

The WHO Global Code of Practice on the International Recruitment of Health Personnel: The Evolution of Global Health Diplomacy

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The May 2010 adoption of the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel created a global architecture, including ethical norms and institutional and legal arrangements, to guide international cooperation and serve as a platform for continuing dialogue on the critical problem of health worker migration. Highlighting the contribution of non-binding instruments to global health governance, this article describes the Code negotiation process from its early stages to the formal adoption of the final text of the Code. Detailed are the vigorous negotiations amongst key stakeholders, including the active role of non-governmental organizations. The article emphasizes the importance of political leadership, appropriate sequencing, and support for capacity building of developing countries' negotiating skills to successful global health negotiations. It also reflects on how the dynamics of the Code negotiation process evidence an evolution in global health negotiations amongst the WHO Secretariat, civil society, and WHO Member States.

INTRODUCTION

The loss of highly skilled personnel, colloquially referred to as 'brain drain,' has been a central concern of developing countries for the last half century. Despite a call by developing countries, limited international structure has emerged to equitably manage the gains and losses from the largely asymmetric movement of skilled workers.

Over this last decade, in the context of a renewed focus on health systems and greater awareness of the scope of the global health workforce shortage—with an estimated four and a half million additional health workers needed immediately—developing country concerns related to the international migration of health workers, particularly of those whose training is publicly subsidized, have regained prominence. The demand for health workers in middle- and high-income nations is escalating and is increasingly being met through reliance on foreign health workers, very often from low-income countries.

The migration of health workers to middle- and high-income countries is exacerbating existing inequities in the distribution of the global health workforce and further compromising health systems in some of the poorest countries in the world. As illustration, while their home countries struggle with serious health workforce shortages, over half the potential physician workforce of Angola, Antigua and Barbuda, Grenada, Guyana, Haiti, Liberia, Mozambique, Saint Vincent and the Grenadines, Sierra Leone, Tanzania, and Trinidad and Tobago currently serves the populations of OECD countries.¹

At its core, the challenge associated with health worker migration points to a lack of coherence between the global health-related development agenda and the domestic health workforce policies of many donor nations. Ameliorating the negative effects of health worker migration necessitates an international structure to further dialogue and guide cooperation among and within states on issues related to the international recruitment and migration of health workers.² Without serious engagement on these issues, improvements to health in low-income countries, as well as significant donor investments and credibility, are placed in jeopardy.

The May 2010 adoption by the World Health Assembly (WHA) of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) puts in place a global architecture, including the identification of ethical norms as well as institutional and legal arrangements, to guide international cooperation on the issue of health worker migration and serves as a platform for continuing dialogue.³ It articulates principles and practices critical to the improvement of the global health system. Only the second code of its kind promulgated by the WHO, the process towards development of the Code evidences the growing maturity of global health diplomacy. Multilateral agreement amongst all 193 WHO Member States has been achieved on an issue of long-standing concern to developing countries, one that until recently was viewed as irreconcilable with the interests of high-income nations. The choice of a non-binding approach to address an issue that is dynamic, complex, and highly sensitive also reflects more nuanced understanding by Member States of the nature and utility of binding and non-binding international legal instruments to further global health. This article analyzes the history of the negotiations of the Code and the significance of this new instrument for global health diplomacy and global health governance.

THE GLOBAL MIGRATION OF HEALTH PERSONNEL

The global health workforce shortage and inequitable distribution of health workers among and within nations has reached crisis proportions. Launching the UN Decade of Human Resources for Health, the 2006 World Health Report, *Working Together for Health*, made prominent the extent of the global health workforce crisis.⁴ According to WHO, 57 countries face critical health workforce shortages, with a total deficit of 2.4 million doctors, nurses, and midwives. These shortfalls are greatest in sub-Saharan Africa—the recognized epicenter of the global health workforce crisis. Sub-Saharan Africa currently bears 24% of the world’s disease burden, but has only 3% of health workers and less than 1% of the world’s financial resources to respond to this burden. The disparity in global access to health personnel almost defies comprehension. As a particularly striking example, in Malawi, approximately 2 doctors serve a population of 100,000 people, while in the United States, 256 doctors serve a similarly sized population.⁵ Rural populations everywhere, but especially in low-income nations, suffer most directly from shortages because available health personnel tend to cluster in urban areas.

Compounding existing shortages and inequitable distribution of the health workforce, the past few decades have witnessed expansion in the international migration of health workers, with patterns of migration becoming increasingly complex.

Aging populations in high-income nations, new medical technologies, increased specialization of health services, as well as emerging hubs of health care delivery in regions such as the Gulf States and South-East Asia, are driving up the demand for health workers globally. In addition to the increasing magnitude of the international migration of health workers and associated adverse effects on developing countries' health systems, there is increasing concern related to the mechanisms of international recruitment and the inequitable treatment of emigrant health personnel in the host country. It is also understood that the movement emigrant health personnel exhibit is highly dynamic and not limited to specific sets of countries or geographic regions.

The Organisation for Economic Co-operation and Development (OECD) has identified that 18% of physicians and 11% of nurses working in OECD nations are foreign born and that the international migration of health workers to OECD nations is increasing.¹ The OECD points to evidence that the number of overseas-educated physicians who passed Step 3 of the United States Medical Licensing Examination—a prerequisite to practicing as a physician in the United States—increased by 70% between 2001 and 2008. It is estimated that the United States, already the largest global employer of health workers, will have a physician shortage of approximately 63,000 by the year 2015—with many calling for increased reliance on foreign-trained physicians to meet this demand.⁶ Similar increases in reliance on foreign health workers, alongside escalating future demands, can be seen in other OECD nations, notably Australia and Canada.

The increasing demand and reliance on foreign health workers is not simply limited to OECD nations. Already the vast majority of health workers practicing in the Gulf Cooperation Council (GCC) countries of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates are immigrants, with estimates that 75% of the physicians and 79% of the nurses practicing in the region are foreign expatriates. Moreover, it has been estimated that demand for health care services in the GCC countries is expected to increase by 240% in the next two decades, the highest increase of any region in the world, further increasing demand for health personnel.⁷

'Pull' factors, including targeted recruitment efforts, as well as financial and other incentives from wealthy destination states, combined with 'push' factors in source countries, such as low wages, poor and unstable working environments, and dilapidated public health systems, are contributing to the international migration of health workers. As health workers seek job opportunities at home and abroad, in a dynamic and increasingly globalized health labor market, recent studies show that the problem of acute shortages of health workers, particularly as affecting rural populations, is deepening in many poor states.

