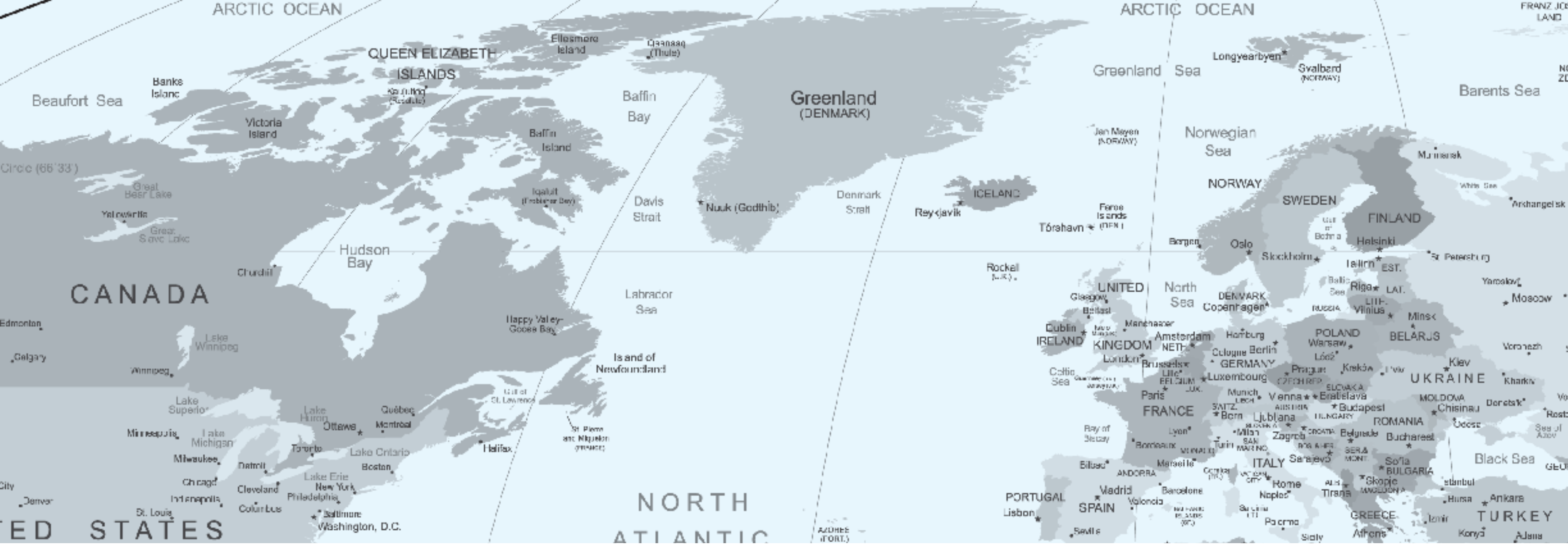
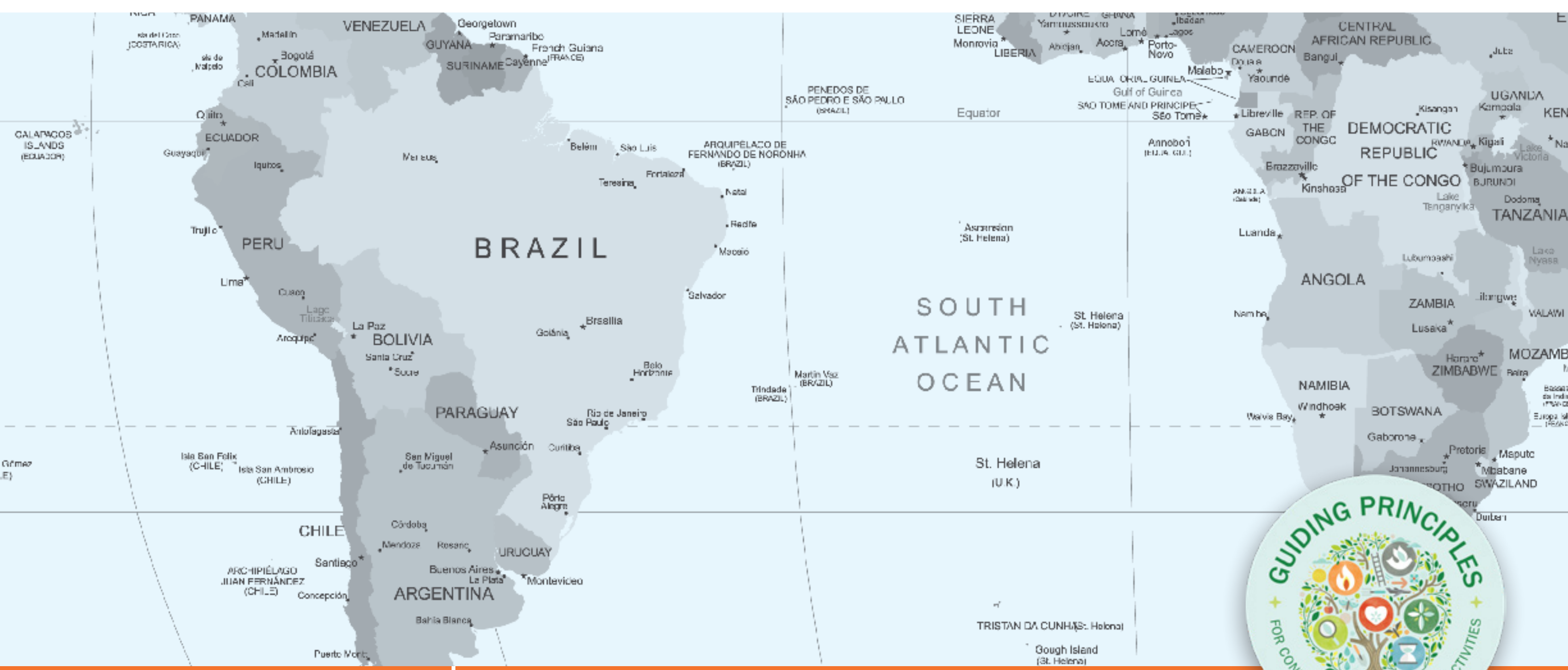
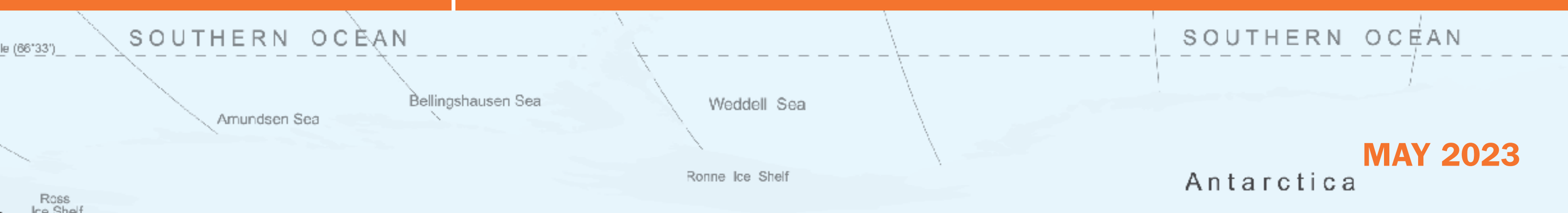


The Future of Health Workforce

DISCUSSION PAPER: INSIGHTS AND OPPORTUNITIES TO TRANSFORM INTERNATIONAL HEALTH WORKFORCE RECRUITMENT AND CAPACITY



We Will Empower Bold Change to Elevate Human Flourishing.℠



MAY 2023

Guiding Principles

for CONDUCTING GLOBAL HEALTH ACTIVITIES

PRUDENCE

Don't just do it

Good judgment requires controlling our enthusiasm to do good so that we also do it well, even in times of emergency. Technical expertise is necessary but not sufficient for action. International activity requires many things, including assessment, planning and evaluation.

AUTHENTICITY

Know thyself, know thy partner

There are many motivations for U.S. and international organizations to engage in international health activities. An invitation from a true partner who is part of the local community and its health system, knowledge and understanding of our respective motives and full transparency regarding our goals are all necessary if we are to do our best work.

HONESTY

Trust is earned and learned

Meaningful partnership requires a high level of trust and multiple lines of communication. Both U.S. and international partners must recognize that the other likely perceives risks in being totally honest. Both must listen for things said and unsaid, which takes both time and practice.

PATIENCE

Build capacity, not dependency

We should neither conduct activities that a local community can do for itself nor participate in one-way financial giving. The process of getting to know your partner — in order to build capacity — often takes longer than expected and requires patience.

EXCELLENCE

Best intentions do not equal best practices

Something is not always better than nothing. Low-resource settings do not permit lower standards. The high standards we follow in the U.S. — in delivering health care and developing partnerships — should not be set aside when working abroad. The laws of the country must be followed, the men and women providing services must be competent in their roles, and outcomes must be measured by quality, not simply quantity.

HUMILITY

We all have something to learn

Partnerships marked by mutuality and respect build relationships where both the U.S. and international partners benefit and take away relevant lessons. True cultural competence is necessary for a two-way learning process in any development activity.

A Note from CHA

This discussion paper is presented to provide U.S. and global health leaders with a greater awareness and understanding of the significance, interconnectedness and repercussions of the current Global Health Workforce Crisis. It was developed as a tool for Sponsors and Executives (C-suites, clinicians, human resources, global health and others involved in recruitment of health workforce) to begin dialogue and discernment on this important global health issue and our response as a Catholic health ministry.

