will consider how COVID-related disruptions, particularly health-related vulnerabilities, might require the revision and extension of safeguards against active international recruitment. Their findings will be reflected in the update of the Health Workforce Support and Safeguards List (2023), to be published ahead of the 152nd session of the Executive Board.

20. In the interim, all Member States and relevant stakeholders are guided to apply the precautionary principle in international recruitment and encouraged to renew their individual and collective efforts to implement the Code, engage in technical cooperation and file reports; without such efforts, market-led and/or pandemic-driven economic demand for international health personnel may have direct or inadvertent consequences on access to health in other countries.

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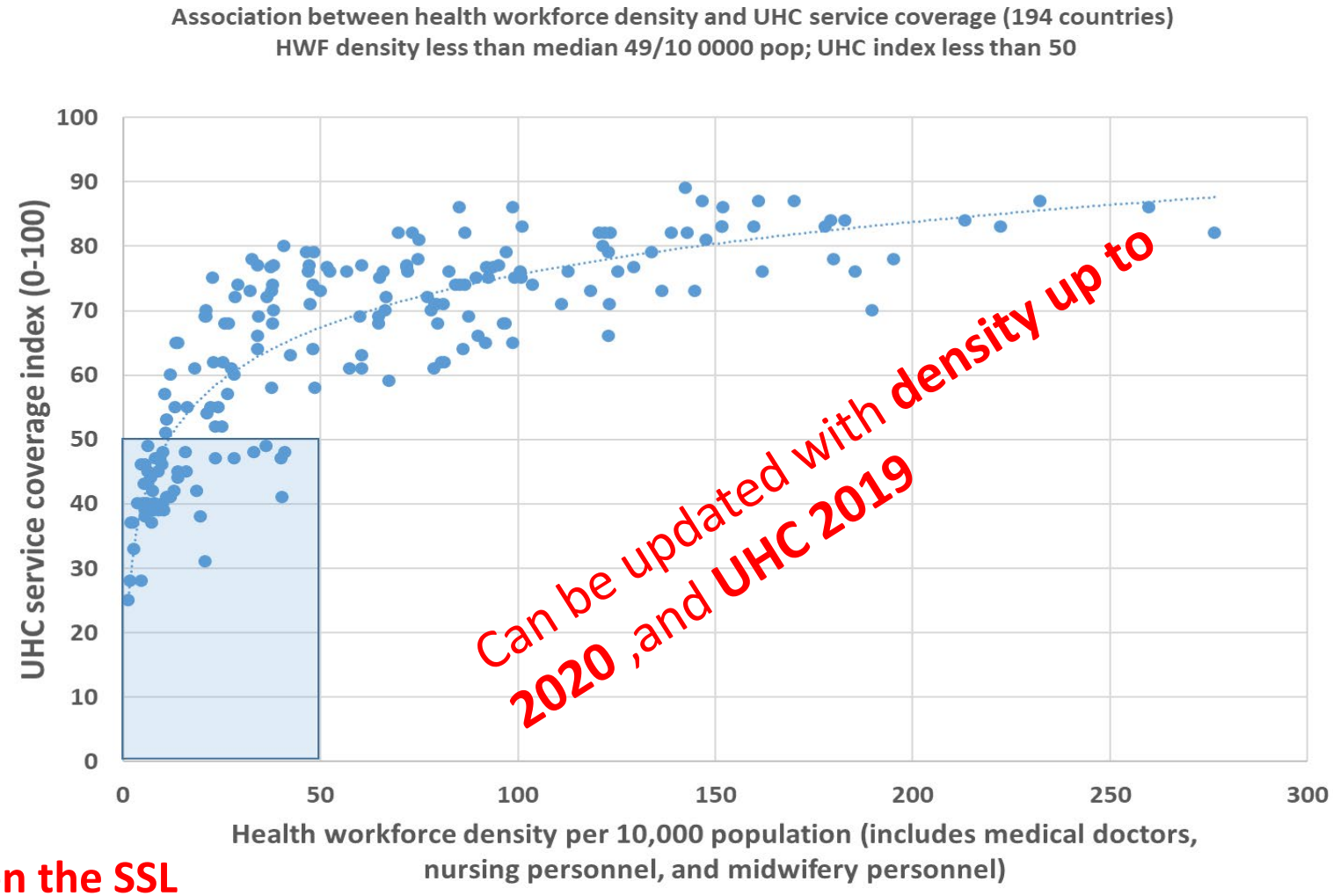
SSL 2020 (was based on density up to 2018, and UHC SCI 2017)