While there is significant debate on the causes for and long-term economic effects of health worker migration from low-income countries, there is little doubt that emigration of health workers is resulting in unsustainable gaps in the public health systems of many developing countries. As identified earlier, over 50% of the physicians from Angola, Antigua and Barbuda, Grenada, Guyana, Haiti, Liberia, Mozambique, Saint Vincent and the Grenadines, Sierra Leone, Tanzania, and Trinidad and Tobago practice as expatriates in OECD countries. A recent World Bank report on nurse emigration patterns from English-speaking Caribbean nations evidences similarly high levels of emigration for nurses from the region. The World Bank identifies that there are

currently three times as many English-speaking Caribbean Community (CARICOM) trained nurses working abroad, primarily in Canada, the UK, and the US, than in the region itself. The World Bank additionally reports that 30% of approved nursing positions in the region are currently vacant and that the demand for nurses in the English-speaking countries of the CARICOM region is expected to increase significantly over the next fifteen years.⁸

It should be stressed that addressing the myriad of challenges associated with the international recruitment and migration of health workers will not in itself solve the shortages and inequitable distribution of health workers present in low-income countries. The reasons for these shortages are many, including the lack of training capacity, limited civil service budgets and public sector fiscal space, limited managerial capacity, weak information systems, and significant internal migration to the private and the NGO sector. However, the international migration of health workers, particularly the current and estimated future reliance on foreign health workers in wealthy nations, does point to a mutual or shared responsibility for destination nations to engage in dialogue with and to support health systems in countries facing severe health workforce shortages. The above-described trends associated with the international recruitment and migration of health workers highlight the need for a coordinated and global approach to mobilizing action in this area.

THE DEVELOPMENT OF THE WHO GLOBAL CODE OF PRACTICE

Initiation of the WHO Global Code Process

In order to advance a global framework for dialogue and cooperation amongst states on international health worker recruitment issues, the World Health Assembly, the legislative body of WHO, adopted Resolution 57.19 in May 2004, mandating that the Director General develop a non-binding code of practice on the international recruitment of health workers in consultation with Member States and all relevant partners.⁹ The resolution marked the first time that the World Health Assembly had invoked the constitutional authority of WHO to develop a non-binding Code since the 1981 International Code of Marketing of Breast Milk Substitutes.

The WHO Global Code process was preceded by a number of initiatives to address international health worker recruitment concerns on a country-by-country, multilateral, and transnational basis. Over the last decade, countries have adopted a number of non-binding instruments aimed at tackling the challenges associated with international health worker recruitment, including the Commonwealth Code of Practice for the International Recruitment of Health Workers, the Pacific Code of Practice for the International Recruitment of Health Workers in the Pacific Region, and the United Kingdom National Health Service Code of Practice for the International Recruitment of Healthcare Professionals. During this period, there has also been a proliferation of non-binding instruments adopted under the auspices of professional associations and unions, such as the World Medical Association, the International Council of Nurses, and the European Federation of Public Service Unions. Bilateral agreements between source and destination countries that formalize ongoing dialogue and address rights and

responsibilities in ethical international recruitment also multiplied over the ten years prior to the adoption of the Code.¹⁰

Existing voluntary codes of practice and other similar non-binding instruments have been widely criticized as weak and ineffective in addressing the core challenges of health worker migration and its impact on health systems. Critics have argued, for example, that such non-binding instruments have been largely ineffective in limiting health worker migration from poor countries or protecting the human rights of health workers because they lack meaningful mechanisms to collect data and to monitor national compliance.¹¹ In addition, unlike the WHO Code, none of the earlier instruments set forth a global approach necessary to addressing a global problem or mobilized the funding required for implementation.

Despite early support for the development of a WHO Global Code, the initiative lacked political support, resources, and policy direction. However, in early 2008, the Code effort re-emerged as the issues surrounding health systems and health worker recruitment rose in stature in the global health policy agenda of states. Development and drafting of the Code were led by the World Health Organization's Department of Human Resources for Health (WHO/HRH) and a potential framework for the proposed Code was first presented by WHO/HRH at the Global Forum on Human Resources for Health in Kampala in March 2008, although that framework was not ultimately used in the drafting of the Code.

The efforts of the Health Worker Migration Initiative (HWMI), a partnership among Realizing Rights, the Global Health Workforce Alliance (GHWA), and WHO, were also critical to the renewed focus on developing the WHO Global Code. The HWMI was composed of two closely linked entities, the Global Policy Advisory Council ('the Council'), whose secretariat was Realizing Rights, and the Technical Working Group (TWG), whose secretariat was WHO/HRH. The idea of the partnership, linking rigorous research and evidence with high level political leadership and engagement, emerged in 2006 on the occasion of the UN General Assembly Special Session on Migration and Development. The HWMI was officially launched during the World Health Assembly in May of 2007 as a formal initiative of Realizing Rights, GHWA, and WHO.

The Council, co-chaired by Hon. Mary Robinson, former President of Ireland and UN High Commissioner for Human Rights, and Dr. Francis Omaswa, Executive Director of GHWA, played a significant role in supporting the development of the WHO Global Code. The Council was comprised of forty high-level sitting and former policy makers from sending and receiving nations, as well as high-level representatives from international organizations. The Council included current and former ministers of labor, development, and health, as well as high-level representatives from WHO, the International Labour Organization, and the International Organization for Migration. The Council aimed to further mutually acceptable solutions to the issue of health worker migration in a manner that honored both the right to health and freedom of movement. Through its members and meetings, the Council provided both political and technical support to the work of the WHO Department of Human Resources for Health in the development of the Code.

Despite growing support for international cooperation, many observers continued to dismiss the potential contribution that a non-binding code of practice could make to issues surrounding international health worker recruitment. It was

argued that the proposed Code was not legal or could have no impact in state practice because it would be technically non-binding as a matter of international law. To respond to such concerns, as well as to galvanize stakeholder interest, at its May 2008 meeting in Geneva, the Global Policy Advisory Council commissioned a paper to facilitate critical discussion on the potential strengths of non-binding instruments in international legal practice and how the proposed code could best be structured and negotiated to advance global consensus and action on international health worker migration issues.¹² WHO, GHWA, and Realizing Rights hosted a two-week Online Global Dialogue in March and April 2008 to further disseminate the information set forth in the scholarly paper and to engage discussion on the potential value and content of the Code. The Online Dialogue included 749 participants from 102 countries.