As Catholics, we are uniquely called to global solidarity. One of God's greatest gifts is the universal character of the Church, blessing and calling us to live in solidarity with our sisters and brothers in faith. [1] Solidarity "is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all." (cf. Sollicitudo rei socialis, 38) For over 100 years, CHA and Catholic health care in the United States have worked to bring alive this vision of justice, peace and the common good.

The issue of health workforce and its role in achieving health equity are goals the Catholic health ministry has grappled with for years. We agree with the broader Church that all owners, managers, executives and consumers are moral agents who through our choices enhance or diminish economic opportunity, community life and social justice for all. (A Catholic Framework for Economic Life, USCCB) Therefore, as we work to fulfill the Church's call to global solidarity, it is important that we reflect on how the health ministry learns, educates, serves and acts in support of this vision. The current global health workforce crisis provides us with an opportunity to advance our shared commitment to pay special attention to our neighbors who are poor, underserved and most vulnerable

Over the past decade, the global health sector has gone through a period of rapid and transformative change. In response to these evolving dynamics, the Catholic Health Association of the United States (CHA) examined these changing global health and technology trends and their impact on future partnership opportunities. Among the many important issues raised in the research were the ongoing and worsening deficits in the global health workforce. CHA knew that this was a topic that needed more attention. To that end, we developed a special working group focused on the global health workforce, utilizing the findings of the aforementioned research.

As a result, we provide you with this discussion paper that provides insights and opportunities to invest, practice and advocate for the Future of the Global Health Workforce. We hope it helps CHA and the Catholic health ministry respond in a way that highlights our continued commitments to improve and protect the health of our society while global solidarity, peace, justice and common good.

Bruce Compton,
Senior Director, Global Health
Catholic Health Association
of the United States

Nate Hibner,
Senior Director, Ethics
Catholic Health Association
of the United States

[1] Called to Global Solidarity International Challenges for U.S. Parishes, United States Catholic Conference, 1997

Executive Summary

Global Health Workforce – Accenture Research

Discussion Paper: Insights and Opportunities to Transform International Health Workforce Recruitment and Capacity

This report addresses the global health care workforce shortage and its impact on health care systems. It examines current practices, showcases case studies and highlights the role of U.S. Catholic health care leaders in developing a fair and globalized health care workforce.

Valuable insights and recommendations for shaping talent pipelines are provided in the report which is intended for leaders in the Catholic health ministry, including Sponsors, C-suite members, Chief Human Resource Officers (CHROs), Chief Nursing Officers (CNOs) and global health leaders.

The research was conducted independently by Accenture in collaboration with CHA's Working Group on Global Health Workforce for the Future. It involved a comprehensive literature review and interviews with over 30 global stakeholders from high, medium and low-income countries, many associated with the Catholic health ministry.

Key insights and opportunities highlighted in the report include the significant risk posed by the global health care workforce shortage, contributing factors such as the COVID-19 pandemic, burnout, violence toward healthcare workers and an aging workforce. The report also discusses challenges in recruiting local health workers, the negative consequences of brain drain and the overreliance on international recruitment.

Global context, policy landscape and initiatives promoting ethical international recruitment practices are discussed in the report highlighting current practices, critical needs, challenges and areas for improvement.

A proposed framework for ministry leaders emphasizing ethical international recruitment is included in the report. The framework addresses issues including the following:

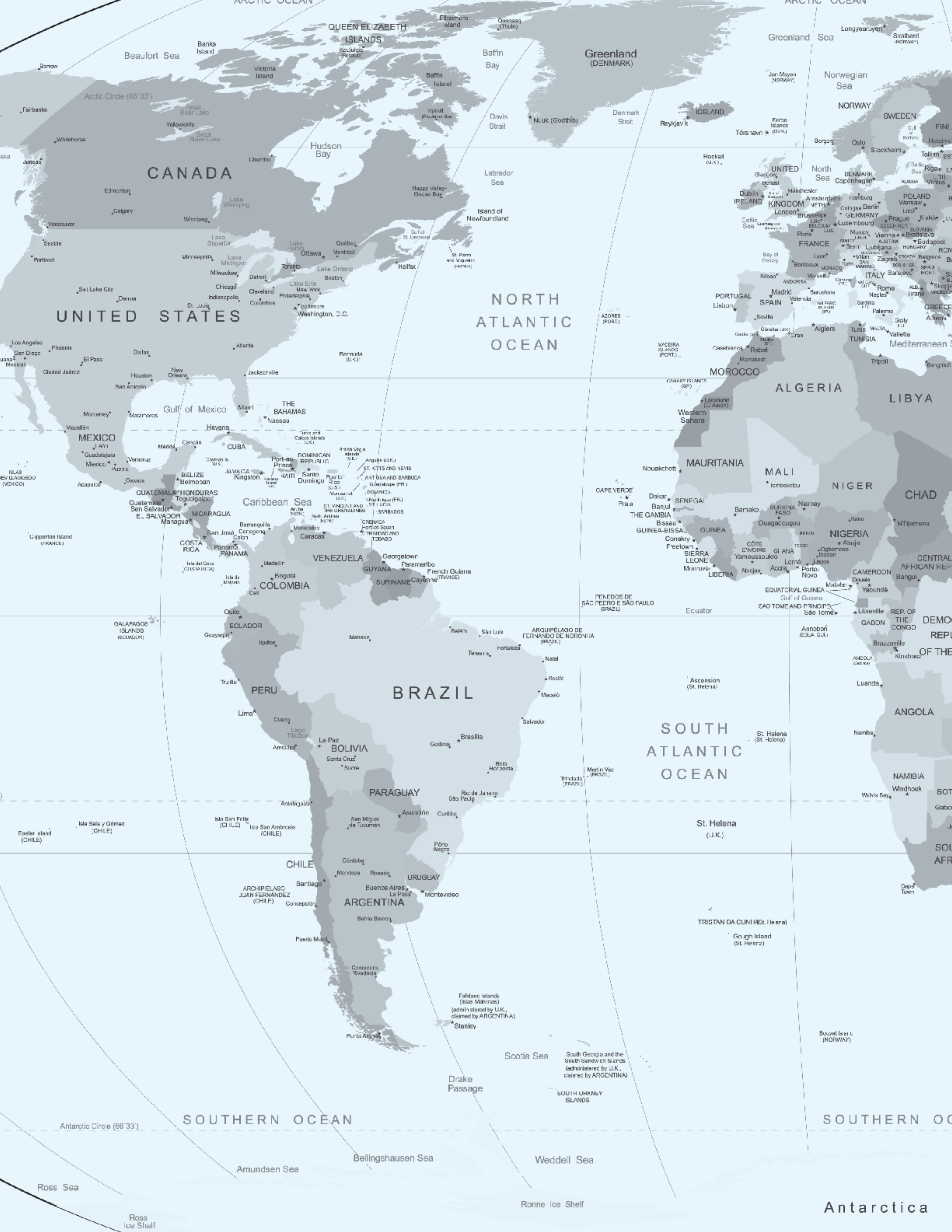
- investing in strengthening the health care workforce in low-and middle-income countries,
- practicing ethical behavior in global recruitment,
- advocating for improvements in domestic and global pipelines and working conditions,
- driving systemic change to enhance global health capacity.

The report concludes by emphasizing the need for leadership to redefine ethical practices, strengthen the global healthcare workforce, advocate for new recruiting standards and recognize the collective responsibility in solving the international recruitment crisis and workforce shortage.

Implementing the report's insights and recommendations allows Catholic health leaders and partners to transform international recruitment practices, strengthen global healthcare capacity and uphold the right to health for all.

About Us

Catholic health is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today. Comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. At the national level, these organizations join together in the Catholic Health Association of the United States. In CHA, the ministry raises a collective passionate voice for compassionate care.