47 countries on the SSL

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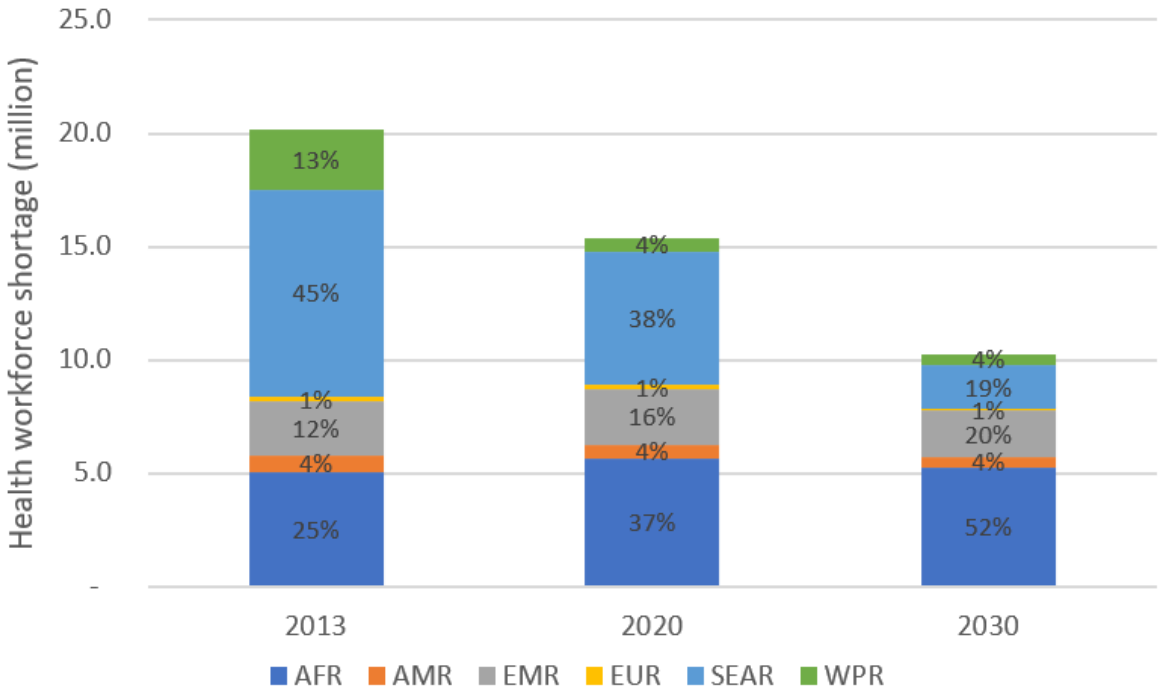
New UHC SCI *values for 2021 will be published end 2022, early 2023*
NHWA annual update on ***HWF density****: values for 2021 will be available end 2022*

Additional sources of vulnerability – HWF shortages



Note: Relative contribution of each region to shortage is displayed as percentage inside bars.

Figure A1. Distribution of the global health workforce shortage by WHO region in 2013, 2020 and projected shortage in 2030

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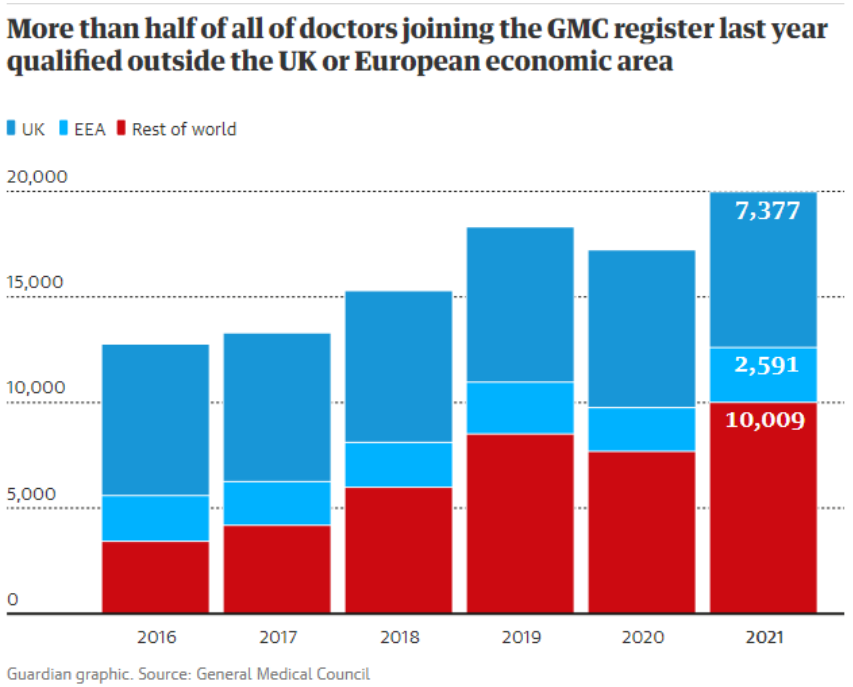
Migration