Preparation of First Draft Text and Early Stages in the Negotiation Process

Technical legal work and the preparation of the first draft of the Code commenced in earnest in July 2008 at the WHO headquarters in Geneva immediately after the final declaration of the G8 Summit in Toyako, Japan. The first draft of the Code prepared under the auspices of the WHO/HRH was ready for consideration by Member States by the end of August in 2008.

The first draft of the Global Code endeavored to establish a global architecture for national and international dialogue and action on international health worker recruitment and migration. The brief first draft, consisting of eleven articles, did not aim to address and resolve all of the substantive issues raised by the international recruitment of health personnel or the substantial challenges to the health systems of low-income states raised by health worker migration. Rather, the goal of the first draft was to set forth a brief, straightforward framework and platform for substantive negotiations. It was expected that WHO Member States would negotiate more detailed commitments in the final text of the Code or in later instruments.

Notably, the first draft of the Code did aim to respond to criticisms of other non-binding instruments in this realm by recommending voluntary measures to promote national compliance. Consistent with contemporary international practice in other realms of international law, the first and all of the following drafts of the Code recommended a robust and transparent framework for global governance, including voluntary mechanisms for effective and periodic information sharing, reporting, and supervision of implementation.¹³

In September of 2008, the WHO Secretariat launched a web-based global public hearing on the first draft of the proposed Code. In addition, the draft text was presented by the WHO Human Resources for Health Department and considered at WHO Regional Committees in September and October 2008 in the European Region, South-East Asian Region, and Western Pacific Region. The Council also met for two days in September 2008, with members including the then-Chair of the WHO Executive Board reviewing the text line-by-line and providing specific input through the online public hearing process. Based on the input provided by the regional committee meeting and the global public hearing, the WHO Secretariat and its advisers prepared a second draft of the proposed Code in November 2008.

The second draft of the Code was considered by the WHO Executive Board in January 2009 at one regular session and at one closed informal session. While there was wide agreement on many parts of the text, there was also divergence on some key aspects of the draft that reflected the underlying complexity of the issues and differences amongst states surrounding health worker recruitment and migration. For example, a number of industrialized countries, including Hungary, on behalf of the European Union, and the United States, expressed concern that the draft Code was overly prescriptive for a non-binding instrument. Japan, the United States, and other delegations asserted that provisions on monitoring and implementation were inappropriate for a non-binding instrument. In contrast, a number of countries, including Mauritania on behalf of the WHO African Region (WHO AFRO), as well as Malawi and South Africa, emphasized that the Code needed “teeth” and to be “enforced.” As a further example, Member States of the WHO AFRO region, Sri Lanka, and others expressed the view that the Code must also include mechanisms to compensate developing countries for the migration of health workers to high-income states. Other participants, particularly some destination states, indicated that bilateral support was a preferred alternative and that a compensatory mechanism should not be included in the Code.

Notably, many Member States, including Mauritania on behalf of the WHO AFRO region, Hungary on behalf of the European Union, Brazil, Djibouti, The Bahamas, and China expressed the view that the second draft paid insufficient attention to the impact of migration on the health systems of developing countries. Some delegations also argued that the draft overemphasized the rights of health workers at the expense of the health systems of source states and could be interpreted as encouraging migration.

In recognition of the important differences amongst countries on issues surrounding health worker recruitment, there was widespread agreement that the draft Code required further consultation amongst Member States and subsequent revision before it could be forwarded to the World Health Assembly for negotiation and adoption. At the same time, some state delegates privately expressed the view that delaying negotiation and adoption of the Code for one year could create a more fertile negotiating environment by allowing time for a new United States presidential administration to take office and establish policy that might be more supportive of the Code effort. Consequently, it was agreed that the Secretariat should initiate a consultative process on the draft Code, including consideration of the draft Code at the WHO regional committee meetings in the fall of 2009 before the issue of the Code would be revisited by the Executive Board in January 2010.

Following the January 2009 Executive Board session, issues related to the Code were considered in national, regional, and international meetings in preparation for fall 2009 regional committee sessions. Some Member States held national consultations and some regional offices convened regional and sub-regional meetings. In addition, a draft WHO Code was highlighted in international settings. In July 2009, the countries of the G8 Summit (L'Aquila, Italy, 8–10 July 2009) encouraged WHO to develop a code of practice on the international recruitment of health personnel by 2010. The ministerial declaration of the 2009 High-level Segment of the United Nations Economic and Social Council also called for the finalization of the WHO Code. In September and October 2009, all six regional committees discussed the key issues relating to a Code.

The Secretariat revised the text and prepared a third draft of the Code in order to take into account the views and comments expressed by members of the WHO Executive Board in January 2009 and the outcome of the subsequent sessions of the Regional Committees.¹⁴ In particular, the Code was deftly revised to considerably strengthen the emphasis of the text on the interests and concerns of source countries in the health worker migration process but, at the same time, incorporate the views of destination states by, amongst other things, softening the perceived "prescriptive" language of the draft text.

In January 2010, the draft Code was once again before the WHO Executive Board. While some Member States expressed disagreement with aspects of the draft text, or proposed mechanisms for improvement, it was unanimously agreed that the draft Code was a good basis for negotiation and should be forwarded to the May 2010 World Health Assembly for negotiation and possible adoption. Mauritania on behalf of the WHO AFRO states, Hungary on behalf of the European Union, Canada, Samoa, Moldova, Russia, New Zealand, India, Bangladesh, Paraguay, France, Switzerland, the Bahamas, Japan, Oman, South Africa, Zimbabwe, and Iran all spoke in favor of forwarding the draft Code to the World Health Assembly for negotiations.