ARCTIC OCEAN
QUEEN ELIZABETH ISLANDS
Ellesmere Island
Beaufort Sea
Banks Island
Victoria Island
Baffin Island
Baffin Bay
Greenland
(DENMARK)
Greenland Sea
Svalbard
(NORWAY)
Longyearbyen
Jan Mayen
(NORWAY)
Norwegian Sea
Arctic Circle (66°33')
Barrow
Fairbanks
Great Bear Lake
Yellowknife
Great Slave Lake
Whitehorse
Davis Strait
Nuuk (Godthåb)
Denmark Strait
ICELAND
Reykjavík
Tórshavn
NORWAY
SWEDEN
Oslo
Stockholm
Bergen
Hudson Bay
Churchill
Juneau
CANADA
Edmonton
Calgary
Labrador Sea
Happy Valley-Goose Bay
Lake Winnipeg
Winnipeg
Vancouver
Island of Newfoundland
Rockall
(U.K.)
UNITED KINGDOM
North Sea
DENMARK
Copenhagen
Glasgow
Belfast
Dublin
IRELAND
Manchester
London
Amsterdam
Hamburg
Berlin
POLAND
Warsaw
Celtic Sea
Brussels
GERMANY
Prague
Luxembourg
Paris
Munich
Vienna
Bratislava
Budapest
FRANCE
Bern
Ljubljana
Zagreb
Lyon
Milan
Belgrade
Bay of Biscay
Bordeaux
Marseille
ITALY
Sarajevo
Seattle
Portland
Lake Superior
Minneapolis
Lake Michigan
Milwaukee
Lake Huron
Québec
Montréal
Ottawa
Toronto
Lake Ontario
Halifax
Boston
Detroit
Chicago
Cleveland
Lake Erie
New York
Philadelphia
Indianapolis
Columbus
Baltimore
Washington, D.C.
Salt Lake City
Denver
St. Louis
UNITED STATES
NORTH ATLANTIC OCEAN
AZORES
(PORT.)
Bilbao
ANDORRA
PORTUGAL
Madrid
Barcelona
Rome
Naples
Lisbon
SPAIN
Valencia
Sardinia
Palermo
Sicily
GREECE
Athens
Seville
Algiers
Tunis
Valletta
MALTA
TUNISIA
Mediterranean Sea
Oran
Rabat
Casablanca
Marrakech
MADEIRA ISLANDS
(PORT.)
Tripoli
Los Angeles
Phoenix
San Diego
El Paso
Dallas
Atlanta
Bermuda
(U.K.)
Ciudad Juárez
Houston
New Orleans
Jacksonville
San Antonio
MOROCCO
ALGERIA
LIBYA
CANARY ISLANDS
(SP.)
Laayoune
(El Aaiún)
Western Sahara
Gulf of Mexico
Miami
THE BAHAMAS
Nassau
Monterrey
Matamoros
Havana
Mazatlán
MEXICO
Mérida
Cancún
CUBA
Guadalajara
Veracruz
Mexico
Puebla
Port-au-Prince
HAITI
DOMINICAN REPUBLIC
Santo Domingo
JAMAICA
Kingston
BELIZE
Belmopan
Oaxaca
Acapulco
ST. KITTS AND NEVIS
ANTIGUA AND BARBUDA
DOMINICA
BARBADOS
ST. VINCENT AND THE GRENADINES
GRENADA
TRINIDAD AND TOBAGO
Port-of-Spain
GUATEMALA
HONDURAS
Tegucigalpa
Guatemala
San Salvador
EL SALVADOR
NICARAGUA
Managua
Caribbean Sea
Barranquilla
Maracaibo
Caracas
San José
COSTA RICA
Panamá
PANAMA
Clipperton Island
(FRANCE)
Nouakchott
MAURITANIA
MALI
NIGER
CHAD
CAPE VERDE
Praia
Dakar
SENEGAL
Banjul
THE GAMBIA
Bissau
GUINEA-BISSAU
GUINEA
Conakry
Freetown
SIERRA LEONE
Monrovia
LIBERIA
Bamako
BURKINA FASO
Ouagadougou
Niamey
NIGERIA
Abuja
N'Djamena
CÔTE D'IVOIRE
Yamoussoukro
GHANA
Accra
Lomé
Porto-Novo
Lagos
CENTRAL AFRICAN REP.
CAMEROON
Douala
Yaoundé
Bangui
VENEZUELA
Georgetown
GUYANA
Paramaribo
SURINAME
Cayenne
French Guiana
(FRANCE)
Medellín
Bogotá
COLOMBIA
Cali
EQUATORIAL GUINEA
Gulf of Guinea
SAO TOME AND PRINCIPE
São Tomé
Libreville
GABON
REP. OF THE CONGO
Brazzaville
Kinshasa
Quito
ECUADOR
Guayaquil
GALAPAGOS ISLANDS
(ECUADOR)
Ecuador
Iquitos
Manaus
Belém
São Luís
Fortaleza
Teresina
Natal
Recife
Maceió
Salvador
ARQUIPÉLAGO DE FERNANDO DE NORONHA
(BRAZIL)
Trujillo
PERU
BRAZIL
Ascension
(St. Helena)
Luanda
ANGOLA
Lima
Cusco
Lago Titicaca
La Paz
BOLIVIA
Arequipa
Santa Cruz
Sucre
Brasília
Goiânia
Belo Horizonte
SOUTH ATLANTIC OCEAN
St. Helena
(St. Helena)
Namibe
NAMIBIA
Windhoek
Walvis Bay
PARAGUAY
Asunción
Antofagasta
Rio de Janeiro
São Paulo
Curitiba
Trindade
(BRAZIL)
Martin Vaz
(BRAZIL)
San Miguel de Tucumán
Isla San Félix
(CHILE)
Isla San Ambrosio
(CHILE)
Isla Sala y Gómez
(CHILE)
Easter Island
(CHILE)
St. Helena
(U.K.)
Pôrto Alegre
CHILE
Córdoba
Mendoza
Rosario
URUGUAY
Santiago
Buenos Aires
La Plata
Montevideo
ARCHIPIELAGO JUAN FERNÁNDEZ
(CHILE)
Concepción
ARGENTINA
Bahía Blanca
Cape Town
TRISTAN DA CUNHA (St. Helena)
Gough Island
(St. Helena)
Puerto Montt
Comodoro Rivadavia
Falkland Islands
(Islas Malvinas)
(administered by U.K., claimed by ARGENTINA)
Stanley
Punta Arenas
Bouvet Island
(NORWAY)
Scotia Sea
South Georgia and the South Sandwich Islands
(administered by U.K., claimed by ARGENTINA)
Drake Passage
SOUTH ORKNEY ISLANDS
SOUTHERN OCEAN
Antarctic Circle (66°33')
Bellingshausen Sea
Weddell Sea
Amundsen Sea
Ross Sea
Ross Ice Shelf
Ronne Ice Shelf
Antarctica

Table of Contents

Executive Summary 2
Chapter 1: Introduction 6
Chapter 2: Why Now and The Global Need 7
Chapter 3: The Current State Landscape 13
Chapter 4: Solutions & Opportunities 17
Chapter 5: Going Forward 21
Acknowledgements 22

Chapter 1: Introduction

What Is the Purpose of This Report?

The health care workforce shortage is an international challenge impacting countries at all levels of socioeconomic development. This report set out to examine the current state of practices, spotlight case studies and innovative solutions, and discuss the role of U.S. Catholic health leaders and health care leaders globally in advancing an equitable and globalized health care workforce that safeguards health care workers, the health care systems and patients in communities across the globe.

Who Is the Intended Audience of This Report?

The report provides insights and recommendations for any health leader who is participating in the recruitment of health care workers and provides key considerations as they shape their current and future talent pipelines. This report was developed to be widely shared and socialized with leaders in the Catholic health ministry including sponsors, members of the C-suite, Chief Human Resource Officers (CHROs), Chief Nursing Officers (CNOs) and global health leaders.

Methodology

The research for the report was conducted independently by Accenture, who worked with CHA's Working Group on Health Workforce for the Future to shape the scope and obtain feedback on data collection. Secondary research included a literature review of more than 70 publications, articles and reports.

The team also conducted interviews with over 30 global stakeholders to gather qualitative input. Our discussions included voices across high, medium and low-income countries, many whom were from within the Catholic health ministry. We also interviewed key partners of the ministry currently serving as health care leaders, physicians, policy experts and advocates. A full list of stakeholders engaged with for the development of this report can be found in the Appendix.

Framework for Future Discernment

The report offers a framework for ministry leaders which emphasizes an ethical approach to international recruitment in health care. It includes the following elements:

1. INVEST: Strengthen LMIC healthcare workforce through pre-service training and reciprocal partnerships.
2. PRACTICE: Hold agencies accountable and protect LMIC health capacity with ethical behavior.
3. ADVOCATE: Improve domestic pipeline and advocate for better working conditions and global safeguards.
4. LEAD: Catholic health leaders can drive systemic change and enhance health capacity globally.

The framework promotes ethical recruitment, equitable practices and protection of LMICs, aiming for global health equity and the right to health for all.

Chapter 2: Why Now and the Global Need

The Global Health Care Workforce Shortage

"I have never seen anything like what we are seeing right now. It feels different, it looks different. It is happening everywhere in every sector, and health care happens to be most touched by the shortage"

As of 2020, the global health care workforce was comprised of 65.1 million nurses, medical doctors, pharmacists, midwives and additional critical occupations[i]. Our ability to respond to new pandemics, the ongoing climate crisis, increasing conflict and migration, and to care for those who are most in need relies upon resilient and abundant health workers. Without an adequate and equitably distributed global health care workforce, the state of the world's health is at great risk, and we would fail to achieve many, if not all, of the UN's 2030 Sustainable Development Goals (SDGs)[ii].

Leading global health leaders and communities from around the world have been raising the alarm as the growing workforce shortage continues to worsen globally. Currently, an estimated global shortage of 10 million health workers is expected by the year 2030 – placing many already vulnerable communities at the brink of health disaster[iii].

In response to their own growing health care shortage, many high-income countries have turned to international recruitment to bolster their health care worker gaps. This growing dependency on recruitment of international health care workers coupled with lack of investment in the home countries is driving dangerous depletion and destabilization of health care capacity for the most poor and vulnerable countries across the globe.

As health care leaders respond to the looming shortage, we must re-examine our own international recruitment behaviors and strategies so that all communities are able to achieve the fundamental right to the highest attainable standard of health[iv].

Emerging Trends

In the context of high-income countries, particularly in the United States, five key trends emerge for the growing gap of health work force:

1) the impact of the COVID-19 pandemic
2) working conditions that exacerbate burn out
3) an increase in violence directed towards health care workers
4) aging of the current health care workforce population
5) domestic recruitment challenges

While these themes are most apparent in the US, they equally apply for the world's largest economies including, but not limited to, Germany, United Kingdom, Italy, Canada and Australia.