- Non-SSL countries, with low HWF density losing staff
- High income countries increasing international recruitment



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Summary of sources of vulnerabilities

UHC SCI

WHO Pulse surveys
disruptions in essential services
=> Impact on coverage

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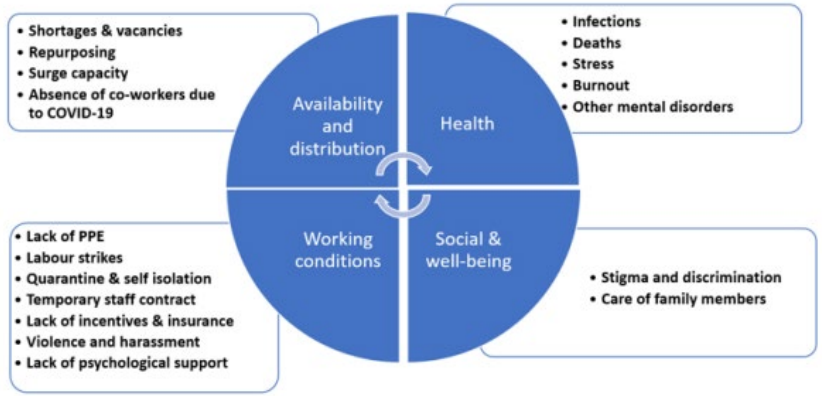
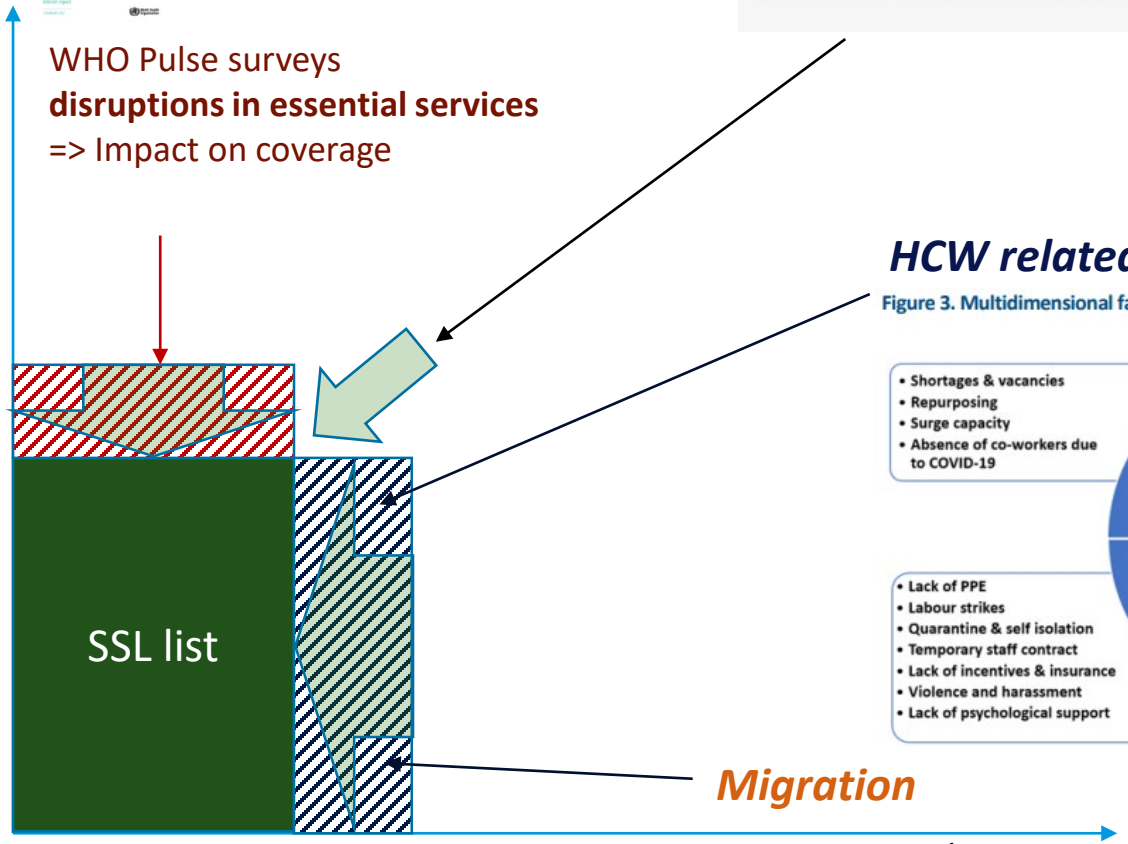
PRESS RELEASE | JANUARY 11, 2022