Alongside the formal WHO process, Council members and others supported an informal political process to both inform and engage Member States around support for a substantive WHO Code. Norway's leadership in this process, both in its capacity as a Member State and as an active member of the Council, was invaluable. The Health Workforce Advocacy Initiative, a civil society network supported by GHWA, coalesced around the Code development process and engaged Member States both in their individual and collective capacities. The Council, through its meetings and partnerships, additionally worked to highlight the content and importance of a WHO Code to both source and destination Member States. Particular emphasis was placed on engaging constructively with President Obama's incoming administration. Hon. Mary Robinson and others reached out on numerous occasions to the highest levels of US government, including to President Obama through his advisors, to encourage support for the WHO Code. Through his speech in Ghana, President Obama, as part of his first presidential visit to sub-Saharan Africa, specifically articulated the link between donor incentives, health worker migration, and gaps created in primary care in Africa. This important speech was critical to easing strong US administration opposition to development and adoption of the WHO Code.

While it was African countries that championed the call for development of the Code, their engagement with the initial drafts of the proposed WHO Code was relatively limited. The Council endeavored over the course of the Code development process to inform and engage source countries, particularly sub-Saharan African countries, with the draft Code text. A week before formal Code negotiations at the World Health Assembly in May 2010, Norway and the WHO EURO region supported the Council in hosting a two-day Inter-Regional Dialogue around the text and contentious issues of the Code. Norway, in particular, supported the Council in ensuring strong representation of African nations at the meeting. The meeting included fifty-five participants from thirty-two countries, with fifteen from Africa. Some of the national governments represented at the meeting included South Africa, Norway, the United States, Botswana, Ghana, Uganda, Kenya, Brazil, Zimbabwe, the United Kingdom, France, Hungary, and Spain

(which held the European Union presidency)—many of whom were to play a leading role in Code negotiations. The two-day meeting was perhaps most important in familiarizing some participants with the text and underlying points of contention associated with the draft Code before formal negotiations took place, as not all of the Member States had participated in the WHO Executive Board deliberations over the past two years. The participants were united in recognizing that the areas of contention could not be allowed to jeopardize adoption of the Code.

Negotiation of the WHO Global Code at the May 2010 World Health Assembly

The Sixty-Third World Health Assembly, on its opening day, May 17, 2010, established a “drafting committee” open to all Member States to negotiate the text of the Code of Practice that had been forwarded by the January 2010 Executive Board. Under the chairmanship of an experienced negotiating chair, Dr Viroj Tangcharoensathien of Thailand, and the support of the WHO Secretariat, led by Dr. Manuel Dayrit, the Director of the WHO Department of Human Resources for Health, the final text of the WHO Global Code was negotiated in this closed drafting group, which met over three days during the May 2010 World Health Assembly, including a final negotiating session lasting until 4:30 AM on Thursday, May 20, 2010.

Over thirty countries, including representatives of many of the key players in the global health recruitment debate, such as South Africa, Norway, the United States, Botswana, Switzerland, Uganda, Kenya, Brazil, Thailand, Zimbabwe, New Zealand, Australia, Canada, and the European Union, represented by Spain (as well as some of its Member States such as the United Kingdom, France, Belgium, and Germany) participated in the global negotiations. While many of the major players participated throughout the negotiations, notably missing from the drafting group were countries such as India and Japan that had been vocal participants in debates at the Executive Board and the regional committees.

While there remained important differences between countries, under the keen stewardship of Dr. Viroj the negotiating group forged a consensus document that contains voluntary recommendations on many of the issues surrounding international recruitment of health personnel. The draft was negotiated by first identifying the key issues in dispute and then proceeding through the text provision by provision until consensus was achieved.

Global health workforce recruitment and migration is a complex and multidimensional global health challenge and a number of the critical issues that had challenged the development of the text throughout the negotiation process were central to the debates of the drafting group. However, as the draft text had been revised several times prior to the World Health Assembly by the Secretariat, the differences amongst countries had been considerably narrowed. Consequently, the final text of the Code can be fairly described as only subtly different from the last draft prepared by the Secretariat: reflecting fine differences in tone and precision, but only limited substantive changes.

A recurring issue in the discussions leading up to the World Health Assembly and the drafting group itself was the perceived “prescriptive” nature of the voluntary Code.

As described above, during the Executive Board debates a number of high-income countries argued that the tone of the draft Code was too prescriptive or mandatory for a non-binding instrument. Most of the high-income countries present in the closed drafting sessions joined in support for modification of the draft Code during the World Health Assembly, including Canada, New Zealand, Spain on behalf of the European Union, the United States, Monaco, and others. Without any objection from low-income states, the draft Code was revised to eliminate terms such as “standards” and “comply.” At the same time, Member State commitments under the Code were modified throughout much of the text, such as changing the word “should” to terms such as “should consider” or “should encourage.” It can well be argued that, since the Code is non-binding and only makes recommendations to governments, these subtle changes have no impact on the substance of the Code and are likely to make no meaningful difference in state practice. However, the case can also be made that such changes, by undermining the precision of the commitments in the text, could potentially impact or even soften the sense of obligation amongst Member States to comply with the underlying norms in the Code.

Another key issue that arose during the consultations surrounding the draft Code was whether the instrument should narrowly focus on establishing voluntary principles and practices related to international recruitment or whether the scope of the instrument should be broadened to address the impact of health worker migration on health systems generally. Revisions to the text during the drafting committee did not fully clarify this issue. Early in the drafting group, high-income states tailored the text of the Code, particularly the Objectives in Section 1, to focus exclusively on recruitment and to leave out the larger issues of migration. However, a careful reading of the final text of the Code reveals that broad issues of health workforce migration, including “brain drain” from developing countries, comprise a substantial part of the substance of the text. For example, Article 5 focuses on general issues surrounding health system sustainability and Articles 6 and 7 are centered upon collection and exchange of information on health personnel migration.

An important area of concurrence amongst high and low-income states during the drafting group revolved around human rights issues under Article 4 of the Code. As described above, issues surrounding how to honor the right of developing countries to strengthen their health systems and the rights of health workers to migrate to countries that wish to admit and employ them was a long-standing concern in the drafting of the Code. During the World Health Assembly deliberations, the right to health of source countries became the dominant concern in this balance as interests amongst high-income and low-income participating states aligned. Consistent with international human rights law and pre-existing codes, such as the Commonwealth and the Pacific Codes of Practice, the draft WHO Code explicitly incorporated language on the human rights of health workers in Article 4 to fairness and equality of treatment. High-income countries modified the language in this Article by, amongst other things, subjecting rights to “applicable law.” The effort of high-income countries to limit the broad recognition of rights aligned with the interests of low-income countries who had long argued that the draft Code had prioritized the rights of workers at the expense of the health systems of developing countries.