Also of note is the lack of nurse educators in the US and globally.

The Impact of the COVID-19 Pandemic

Prior to the start of the COVID-19 pandemic in 2020, the health care system in the US was already struggling with maldistribution of health care workers regionally, as well as cycles of both shortages and surpluses[v,vi].

As the COVID-19 pandemic continued to unfold, it placed an extraordinary strain on health care workers due to stressful demands such as increased risk and elevated exposure of the highly transmissible virus and work overload due to an increase in illness and severity of patients[vii,viii]. In 2021 the WHO estimated that between January 2020 and May 2021, between 80,000 and 180,000 health care workers had lost their lives due the COVID-19 pandemic, all the more furthering the shortage faced at the global level[ix].

"I don't think we have ever had enough nurses. We have NEVER had enough nurses"

While COVID-19 was and continues to be a major exacerbating force on the growing health care worker shortage, health care leaders noted that workforce shortage and fragility has always existed. The pandemic simply brought these critical issues to a boiling point.

Burnout

The current health care working environment is unsustainable and unsatisfactory. A recent Accenture multi-country study found that the health care industry faces a 26% industry gap between health care workforce needs and what their employers are providing[x].

Catholic health leaders frequently pointed to an outdated nursing model that does not account sustainability and flexibility of health care workers – especially for nurses. CNOs reported that their staff wished to reform the 12-hour shift structure and build a more human approach that includes career growth, non-weekend shifts and virtual options.

According to the American Nursing Association, more than 60% of nurses experience burnout across all US hospital and health facilities. **Source**

Nurses who already see their jobs as physically and mentally demanding[xi] are now also experiencing escalating workloads due to a growing shortage and chronic underinvestment. The nurses that choose to stay are required to do more and more, contributing to burnout rates never seen before[xii].

Violence Towards Health care Workers

Workplace violence experienced by health care staff is reportedly on the rise at a rate greater than ever. While the reasons driving the increase in violence are complex, US health system leaders have reported a combination of racism, political divide and frustration with the health care system as common motives[xiii].

The National Nurses United organization reported nearly 50% of all US based nurses indicated an overall increase in workplace violence in a 2021 survey[xiv].

25% of health care workers report that they are ready to leave their current role due to the frequency of exposure to violent and aggressive attacks. **Source**

On a global scale, violence towards health workers is an alarmingly growing trend. The University of South Australia published a report that uncovered a significant increase in reported experiences of abuse and threats, especially among early career nurses and midwives[xv]. The unprecedented amount of trauma and frequent harassment is pushing many health care workers to leave the industry and is currently resulting in an increasing number of strikes and walkouts by health care workers[xvi].

The Aging Workforce

The nursing industry is currently facing a unique and unprecedented two-pronged aging challenge. By 2030, nearly 20% of the global nursing workforce (4.7 million) will have reached retirement age and exited the workforce[xvii].

Unlike any other industry in the world, these retiring nurses would each subtract from the health workforce, while also adding to the growing health demand of aging populations[xviii].

Domestic Recruitment Challenges

Securing local health workers from the local talent pool has been a major challenge across the globe. New Zealand reports 1 in 3 nursing students dropping out before graduation due to financial or family constraints and the United Kingdom reports a 20% drop in new nursing school applications for 2023-2024[xix,xx].

In 2021, US nursing schools turned away nearly 92,000 qualified applicants due to insufficient number of faculty, clinical sites and budget constraints[xxi]. While we see high interest in the nursing field in the US and an overall 3.3% increase enrollment of entry-level baccalaureate nursing programs, the current pipeline model will not be sufficient to meet the demands of the looming gap[xxii].

"When I hear the words health care shortage it breaks my heart because it is really about the patients. It affects health care across multiple communities, our loved ones are not getting the care that they need."

The trends explored above are forcing health care leaders in high-income countries to think about new ways to urgently meet the growing demands of patient care during a time of increased demand for health workforce due to retirement and burnout. One of the most alarming, yet commonly growing practices observed is a sharp increase and overdependency of migrant health care workers. Many of these migrant health care workers come from countries of origin that already have serious strains on their health care systems.

The Crisis of International Recruitment

As of 2021, nearly 2.8 million foreign-born health care professionals are currently employed in the United States health care sector. **Source**

International recruitment of health care workers from LMICs to HICs is not a new phenomenon. In fact, since the 1960s the United States has relied on more than 150,000 nurses from the Philippines to meet the needs of the expanding American health care system[xxiii]. It should clearly be noted that the contribution of foreign-born health care workers in the United States, and across the globe, should not be understated as they play a deeply vital role in building health care resilience.

Nurse to Patient Ratio – per 1,000 people	
United States	15.7 (2018)
Australia	13.1 (2019)
Canada	11.1 (2020)
United Kingdom	8.9 (2020)
Philippines	5.4 (2019)
Nepal	3.3 (2020)
Mexico	2.8 (2019)
Bolivia	1.6 (2017)
Uganda	1.6 (2020)
Zambia	1.0 (2020)
Jamaica	0.9 (2018)
Honduras	0.7 (2019)
Tanzania	0.6 (2018)
Mozambique	0.5 (2020)

Data from The World Bank

However, due to numerous trends, active international recruitment of health care workers has rapidly accelerated in countries like the United States, Canada, the United Kingdom and other HICs. Due to the sharp uptrend in international

recruiting and the global shortage of health care workers in nearly every country, WHO added eight new countries to the WHO Health Workforce Support and Safeguard List in March 2023[xxiv].

"The impacts on these countries is a really big area to look at. When you take from one place there is nothing to replace"

The WHO defines a median density of 49 health care providers per 10,000 persons as the cutoff threshold of indication for countries facing the most pressing health care workforce challenges. Any country who has a provider ratio below the median, and that also has a universal health coverage service coverage index below a certain threshold, will be included on the WHO safeguard list. **Source**

Eight Countries Recently Added to the 2023 WHO Safeguard List

1. Comoros
2. Rwanda
3. Zambia
4. Zimbabwe
5. Timor-Leste
6. Lao People's Democratic Republic
7. Samoa
8. Tuvalu **Source**

The 55 safeguarded countries, informed by a threshold approach recommended by the Expert Advisory Group on the Global Code of Practice on the International Recruitment of Health Personnel, are experiencing some of the world's lowest health care workforce density numbers. This workforce gap is a significant crisis for these countries. It weakens health systems for universal health coverage and hinders the overall state of health security[xxv]. The WHO strongly discourages active recruitment of health care professionals from each of the 55 countries identified[xxvi].

Perspectives from Impacted Countries

Our research opened important dialogue on this topic with Catholic health leaders and partners from around the globe. Their stories and experiences sharply underlined the issue of over-recruitment and the communities it leaves behind. *Read their perspectives below:*

The Brain Drain in Ghana

"Developed countries come with big checks and take our health care workers. If you train 100 doctors, more than 50 disappear. The brain drain is a big problem."

The Nigeria Medical Association reports 50 doctors leave Nigeria every week to work abroad, largely due to low wages and the rising cost of living in their country. **Source**

In 2020, the World Bank reported an average of 3.6 nurses and midwives per 1,000 people in Ghana[xxvii]. Since then, Ghana has reported a new wave of "brain drain" and the Ghana Registered Nurses and Midwives Association (GRNMA) has raised urgent concerns advising immediate action to prevent a dire catastrophe on health care delivery to Ghanaians[xxviii]. The Government of Ghana have even previously instituted a ban on nurses leaving the country for work abroad – this controversial legislation has since been scrapped but the "brain drain" concerns persist.[1]

[1]In an effort to stop the exodus of health care workers, Ghana previously implemented a bonding policy in the realm of a 5-year service requirement for all government trained nurses. If a government trained nurse chose to take their talents abroad, they were required to pay the government for the cost of their training. Challenges still remain with both retention and exodus, however the country has since scrapped the policy due to picketing by health care workers and activists demanding underemployment be addressed before pushing the burden on the individual health care workers.

Zambia's Health care Worker Crisis

"There are factors that force Africans to leave to go work in a high-income country. If you look at the drains – most of those who leave are trained by the government. It is not just the brain leaving, it is the dollars leaving from Africa to Europe."

In 2020, the World Bank reported an average of 1 nurse and midwife per 1,000 people in Zambia[xxix]. Since then, the Zambian government and health systems leaders, including the General Nursing Council of Zambia, have formally announced major concern and pointed directly to international recruitment and outward migration of Zambian providers to more affluent countries (e.g., US, UK) which is widening the gap on equitable and quality health care for Zambians[xxxv].

India's Chronic Health care Worker Shortage in Rural Communities

"It is a huge challenge to retain skilled health care professionals with not-for-profit entities in resource limited countries. It takes a lot of effort to train our health care professionals, and at the end of that, many of them transition to a for-profit hospital or to an affluent country, for better financial and professional opportunities. This phenomenon strikes at the heart of our mission - 'compassionate, affordable, quality health care at the margins of the society' - in a significant way..."

In 2020, the World Bank reported 1.7 nurses and midwives per 1,000 people in India[xxxi]. India experiences both internal and external migration from more rural areas to urban cities or richer Gulf States[xxxii,xxxiii]. Sentiment is changing, with growing policy-maker concern, media coverage, and public outcry regarding the "brain drain" problem, which is not new but continues to be experienced in remote areas of India.

Health care for All, but Not Without Health care Workers in Bolivia

"Health care workers that decide to permanently leave are an invaluable loss to all areas of health care..."