Global Growth to Slow through 2023, Adding to Risk of 'Hard Landing' in Developing Economies

HCW related impact

Figure 3. Multidimensional factors related to COVID-19 that impact HCWs





Migration

HWF density

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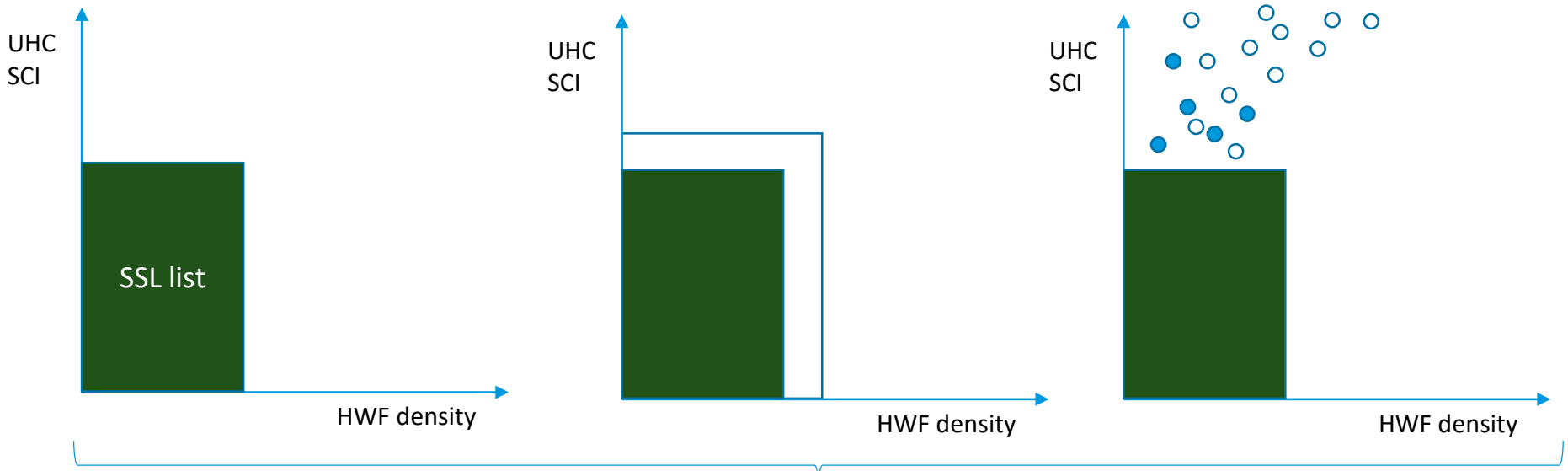
Method: classification or additive consideration of factors - Additive

1. SSL list

2. Potentially vulnerable (low UHC, low density)

3. Additional vulnerability (example projected HWF shortage >50% by 2030)



Binary:
Addition of each = In SSL vs Out of SSL

Categories:
SSL, Potentially vulnerable, Additional vulnerability, No specific concern