Another key area on which there was significant discussion during the negotiations was the way in which the Code should reflect and encourage an appropriate balance between the interests of source states and destination states. The United States led a wide consensus to modify the draft text of the Code in Article 5 to address issues of “health workforce development and sustainability” rather than “mutuality of benefit,” reflecting more of a change in tone and not substance. Other modifications proposed by destination states to the text, however, highlighted the interests of high-income countries. One important area of divergence amongst states was whether the Code should promote bilateral and other arrangements amongst source and destination states. While low-income states had emphasized the importance of such agreements in discussions leading up to the World Health Assembly, the draft language calling upon states to abstain from active international recruitment, unless there exist equitable agreements to support recruitment activities, was deleted from the final text of the Code.

Throughout most of the negotiation process at the World Health Assembly, high-income states, particularly the participating states from the European Union, Canada, the United States, and New Zealand, dominated the interventions and advanced recommendations for change in the draft text. Developing countries and the present emerging economies, particularly the delegates from African states, frequently remained silent during discussions of the substantive provisions of the draft Code, with Norway and Brazil often voicing the position of source countries. However, an important change occurred after midnight on May 20, as the delegates moved from negotiations of the substantive aspects of the Code to discussions of the detailed procedural mechanisms involving data collection, information exchange, monitoring, and implementation, and the ranks of negotiators thinned from a high of over thirty participating states to a core group of delegates from just over twenty Member States. As described above, a number of high-income states had strongly opposed the Secretariat’s detailed inclusion of these critical procedural and institutional mechanisms in the voluntary instrument. An information document prepared by the Secretariat, consisting of Member State proposals to the draft text, documented that countries such as Canada, the European Union, and the United States preferred that such provisions be strictly circumscribed or deleted.¹⁵ However, starting with the deliberations on data collection after midnight on May 20 to the close of the drafting group around 4:30 in the morning, the delegations from African states, including South Africa, Zimbabwe, Kenya, and Botswana, established a united front in favor of maintaining the strong legal and institutional provisions in the draft text against all efforts to modify and limit such provisions. In the end, the detailed legal, institutional, and data sharing provisions established in the final text remained substantively unchanged from the negotiating draft prepared by the Secretariat.

In addition, while some developing countries had pushed during the early stages of the Code process for strengthening the financial mechanisms to promote “compensation” from destination states to source states, there was no effort to negotiate more detailed commitments on financial provisions in the final negotiations. Indeed, there was a keen recognition amongst low-income and emerging market country delegates at the World Health Assembly that high-income states would simply not agree to deeper provisions on financial support to developing countries. As the delegate from Brazil essentially noted, the Code effort should not be held back by lack of agreement on

compensation and maybe in the future there could be meaningful discourse on compensation.

The three-day negotiation of the WHO Global Code of Practice occurred during what was a well-attended and highly charged World Health Assembly. The agenda of the World Health Assembly included negotiation of contentious issues in other substantive and procedural areas. It also saw President Obama's Global Health Initiative promoted by the US delegation. While negotiations on the WHO Global Code were occurring in Committee A, which is responsible for programmatic issues, there were negotiations around WHO governance structures, in particular the process of appointing the Director-General, occurring in Committee B, which is responsible for budget and managerial issues. Delegates to the WHO Global Code negotiations were highly sensitive to shifts in alliances due to negotiation positions taken on other subjects.

The linkages between the various different sessions at the World Health Assembly and their impact on the Code negotiations was made especially evident during discussions hosted by the United States on President Obama's Global Health Initiative on the second day of the Health Assembly. During this session, which was open to all Member States and other participants and observers at the Health Assembly, including civil society, the United States found its efforts to highlight the good works of the Obama Global Health Initiative hampered as delegates from other Member States, as well as other participants, specifically and repeatedly brought up the challenges of health worker migration and the US negotiating position in the closed "room next door."

The drafting committee's final text of the Code was brought forward on May 21, 2010 to Committee A for further discussion before the text was to be accepted by Committee A as final. Many of the negotiators from both source and destination countries privately expressed the view that they remained apprehensive that the process towards adoption achieved by the drafting group could still be derailed by ongoing discussion and negotiation at Committee A. However, the WHO Global Code of Practice elicited no discussion in Committee A. Once accepted for adoption, there was spontaneous applause by all present in the room. According to observers, the applause in the room reflected both the magnitude and urgency of the challenge of health worker migration, as well as the ability to achieve multilateral agreement on such a complex and sensitive subject. It should be noted that at the beginning of the Code development process there was considerable debate and little agreement on whether health worker migration was even resulting in negative effects to health systems in developing countries and whether consensus could ever be achieved on the proposed WHO Code.

The WHO Global Code of Practice on the International Recruitment of Health Personnel was formally adopted on Friday, May 21, 2010 at the closing session of the Sixty-Third World Health Assembly.¹⁶ Director-General Margaret Chan identified the adoption of the WHO Global Code as one of the major achievements of the Assembly, referring to adoption of the Code as a "real gift to public health, everywhere."¹⁷

The WHO Global Code of Practice

The final text of the WHO Global Code includes a preamble and ten articles: Objectives; Nature and scope; Guiding principles; Responsibilities, rights and recruitment practices; Health workforce development and health systems sustainability;

Data gathering and research; Information exchange; Implementation of the Code; Monitoring and institutional arrangements; and Partnerships, technical collaboration and financial support.

The WHO Global Code's preamble and first three articles, Objectives, Nature and scope, and Guiding principles, provide the context and define the scope of the Code effort. The WHO Global Code of Practice is a voluntary instrument that articulates global ethical norms—"principles and practices"—around the international recruitment and migration of health workers. Moreover, the WHO Global Code explicitly seeks further dialogue and cooperation among and within Member States on these issues. The preamble and first two articles make especially prominent the Code's focus on supporting health systems, particularly in developing countries, countries with economies in transition, and small island states. The Code's Guiding Principles reaffirm the Code's focus on the need to provide technical and financial assistance for health personnel development; affirm the human right to the highest attainable standard of health; call for a better "managed approach" to the international recruitment of health workers; call also for the development of a sustainable health workforce in all countries; and point to the need to protect and fulfill the rights of health workers that do emigrate.