In 2017, the World Bank reported an average of 1.6 nurses and midwives per 1,000 people in Bolivia[xxxiv]. In 2019, the Bolivian government underwent health care reform and implemented the Single Health System Model (SUS), a public health system that was set to provide free health care to 50% of the population[xxxv]. However, a major barrier for SUS success is the lack of sufficient and distributed health care workers, which has only grown with the global shortage.

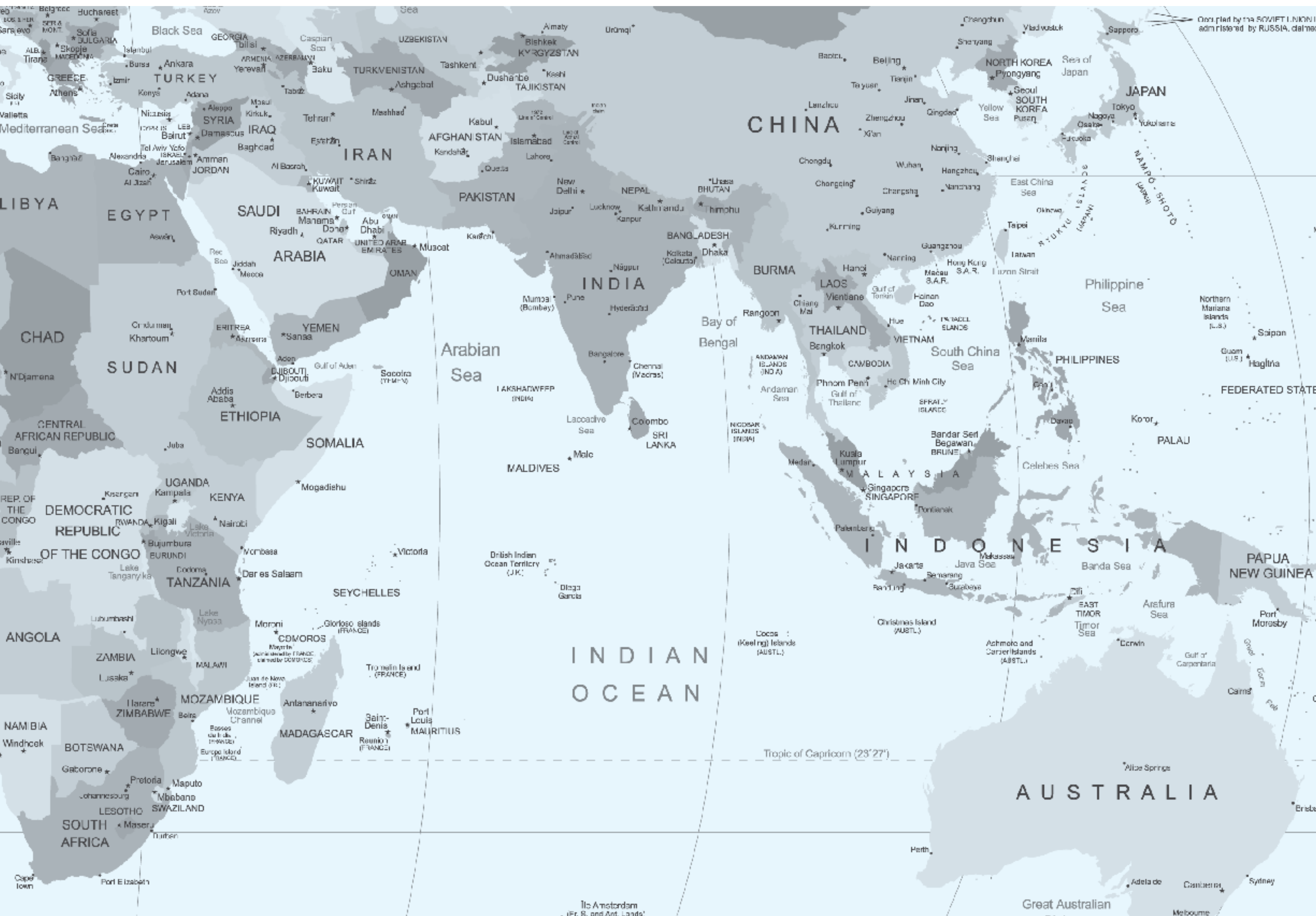
Depleting Health Capacity during the Pandemic

Jamaica, one of the countries heavily relied upon during the post-World War II rebuild of the UK and the implementation of the NHS, has been a prominent voice in the dire emergency of losing health care workers to recruiting HICs[xxxvi]. In 2022, the Nurses Association of Jamaica's Publication Committee continued to sound the alarm when more than 700 nurses left the country at the start of the COVID-19 pandemic[xxxvii].

The Urgent Need to Take Action on the Brain Drain

We must confront the sharp rise of active international recruitment and rethink our current recruitment and retainment practices to better safeguard countries and communities who are disproportionately bearing the burden of the global health care workforce shortage.

The right to migration, especially for those who are seeking safety and opportunity, is one to be protected and respected. Catholic health will always support humane and people-led migration of health care workers that is mutually beneficial to the origin countries[xxxviii]. What we must collectively address and re-examine is the ethics of international recruitment practices, so that we can practice responsibility for global health care capacity and resilience.



Chapter 3: The Current State Landscape

The Global Context and Policy Landscape

The issue of health care workforce shortage and international recruitment crisis has been steadily growing, forcing country leaders and policymakers across the world to action.

In April of 2023 the WHO Fifth Global Forum on Human Resources for Health convened and discussed the issue of health care workforce shortage and migration challenges. Specifically, the convening encouraged implementation of bi-lateral agreements between sending and recruiting countries to work in a more reciprocal way.

One exemplar partnership is the bilateral agreement between the Irish Health Service Executive (HSE) and the Ministry of Health in Mozambique (MISAU)[xxxix]. The partnership model focused on the exchange of knowledge between the countries health systems as well as capacity and capability improvement through coaching conversations, training of team leaders and addressing quality of local resources. As a result of the bi-lateral agreement, maternal mortality has decreased by up to 50% in some areas of Mozambique due to the partnership in funding and twin training models[xl].

International Organizations Advancing Ethical International Recruitment Practices

In addition to the independent responses by nations, there are several international organizations promoting more ethical intentional recruitment practices.

The WHO promotes the utilization of the voluntary Global Code of Practice on the International Recruitment of Health Personnel for all bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening[xli].

The Tropical Health and Education Trust (THET) is a prominent UK organization with a focus on partnership to train and educate health workers in Africa and Asia[xlii]. Most recently the organization has launched the Health Equity for ALL (HEAL) campaign to strengthen UK Aid investments in the global health care workforce[xliii].

The Current State Practices of Health System Leaders (The Good and Bad)

"We are actively looking at taking one-fourth of our current staffing need to see if we can fill it with international nurses"

Today, both Catholic and non-Catholic health systems are actively participating in international recruitment of health care workers and contributing to the disproportionate burden being experienced in LMICs. Health system leaders currently play a critical role in the demand-side of recruitment and will also have a critical role in the future of this space. Here we share the honest reflections of CNOs, CHROs, and other health system leaders on the realities of their challenges and needs, current practices and priorities going forward.

Key Needs and Challenges

In light of the growing global health care worker shortage Catholic health systems leaders expressed pressure to respond to three key challenges that ultimately drive dependency on international recruitment:

- an already preexisting shortage that was then heightened by the COVID-19 pandemic
- an outdated nursing model that leads to high turnover and burnout
- concerns with ensuring adequate patient care

What We're Doing Well

"Our first cohort of recruited international health care workers arrives in late 2023. At the end of 2024, we must ask ourselves if we live according to the ethical decision we made. We will consider if we provided the experience we desire for our international nurses and if we could do differently to enhance our ethical discernment. What's next could mean that we need to pause, and we are open to that…"

Addressing the global health worker shortage is not an easy task for today's health care leaders. We set out to understand their best practices for ethical international recruitment.

While we did not find commonly used best practices for directly working alongside least developed countries– we did find strong examples for principled recruitment and integration of international workers, which showcased a deep abiding commitment to Catholic health principles to serve the poorest and most vulnerable – both domestically and abroad.

Utilization of Recruiting Agencies Utilizing Ethical Frameworks

"We are actively looking at taking a quarter of our need to see if we can fill it internationally… we are deliberate about choosing the recruitment agency we work with. We are deliberate about not removing really important members from a society where it would be detrimental to a country…"

Catholic health leaders shared their principles and trust in only engaging staffing agencies that abided by ethical practices and policies. Many of the trusted agencies were certified and utilized the Health Care Code for Ethical International Recruitment and Employment Practices, a code first published and launched in 2008 by The Alliance at CGFNS International[xliv].

"We are working with partners that have a presence in 70+ countries. One of the reasons that we chose these groups is that they can prioritize recruitment in countries where there is less risk to care access. Our partners will not recruit in a country where health care systems would be compromised."

Catholic health leaders also shared that they participated in moral reflection and discernment before choosing to participate in the recruitment of international health care workers. One hospital leader stated that before he determined the number of international health care workers to request from an agency, his leadership underwent a discernment discussion including a Catholic Ethicist to ensure the approach was in alignment with Catholic health principles of health equity for all.

Investment in the Domestic Talent Pipeline

"The key to this solution in workforce, is talent pipelines, this is how you will get to a sustainable cost to labor. We are the largest employer in those communities - we're the employer and oftentimes those employees are patients themselves so we need to uplift those communities."