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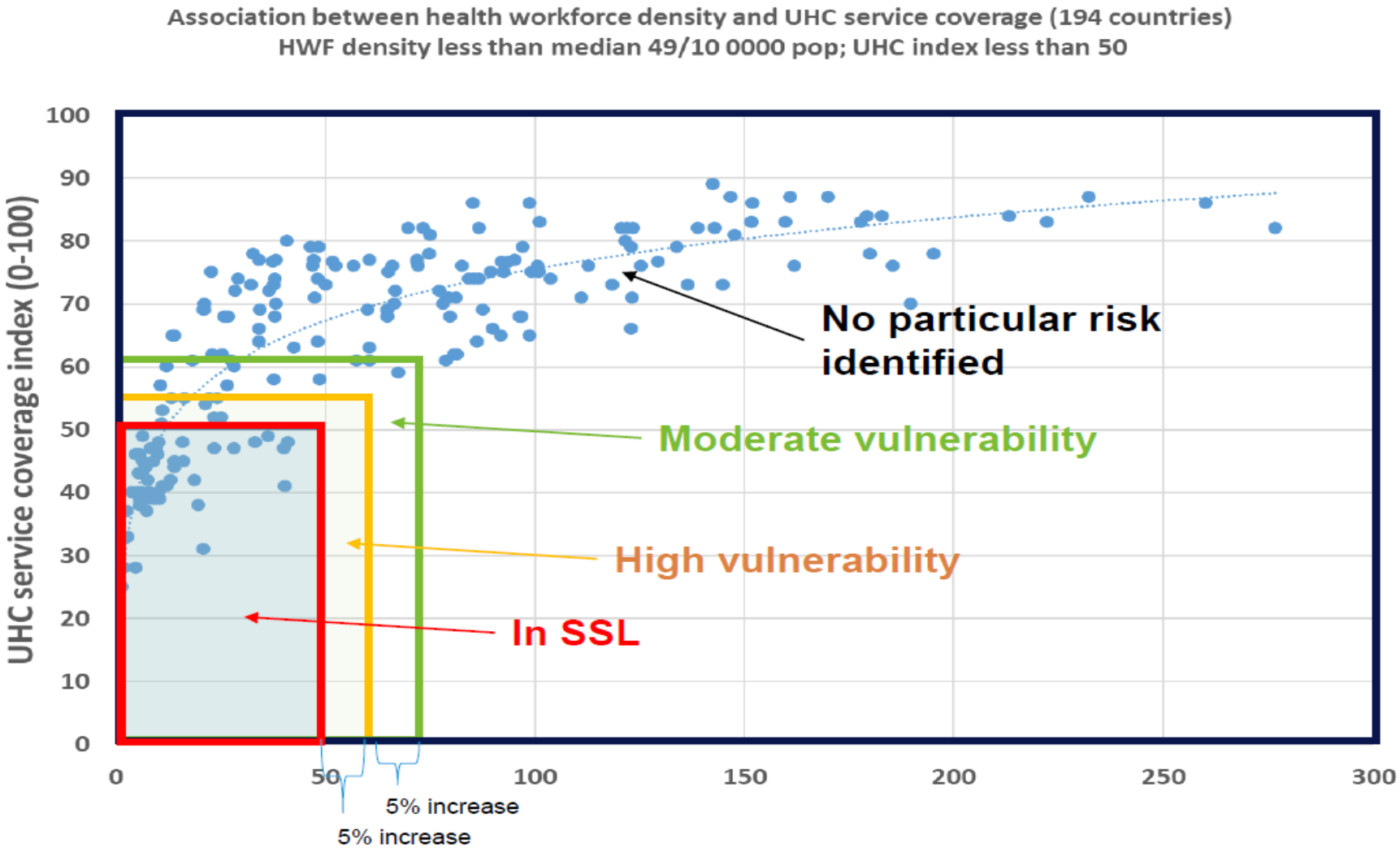
Moving from binary to categorization of vulnerability



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Next steps

- EAG to finalize guidance on methods and criteria based on preliminary analysis by Secretariat (Sep-Oct 2022)
- Secretariat to update Support and Safeguard List based on EAG guidance (Nov-Dec 2022)
- Update SSL published (Jan 2023)
- Member States can consider vulnerabilities and safeguards in the SSL in their health workforce development, retention and migration policies (2023 onward)

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Thank you

For more information, please contact:
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https://www.who.int/teams/health-workforce/migration/code-nri/
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