Article 4 of the Code, Responsibilities, rights and recruitment practices, articulates the ethical responsibilities of stakeholders to ensure fair recruitment and equitable treatment practices as relevant to emigrant health workers. Article 4 of the Code additionally calls on recruiters and employers to be aware of and not seek to recruit health workers with existing domestic contractual obligations, and for health workers to be transparent about their contractual obligations.

Article 5, Health workforce development and health systems sustainability, is at the core of the WHO Global Code. The Article discourages active recruitment from countries with critical health workforce shortages, encourages utilization of Code norms as a guide when entering into bilateral, regional, and multilateral arrangements to further international cooperation and coordination, identifies the need to develop and support circular migration policies between source and destination countries, encourages countries to develop sustainable health systems that, as far as possible, would allow for domestic health services demand to be met by domestic human resources, emphasizes the importance of a multi-sectoral approach in addressing the issues, and places particular focus on the need to develop health workforce policies and incentives in all countries that support the retention of health workers in underserved areas.

The Code's sixth article, Data gathering and research, responds to the significant lack of data and research in the area of health personnel migration, particularly as it affects health systems. It urges Member States, with support from WHO, to strengthen their efforts in this area and to translate data collected and research conducted into effective health workforce related policies and planning. In the field of health worker migration, improvement in data gathering and research efforts is necessary for a number of critical reasons. Most significantly, the current evidence-base on health worker migration trends and patterns is fragmented. The formulation of effective policies addressing the drivers, trends, and impacts of health worker migration needs to be grounded in a sound evidence base. The challenges involved in data collection and analysis are compounded by a lack of consistency in definition of relevant data items

among countries. Consequently, a major contribution of the Code is to provide a legal framework for data collection.

The Code's next three articles, Information exchange, Implementation of the Code, and Monitoring and institutional arrangements, are focused on the process related to implementation and monitoring of the Code. These three articles are perhaps most important to the future success of the Code. These robust articles incorporate legal and institutional mechanisms to promote cooperation and implementation of the Code that are more robust than similar mechanisms found in some contemporary treaties, including the Framework Convention on Tobacco Control.

Article 7, Information exchange, aims to provide structure around information exchange with regard to both health personnel migration and health systems, including calling on Member States, as feasible, to maintain an updated database of laws and regulations related to recruitment and migration, to maintain updated data related to health personnel, and to designate a national authority responsible for information exchange. Moreover, the designated national authority is asked to provide a report on data and on relevant laws/regulations to WHO every three years for purposes of information exchange with other Member States, with an initial data report to be filed two years (2012) following adoption of the Code.

Article 8, Implementation of the Code, while relevant to all stakeholders, places primary responsibility on WHO Member States to publicize and implement the Code. It specifically calls on Member States to maintain a record of all recruiters authorized to operate within their jurisdiction, to endeavor to utilize only those recruiting agencies that comply with the guiding principles of the Code, and to assess the magnitude of active recruitment from countries facing critical health workforce shortages, as well as the impact of circular migration.

Article 9 of the Code, Monitoring and institutional arrangements, defines the process of Member State reporting to the WHO Secretariat and WHO reporting to the World Health Assembly. Member States are called upon to report activities undertaken, progress made, and difficulties encountered in implementing the Code every three years, starting in 2012. Notably, non-state actors have a critical role to play in the implementation regime as they are also called upon to report their observations on Code implementation to the Secretariat. Based upon Member State and other reports, the Director-General is also called upon to submit a report every three years to the World Health Assembly on the status of the Code and recommendations for its strengthening. These reporting mechanisms are designed to keep the topic of health worker migration and the Code on the active agenda of Member States, WHO, and civil society. Importantly, while Member States are encouraged to report to the WHO, WHO's reporting on the Code is not voluntary. The WHO Director General also must support the information exchange network, develop guidelines and recommendations as specified by the Code, and maintain liaisons with relevant regional and international organizations, as well as concerned NGOs, in support of implementation. Moreover, the Article explicitly identifies the Code as a dynamic text that is to be updated based on the changing nature and impact of the issues it aims to address.

The final article of the WHO Global Code, Article 10, is related to Partnerships, technical collaboration, and financial support. The article is broadly drafted and again stresses the need for global cooperation to support implementation of the Code, with a

particular focus on providing technical and financial support to strengthen health personnel development in countries facing critical health workforce shortages.

The WHO Global Code is neither a perfect text nor the solution to the challenges associated with health worker migration. The substantive norms advanced by the Code remain relatively general and are advanced in a soft manner to Member States. It should be recognized, however, that the WHO Global Code was never intended to be the final answer or encompass the whole solution to the challenges associated with health worker migration. Rather, the goal of the drafters was to establish a global platform that could provide a framework for continuing dialogue and cooperation among states on what is undoubtedly a topic of significant complexity and sensitivity. The WHO Global Code, in particular through the key legal and institutional arrangements contained within the Code, provides a robust instrument for ongoing global cooperation that has the potential to lead to a deepening of commitment over time.

While the long-term impact of the WHO Global Code is yet undetermined, there are already some positive developments that have resulted from the process of negotiation and adoption of the Code. First and foremost, the long-ignored issue of health-worker migration is now centrally on the global political agenda. This has been made most evident by inclusion of the WHO Global Code, as well as some of its relevant norms, in the Outcome Document of the September 2010 UN Millennium Development Goals Summit.

The legal and institutional arrangements present in the WHO Global Code will further ensure that the issue remains on the agenda of the World Health Assembly for the foreseeable future, with reporting by the Director-General mandated every three years. As of November 2011, sixty-nine countries have designated a national authority responsible for Code implementation, as called for by the Code. In addition, in order to assist states in meeting their first reporting obligations in May 2012, the WHO Secretariat took a key step in November 2011 by releasing final guidelines on monitoring the Code's implementation, including a model national reporting instrument. Notably, the guidelines break new ground at WHO and significantly democratize the global health governance process by setting forth a second formal reporting instrument for all other stakeholders concerned with the international recruitment of health personnel. In accordance with the Code's principle of transparency, the draft guidelines provide that regular national reports from WHO Member States and reports from other stakeholders will be made publicly available through the WHO website. Collectively, these features are likely to make certain that the effectiveness of the Code will be kept under public scrutiny and continuous review thereby increasing accountability.