It is critical for health systems to directly foster their domestic talent pipeline for health workers. Best practice solutions from respondents include a focus on upskilling non-licensed hospital staff, more flexible scheduling and staffing opportunities for licensed nurses, and heightened focus on supporting the mental health and well-being of all staff.

Innovation in the Future of Work

"We recognize there are certain things that you do not need a nurse to physically be in the room to do – you could be doing it virtually. This evolved into a co-caring model, a physically present and virtual team comprised of RNs and techs…"

Catholic health leaders also shared a strong focus on utilizing innovation and technology to better understand current staffing needs, forecast for the future, and improve quality care with less workers. Leaders from one Catholic hospital system shared the overwhelming success in bringing telehealth onto a floor and the "co-caring model" for a combined staffing approach. The combination of virtual care providers and in-person staff resulted in a 100% floor staffing rate, 40% decrease in turnover of staff, an overall more managed workload, and greater level of motivation for all involved, including patients.

What We're Not Doing Well

While there were many innovative and inspirational practices around retention and purposeful utilization of both domestic and international staff, there are also important opportunities for improvement.

Over-Reliance on International Health care Workers

"Currently we have around 50 to 100 international nurses, and are looking to double that number in the next year…"

Health leaders continue to recruit a sharply increasing number of international health workers and continue to over-rely and over-depend on staffing agencies to do so. Most CNOs/CHROs indicated an expected yearly increase of international health worker recruitment, specifically nurses.

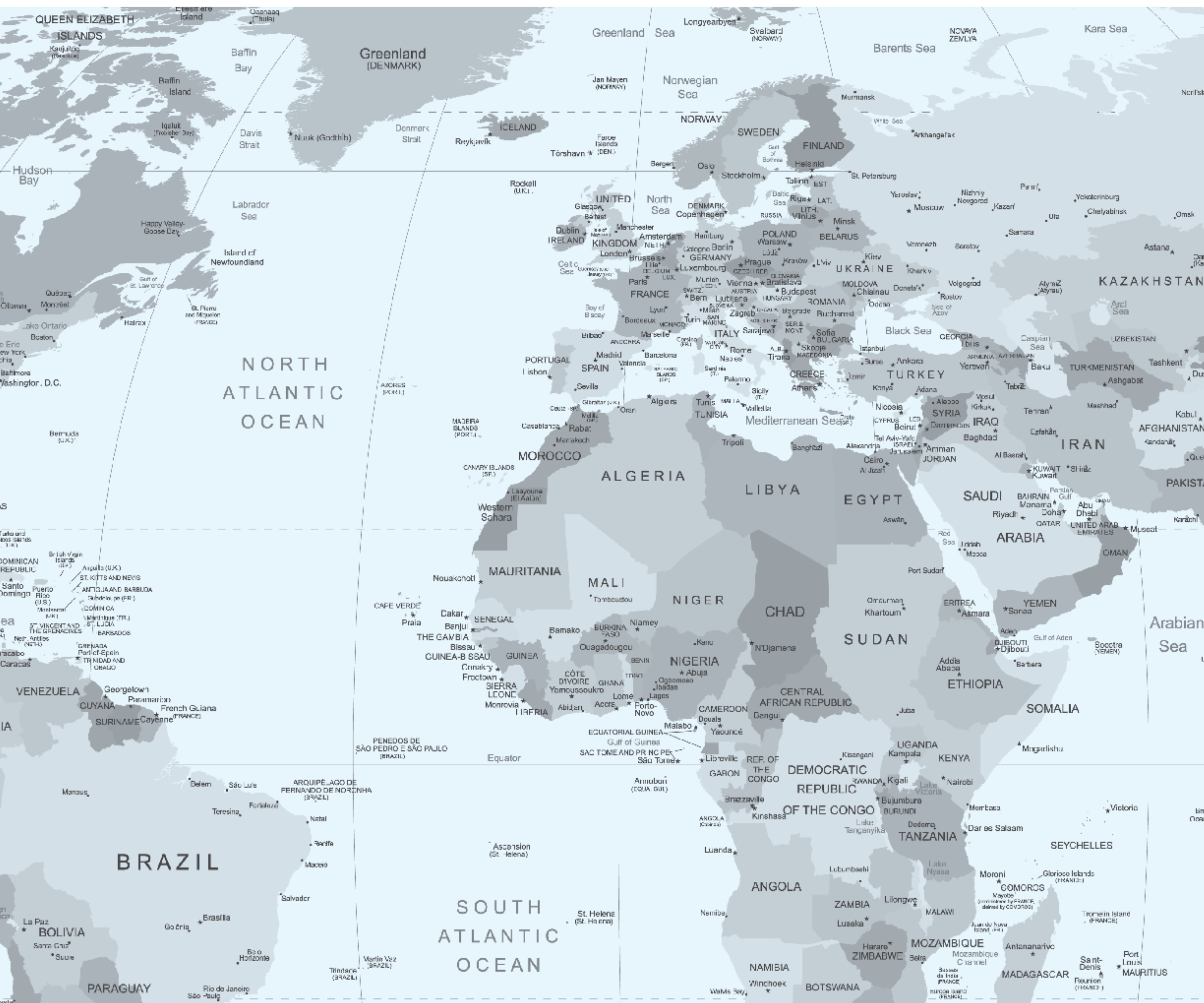
These big international recruiting targets do unfortunately prioritize the needs of their individual hospitals over the needs of a global community (and especially the needs of low-income countries who are losing talent through unsustainable recruitment). It will be important for health system leaders to take a wider lens of health impact. While many health leaders have already deeply invested in migrant worker integration and inclusion movements (e.g., language supports, airport pickup, immigrants' rights, and integration), the same level of attention is currently lacking in considering the unintended consequences and 'ripple effect' of international recruitment on home communities.

Improving Accountability of Trusted Recruiting Agencies

"Do we have a deliberate effort in recruiting internationally? Yes. We are deliberate about how we approach this – we sought organizations that were following the ethical guidelines from The Alliance"

One problematic and reoccurring theme that arose around international recruitment was an over-certainty and over-trust in ethical behavior of recruitment agencies. Catholic health leaders place trust in recruiting agencies to abide by ethical behavior, but currently, no accreditation body is currently and significantly evaluating the specific area of ethical recruitment from fragile countries.

Many Catholic health leaders shared their intention and trust for agencies to follow ethical guidelines, yet the makeup of international staff did include many listed countries featured on the 2023 health care workforce support list and other countries close to the WHO 'red list' threshold for active safeguarding. Many staff also come from countries whose governments have publicly expressed concern and alarm about the growing gaps and "poaching" of their health workers. There must be greater reform in our agreements and expectations working with recruiting agencies and more clearly setting ethical practices for international recruitment.



Chapter 4: Framework for Future Discernment

In this section we highlight a more globally ethical framework that Catholic health leaders can utilize to mitigate harm to vulnerable countries and communities. This framework uplifts three foundations to build more equitable international recruitment practices that advance ethical behavior and safeguard LMICs.

Catholic health leaders have the unique and powerful opportunity to lead the way and invest, practice, and advocate to transform ethical international recruitment practices. Below are proposed opportunities identified through this research:

1. **INVEST:** Directly strengthening the resiliency of LMICs and better under standing strategies to invest in pre-service training, employment and career advancement. Catholic health leaders must take a more active role in driving a positive economic and human-talent impact through clear and reciprocal partnerships with sender countries.
2. **PRACTICE:** Advancing global health equity and ensuring the protection of LMIC health capacity by practicing clear and ethical behavior and holding recruiting agencies accountable to local and global practices.
3. **ADVOCATE:** Strengthening the current domestic pipeline and ultimately decreasing the reliance on international health care workers through collective advocacy. This includes advocacy for better domestic working conditions as well as global safeguarding policies.

Catholic health community can lead real systemic change, and fundamentally shift behaviors and strategies for international recruitment. We have the opportunity to transform health capacity impact for the world's most fragile countries.

CHA's Framework for Advancing More Globally Ethicial Recruitment Practices of International Healthcare Workers

INVEST — How can Catholic health leaders invest in strengthening the health workforce of LMICs?

PRACTICE — How can Catholic health leaders promote and practice globally inclusive ethical recuritment practices?

ADVOCATE — How can Catholic health leaders advocate for globally sustainable recruiting standards

In Practice - Highlight: The Irish Global Health Network, founded in 2004, is led by a diverse group of professionals who are interested in addressing health inequities at a global level, with a focus on those living in LMICs. Through many national partnerships, the Irish Global Health Network has been able to work across issues like NCDs and have imbedded objectives that focus on the promotion of education for professionals at the public local and national level to enhance the capacity building and retention of local providers across Africa and in Ireland.

Exploring Solutions to the Global Shortage and Crisis of International Recruitment Utilizing the CHA Framework Model

Solutions to the global health care workforce shortage that do not deplete LMIC health care workforce do exist and are important to elevate. The solutions we present in this following section are examples of work happening today to better invest, practice and advocate together with global partners to transform international recruitment.

Invest in Strengthening the Health care Workforce of LMICs

Catholic health leaders must invest in the people, institutions and capacity of sender countries. Below we explore two strategies: funds for pre-service training and long-term reciprocal relationships for investing in LMIC recruitment countries.

In Practice - Highlight: Currently, there is no established international funding model dedicated to investing in the pre-service training of health care workers in nations who are experiencing the most dramatic effects of the global shortage. Leaders at THET are driving discussion forward on a proposed joint funding mechanism, similar to The Global Fund, a fund to fight HIV/AIDS, TB and Malaria, as a model to address the complexity of human resources required for health.

1. Collaborate to develop pre-service training

"The biggest thing we can do is train people back in the country that they come from. If we have a lot of people coming to us from one country, we should be training people in that country."

Establish a pre-service training fund for sender countries, especially for countries identified on the WHO safeguard list. Pre-training investment requires country engagement and planning with health care leaders, health care workers and government officials to shape sustainable strategies that fit the economic needs of each country.

2. Establish and develop long term, reciprocal partnerships with the countries

"…we cannot restrict or deny migration. But we can ask how can we promote our youth going to train and learn in HICs? And how can we promote those coming back? Or develop partnerships to send 10, bring 2 back with a certain expertise?"

Address the unique challenges faced by countries most impacted by the global health care workforce shortage, especially the countries sending the most migrant workers[xlv].

Understanding and working to address the complexity of sociopolitical push factors will require long term, trusted and reciprocal partnerships instead of short-term initiatives. Engage with the country partners to encourage and promote strategic partnerships that strengthen capacity for local health care workers to ensure all communities have an opportunity to receive the health care they need.

3. Expand the definition of ethical to take on a more globally inclusive approach

"The very first thing is to make everyone aware of the practices that the alliance put together. Every time that I talk to a nursing colleague that is speaking about international recruitment, I give them this resource because it is very important and everyone must have it…"

Catholic health leaders must lead and practice global solidarity to advance global health equity and safeguard fragile countries. Improving health access and quality in HICs should not be at the detriment of our global neighbors in LMICs. By expanding our service to all people around the world, Catholic leaders have the responsibility to discern new practices and strategies that safeguard the right to health for all.

Rethink and redefine what ethical international recruitment means for your health system. Consider how you might use the principles of the Alliance's Health Care Code for Ethical International Recruitment and Employment Practices to expand ethical behavior across international borders[xlvi]. Catholic health leaders have a real opportunity to also leverage the WHO International Code and lean into the guiding principles of Catholic Health Association[xlvii].

In Practice - Highlight: In response to the need for some of the world's most pressing nursing challenges, Health Carousel, a staffing agency based out of Cincinnati, Ohio has recently expanded to form a new foundation, which is a continuation and expansion of the organization's longstanding "Light the Way" initiative, focused on improving the technical and leadership skills of foreign nurses in their home countries and expanding the industry minimum standards for ethical international recruitment practices.

Additionally, there is opportunity to consider how Catholic health leaders and systems can work best with countries who are not currently safeguarded to create more reciprocal approaches that proactively prevent the depletion of health care workers abroad.

In Practice - Highlight: The Philippines is a country not currently safeguarded by WHO, yet Philippine nurses are the most likely to be employed abroad in a HIC. The Philippine Nurses Association has recently raised concern around the ability to provide essential care to its citizens if health systems leaders do not rethink their extractive and depleting dependency on Filipino nurses. The need has become so dire that the national government is now considering emergency responses such as scholarships and incentives to encourage nurses to remain working within the country.

4. Promote accountability of ethical behavior for staffing agency vendors

Catholic health leaders have a powerful opportunity to demand accountability of ethical recruitment practices amongst their trusted staffing and recruiting agencies[xlviii]. Health system leaders must require and hold their staffing agencies accountable to the WHO Global Code of Practice and the Alliance Health Care Code recommendations (and even going beyond in innovative and responsible practices).

By partnering with ethical agencies (certified by The Alliance Code, actively reporting to the WHO International Code, abiding by local national policies, and taking an active role in the investment of LMIC health care systems), Catholic health leaders can be a major catalyst for change.

Health care leaders can also promote, encourage and build data systems that map the true impact of the shortage and crisis of international recruitment. By creating more transparent understanding of the costs that international recruitment processes have on LMICs, Catholic health leaders can restrict recruitment and protect countries from over-recruitment.

5. Advocate for Investment in the Domestic Health care Worker Talent Pipeline

"Our underinvestment in the training and education of health workers domestically is the first problem. That second problem is that we are simply not retaining people."

Case Study: Bon Secours Mercy Health has recently been in the spotlight for its innovative approach to addressing the current health care talent shortage by providing tuition assistance and career pathways via the Called to Grow program. Through a partnership with Guild Education, Bon Secours provides opportunities to more than 120 clinical certifications, undergraduate degrees, graduate degrees, and nursing degrees at 15 universities and educational institutions and covers 100% of the tuition. So far, the new program has attracted new talent and reported a 20% reduction in turnover in the past year – in which they directly attribute to the partnership and investments made in the talent pipeline.

Catholic health leaders must incubate a strong and enduring pipeline of domestic health workers and invest to open affordable career pathways for domestic health professionals. This may include early educational pipelines such as working directly with local high schools to promote career exploration and encourage pathways into some of the most critically needed roles, such as nursing[xlix].

6. Develop, Advance and Promote Advocacy Strategies at the Local, National and International Level

"A lot of boards are setting KPIs on workforce recruitment and staffing and unless they know the complexities, they will continue to exert pressure in unhelpful ways that will be challenging."

Advancing more ethical international recruitment practices will require ongoing and concerted support for inclusive policies. Local, national and international policies must be updated and activated. Catholic health leaders have an important opportunity to ensure that voices from countries most impacted are included at the decision-making table and that solutions are beneficial for all countries.

In Practice - Highlight: Pan American Health Organization (PAHO) frequently raises concern regarding the lack of research conducted in Latin America, especially during a period of growing crisis such as the global health care workforce shortage. In June 2022, after advancing international policy, the United States Government and PAHO launched the Americas Health Corps (AHC) as part of the Action Plan on Health and Resilience in the Americas to scale up workforce capacity and provide basic and specialized training to more than 500,000 public health, health science and medical professionals throughout Latin America and the Caribbean.

Catholic health leaders must join to collectively develop, advance and promote key policy change at the local, national, and international level[l]. There is enormous need for Catholic leaders to support global standards, guidelines, policies and practices that manage international recruitment. Catholic health leaders must advance this agenda across global conferences, global working groups, new research and other key advocacy channels.

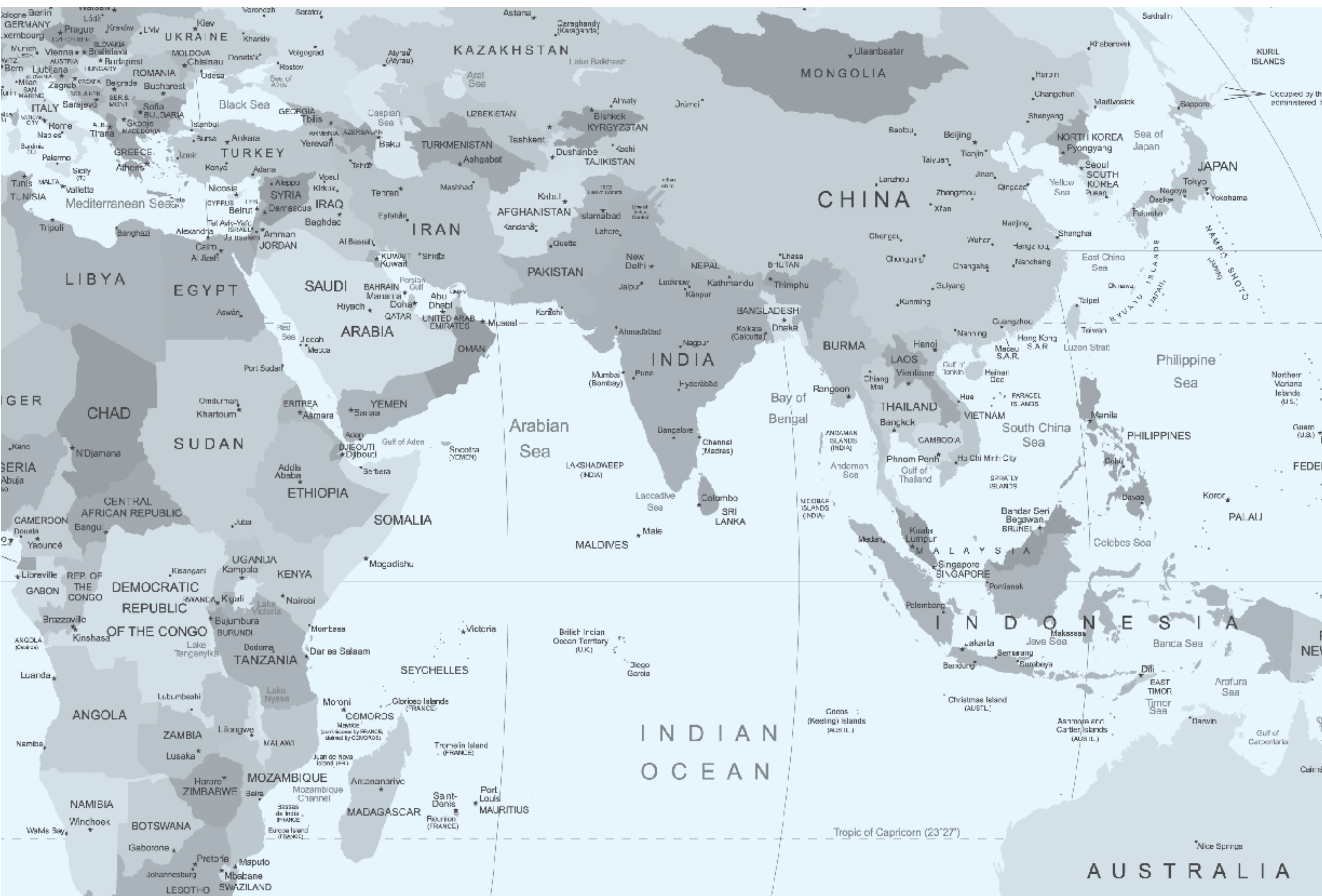
Chapter 5: Going Forward

Catholic health leaders and partners have the opportunity to lead and redefine ethical practices for international recruitment in the global dialogue.