One of the historic obstacles to comprehensively addressing the challenges associated with the international recruitment and migration of health personnel has been the need for and difficulty in engaging with the various sectors within national governments. These include the Ministries of Foreign Affairs/International Development, Health, Labour, Education, and Immigration. Prior to the WHO Global Code negotiations, only a few countries—notably Norway and the Philippines—had engaged in a whole of government approach in reflecting on the issue of health worker migration. In the process of developing a negotiation position, a number of additional Member States engaged across these multiple sectors within their governments. This process of engagement is itself important, with the networks created potentially an

important step towards greater internal coherence and meaningful implementation of the norms articulated by the WHO Global Code.

LESSONS LEARNED FOR FUTURE NEGOTIATIONS: THE EVOLUTION OF GLOBAL HEALTH DIPLOMACY

This article has provided a detailed description and analysis of the WHO Code negotiations. In any political context, the organization of negotiations is a question of political mapping that must respond to political realities and resource constraints. It is well known that issues and interests need to be organized to reduce complexity and promote coalition building and consensus. This review of the Code negotiation and drafting process evidences that certain aspects of the legislative and political processes contributed to the success of the WHO Global Code endeavor.

However, the lessons to be learned from the WHO Global Code negotiations go beyond the mere spectrum of the nuts and bolts of international negotiation processes and provide some deeper insight into the evolution of global health diplomacy over the past decade. The senior author of this article case study initiated the idea of the Framework Convention on Tobacco Control (FCTC), the first treaty negotiated under the auspices of WHO, with the late Professor Ruth Roemer and was the senior legal adviser to WHO during the negotiations of the FCTC and during the negotiations of the WHO Global Code.¹⁸ A comparison of the negotiating processes of the Code and the FCTC clearly is not a scientific endeavor that can fully reveal transformations in global health diplomacy over the past decade. Amongst other things, there are important differences between the two processes, including the fact that the analysis involves a comparison of the negotiations of binding and non-binding instruments. In addition, the Code negotiations were much smaller in scale, involving at its height around forty countries formally negotiating at the World Health Assembly in one session in May 2010. In contrast, the FCTC negotiations involved over 160 countries formally negotiating at six rounds of negotiation sessions held in Geneva from 2000 until 2003. However, as described further below, despite important differences between the nature and scale of the two processes and instruments, the experience of the Code negotiations does appear to evidence some growing maturity and perhaps an evolution in global health diplomacy at WHO amongst the different actors in the process: the Secretariat, civil society, and, most importantly, the Member States.

The WHO Process: Introduction of a Simple Draft Text and Maintaining Control of the Drafting Process

An important factor contributing to the success of the Code negotiation process is that the Secretariat introduced a simple negotiating text early in the process and maintained control of the drafting of the text until formal negotiations at the World Health Assembly in 2010. At first instance, a key strategy was to establish concise and carefully drafted commitments for states to bargain over and flush out. In addition, Secretariat control over the drafting process helped prevent the draft document from spiraling out of control.

The first draft of the Code and process of developing subsequent drafts can be contrasted sharply with the negotiating experience during the FCTC. During the FCTC negotiations, the first draft text prepared by the Secretariat for the negotiating chair contained an entire catalogue of potential substantive obligations.¹⁹ In addition, during the process of negotiating the FCTC in six formal rounds of negotiations open to all Member States, each and every recommendation made by Member States, sometimes amounting to nothing other than mere wording and stylistic differences, was incorporated into the draft, leading to remarkably complex texts and unnecessarily prolonged negotiating sessions. In the case of the Code, the Secretariat contributed to advancing negotiations by maintaining control of the drafting process and incorporating the key themes proposed by Member States and not verbatim text during the early stages of the negotiation process.

The WHO Process: Staging the Negotiations

Widely observed experience in the negotiation of international agreements under the auspices of international organizations evidences that the negotiation of legal instruments tends to be marked by a series of stages that narrow differences amongst countries and the negotiating agenda. There is no single formula for successful negotiations and different arrangements can be used. In some respects, the Code negotiations reflect a good example of sequencing in that the Secretariat draft text went through several political scrubs by a small group of states representatives at the WHO regional committees and the WHO Executive Board before it was opened up for broader negotiation for all WHO Member States at the WHA. Consequently, the draft text was largely acceptable before it was opened up to broad negotiations. However, a critical last stage of the negotiation process involved the Member States taking control and ownership of the document in the final negotiations at the WHA.

Cementing broad stakeholder participation and, therefore, ownership is a critical stage in any negotiation process and a cautionary tale is provided by some international negotiations that failed to incorporate effective participation by relevant stakeholders, particularly states. For example, in the case of the United Nations Guidelines on Internal Displacement, the draft text of the Guidelines was developed by an expert group and never negotiated by governments. When brought for adoption to the United Nations General Assembly, certain countries complained that, since states were not involved in the drafting, the Guidelines lacked legitimacy. Such objections were overcome only by the arguments that the Guidelines merely reflected existing international law and did not set forth new standards.

With that said, it should be recognized that the Code negotiation process was also hampered by the absence of a truly global negotiation process prior to the WHA in May 2010. Issues surrounding health worker recruitment and migration reveal important political divides among states. Although the Code was considered at various international forums and regional committees prior to the World Health Assembly negotiations, there was no formal global consultation necessary to advance consensus, and to move the text and the agreement forward prior to the World Health Assembly in May 2010.

Political Leadership

Political leadership is a critical factor in international negotiations to broker deals and bring innovative thinking. Leadership can come from many sources, including the executive head of an international organization, as was the case with Dr. Mostafa Tolba for many years at the United Nations Environment Programme. It can also be brought by states. Notably, it is mid-sized countries such as Australia, Canada, Switzerland, New Zealand, and Norway that have often provided leadership in areas ranging from the environment to health.

In the context of the WHO Global Code negotiations, Norway led the way among the states. Recognizing the challenges associated with health worker migration, Norway had previously engaged across its ministries to make its domestic need for foreign health workers coherent with its international development efforts. In February 2009, Norway released its internal policy coherence strategy. However, Norway also recognized that unilateral action alone could not meaningfully address the global nature of the challenge. As such, it was a strong advocate for development of a WHO Global Code of Practice. Moreover, Norway was cognizant throughout the process of its own unique economic position and the need to engage other, particularly source country, champions. In addition to country leadership, a strong chair is an essential ingredient of effective negotiations and the Code negotiations were expertly steered throughout the WHA process by Dr. Viroj Tangcharoensathien of Thailand.