International health care workers will always be a valued resource and while we must continue to protect the freedom of individuals to move and migrate, we must also ensure that our recruitment processes do not worsen shortages in countries that cannot afford to lose their long-trained workforce.

As Catholic health leaders, we have a powerful opportunity to invest in strengthening the global health care workforce, practice and promote globally inclusive ethical recruitment practices, and advocate for new recruiting standards. At the heart of this, we must center the experiences of countries and communities who are disproportionately bearing the burden of the workforce shortage and co-create and partner around the solutions of the future.

The international recruitment crisis and workforce shortage will not be solved by one single leader or health system alone. We truly hope that this report serves as a tool by providing findings, powerful case studies, and transformative strategies for a new vision of health equity that safeguards the right of all people to health.



Acknowledgements

This report is the product of collaborative efforts that draw upon the contributions and insights of Catholic health leaders and partners. Catholic Health Association, under the coordination and review of Bruce Compton, has led the creation of this report. Special acknowledgement goes to the main authors Tiffany Rodriguez, MPH and Stephanie C. Loh from Accenture Development Partnerships.

We would like to give special gratitude to CHA's Working Group on Health Workforce of the Future for their insights, connections, and support of this report.

- **Camille Grippon (Co-Chair),** Director, Global Health, Bon Secours Mercy Health
- **George Avila (Co-Chair),** System VP, Change Integration, CHRISTUS Health
- **Brenda Colatrella,** Retired, Associate VP, Corporate Responsibility, Merck
- **Bruce Compton,** Senior Director, Global Health, Catholic Health Association
- **Colleen Scanlon,** Member, Bon Secours Mercy Ministries
- **Julie Trocchio,** Senior Director, Community Benefit and Continuing Care, Catholic Health Association
- **Mary Beth Powers,** Chief Executive Officer, CMMB

We would also like to thank the following experts for sharing their time, perspectives and insights with us throughout the course of this research. A full list of the stakeholders consulted as part of this report can be found below (listed in alphabetical order by first name):

1. **Ann Rhomberg,** Executive Director, Solidarity Bridge
2. **Ben Simms,** Chief Executive Officer, Tropical Health and Education Trust
3. **Brenda Woodcock,** Chief Nurse Officer, Bon Secours Mercy
4. **Father Dr. Charles Chilufya, S.J,** Director of the Justice and Ecology Office at the Jesuit Conference of Africa and Madagascar
5. **Father Dr. Charles Kitima,** Vice Chancellor, St. Augustine University of Tanzania
6. **Chunmei "Mei" Li,** Frontline Health Workers Coalition
7. **David Bryden,** Executive Director, Frontline Health Workers Coalition
8. **Eric Van Duren,** Chief Talent Acquisition Officer, Bon Secours Mercy
9. **Sister Dr. Eugenia Amporfu,** Economist and Professor, Department of Economics, KNUST - Ghana
10. **Ged Byrne,** Global Director, Health Education England
11. **Jodi Pahl,** Chief Nurse Officer, St. Rita Medical Center
12. **Dr. Kate Tulenko,** Health Workforce Expert
13. **Lord Nigel Crisp,** Co-Chair, UK All-Party Parliamentary Group on Global Health
14. **Dr. Maribel Mármol,** Oncologist & Director, Chuquisaca Cancer Institute
15. **Mark Smith**, Staffing & Optimization, Providence
16. **Father Dr. Mathew Abraham,** Catholic Health Association - India
17. **Father Dr. Michael Rozier,** Professor, St. Louis University
18. **Mukul Bakhshi,** Chief Global Affairs Officer, CGFNS
19. **Sister Nelly Chisense,** Catholic Health Association - Zambia
20. **Patricia "Patty" Gavilan,** RN & Manager, Language Services, Bon Secours Mercy
21. **Dr. Sylvain Trepanier,** Chief Nursing Officer, Providence
22. **Vincent Dindia,** Director of Contingent Workforce Operations, St. Rita Medical Center

List of Abbreviations

- AHC: Americas Health Corps
- CHA: Catholic Health Association
- CHW: Community health workers
- CNO: Chief Nursing Officer
- CHRO: Chief Human Resources Officer
- GRNMA: Ghana Registered Nurses and Midwives Association
- HEAL: Health Equity for ALL
- HICs: High-income countries
- HSE: Irish Health Service Executive
- LMICs: Low-and-middle income countries
- MISAU: Ministry of Health in Mozambique
- NHS: National Health System
- PAHO: Pan American Health Organization
- RN: Registered Nurse
- SUS: Single Health System Model
- THET: The Tropical Health and Education Trust
- WHO: World Health Organization

Resources

[i] The Global Health Workforce Stock And Distribution In 2020 And 2030: A Threat To Equity And 'Universal' Health Coverage?
[ii] The 17 Goals
[iii] FACT SHEET: The Biden-Harris Administration Global Health Worker Initiative
[iv] Human Rights
[v] Supply and Demand Projections of the Nursing Workforce: 2014-2030
[vi] We Already Needed More Doctors. Then COVID-19 Hit
[vii] COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce
[viii] Half Of Health Workers Report Burnout Amid COVID-19
[ix] Health and Care Worker Deaths during COVID-19
[x] Reinventing Care Delivery Is Essential to Solve The Clinician Shortage
[xi] What is Nurse Burnout? How to Prevent It
[xii] Confronting Health Worker Burnout and Well-Being
[xiii] Political Hate Targeting Vulnerable Communities and Health care Workers, and Bomb Threats Against Boston Children's Hospital Prompt Condemnation from MNA Board of Directors
[xiv] National Nurse Survey Reveals Significant Increases In Unsafe Staffing, Workplace Violence, And Moral Distress
[xv] Impacts Of COVID-19 And Workloads On NSW Nurses And Midwives' Mental Health And Wellbeing
[xvi] Alarming Increase In Industrial Action By Nurses Is A Symptom Of Global Crisis In Health care Systems
[xvii] How Should We Prepare For The Wave Of Retiring Baby Boomer Nurses?
[xviii] Ageing And Health
[xix] Covid-19 Having Impact On Already-High Rates Of Nursing Students Dropping Out
[xx] Concern Over Decline In Student Nurse Applications For 2023-24
[xxi] Nursing Faculty Shortage
[xxii] Nursing Schools Graduate More Students Than Ever —But It's Not Enough
[xxiii] From AIDS to COVID-19, America's Medical System Has a Long History of Relying on Filipino Nurses to Fight on the Frontlines
[xxiv] WHO Health Workforce Support and Safeguards List 2023
[xxv] WHO Renews Alert On Safeguards For Health Worker Recruitment
[xxvi] WHO Global Code of Practice on the International Recruitment of Health Personnel
[xxvii] Nurses and midwives (per 1,000 people) - Ghana
[xxviii] Brain Drain Of Health Workers In Ghana Could Have Dire Impact On Health care Delivery, Warns Nursing Association
[xxix] Nurses And Midwives (Per 1,000 People) - Zambia
[xxx] Zambian Health Sector Hit By Brain Drain
[xxxi] Nurses And Midwives (Per 1,000 People) - India
[xxxii] Health care Access in Rural Communities in India
[xxxiii] 2: Gendered Mobility and Multi-Scalar Governance Models: Exploring the Case of Nurse Migration from India to the Gulf
[xxxiv] Nurses and midwives (per 1,000 people)
[xxxv] Bolivia's New Health Minister Promises Universal Health Care
[xxxvi] Jamaica To Advocate For Global Solutions To Migration Of Health care Workers
[xxxvii] More Than 700 Nurses Left Jamaica Since COVID-19 Pandemic

[xxxviii] The Human Rights of Migrants

[xxxix] Health Service Executive – Mozambique Ministry of Health Partnership

[xl] Fifth Global Forum on Human Resources for Health

[xli] Already cited WHO Global Code

[xlii] THET Partnerships for Global Health

[xliii] Together, we can HEAL

[xliv] Health Care Code for Ethical International Recruitment and Employment Practices

[xlv] Identifying Key Challenges Facing Health care Systems In Africa And Potential Solutions

[xlvi] Code For Ethical International Recruitment Practices: The CGFNS Alliance Case Study

[xlvii] Guiding Principles

[xlviii] Medical 'Brain Drain': Zimbabwe To Introduce Law Criminalizing Foreign Recruitment

[xlix] Student Interest in Health-Care Careers Takes Off During Pandemic

[l] Migration of Nurses: A Latin American Perspective

Washington Office
1625 Eye Street NW, Suite 550
Washington, DC 20006
(202) 296-3993

St. Louis Office
4455 Woodson Road
St. Louis, Missouri 63134
(314) 427-2500

chausa.org