The Role of Non-Governmental Organizations

The unique partnership between WHO/HRH, GHWA, and Realizing Rights was integral to development of the Code. Realizing Rights' formation of the Global Policy Advisory Council, an independent body and authority, in particular, allowed for a channel that could run parallel to the formal WHO process in shaping and advancing negotiations. The Council, through its secretariat, members, and meetings, was able to complement the WHO Secretariat's efforts by reaching out to specific Member States and hosting an inter-regional discussion in order to clarify and further consensus around contentious issues. The Code effort reflects a new type of civil society participation in global health negotiations at WHO. Through the Health Worker Migration Initiative partnership, Realizing Rights, a non-governmental organization with experience in global governance, was involved with the Code development from the very inception of the process. Realizing Rights' method of work focused on supporting its partners and Member State capacity to move forward mutually acceptable solutions. Moreover, Realizing Rights staff—led by Hon. Mary Robinson—had knowledge and experience in international law and global negotiations and were able to bring this expertise to Council meetings and its contacts with Member States. Mary Robinson's ability to convene and engage stakeholders and key decision makers was undoubtedly an important additional asset.

Notably, neither the Council, its Secretariat, nor the Health Workforce Advocacy Initiative, were ever directly involved in drafting the text of the Code or the formal negotiation process, but rather worked with Member States to provide detailed commentary on draft text and raise awareness and support for the Code. Moreover,

enabled by the technical legal work of the WHO Secretariat on the WHO Global Code, the Council in particular was able to point to a tangible vision and action that political leadership, from both source and destination nations, could further.

The role of non-governmental organizations in the negotiation of the Code stands in contrast with that of the negotiation of the FCTC from 1998 to 2003. NGOs played a much more limited role in participating and guiding the FCTC negotiations primarily because of its lack of expertise and experience in international lawmaking and the limited opportunities to work with Member States and the WHO in closed negotiation sessions that dominated the negotiation process. It should be recognized, of course, that FCTC was the first binding treaty negotiated at the WHO. NGOs participating in the treaty negotiations were largely domestic tobacco control organizations, with no experience in international law and negotiations. In recent years, however, through the Framework Convention Alliance, NGOs and civil society have acquired expertise and experience in the international lawmaking process and have played an increasingly important role in guiding the implementation and the development of the FCTC.

WHO Member States and the Evolution of Diplomatic Capacity

Similar to the apparent growth in legal capacity among members of civil society, the Code negotiations evidence a deepening or maturing of diplomatic capacity to engage in global health negotiations amongst low- and middle-income country delegations. Indeed, there was a striking difference between delegations engaged in the FCTC negotiations and the Code negotiations. During the FCTC negotiations, the vast majority of delegations outside of high-income nations were new to the international law negotiation process and were comprised of representatives from health ministries accompanied by junior mission lawyers or no lawyers at all. During the FCTC negotiation process, such inexperienced delegates were simply and frequently out-lawyered by the experienced negotiators, including highly skilled international lawyers, from high-income states.

The difference in negotiating capacity, including legal expertise, largely, though not exclusively, explains the textual outcome of the FCTC, which consists of soft substantive obligations and shallow institutional and procedural mechanisms. A lack of realistic assessment about the scope of the treaty and the depth of commitments haunted the negotiations of the FCTC from the very beginning of the process. Health ministers from low- and middle-income countries clearly thought it possible to have both deep and wide substantive commitments on tobacco control without losing any participants. During the final days of the negotiations, high-income states were able to negotiate substantially softer substantive commitments in the seventeen articles of the text that set forth tobacco control commitments. But, at the same time that most delegations were focused on the substantive obligations, they neglected attention to the key legal procedural and institutional mechanisms necessary in a framework convention to strengthen and deepen the regime over time. Although a robust procedural framework had been set forth by the Secretariat in the drafts of the FCTC, many of the key legal and institutional mechanisms of global governance were deleted from the text in a side meeting open to all Member States during the final negotiations round in March 2003, in which no developing or middle-income countries participated. Although

the FCTC has, in practice, been remarkably successful in a number of respects, an important consequence of a lack of negotiation experience amongst delegates from low-income countries is a framework convention with uniquely shallow procedural and institutional mechanisms.²⁰

In contrast, in the Code negotiations, the character of the state delegations in the final stages of the WHA negotiations differed markedly and was reflected in the negotiations and the final text. Delegations from emerging economies as well as developing countries, particularly sub-Saharan Africa, consisted of senior diplomats and highly experienced international lawyers. Such delegations came to the table with a keen understanding of what agreement was possible and targeted critical areas of negotiations. Unlike the FCTC negotiations, these delegations, recognizing the realities of the underlying politics of the negotiations, spent precious little time trying to hammer out deep substantive commitments to limit recruitment or create compensatory mechanisms. Rather, the skilled delegates and veteran negotiators focused attention on the critical legal and institutional mechanisms of information exchange and monitoring and reporting that are necessary to maintain the legal regime and perhaps deepen it over time.

The differences in character of the negotiating teams at the FCTC and WHA Code negotiations may reflect a deepening of interest in global health among Member States and an evolution of global health negotiations. As global health has risen on the political agenda, more and more states may be prioritizing global health negotiations and bringing more experienced diplomats and lawyers to the table. If this is the case, it is a welcome development to balance the negotiation dynamics and put high-income and low-income countries on a more even footing in terms of negotiating expertise although not, of course, negotiating power. However, the limited participatory scope of the Code negotiations may mean that it is too soon to draw a definitive conclusion on whether the Code negotiations reflect a genuine evolution in global health diplomacy.

THE EVOLUTION OF GLOBAL HEALTH GOVERNANCE: THE POTENTIAL CONTRIBUTION OF NON-BINDING INSTRUMENTS TO GLOBAL HEALTH GOVERNANCE

Recent developments in global health diplomacy have led to increasing calls for the negotiation and codification of international legal mechanisms to provide a framework for global health cooperation. The experience of the WHO Global Code evidences the important and largely overlooked contribution that non-binding instruments can make to global health diplomacy and may serve as a model for future global health law negotiations.²¹

Although there has been academic interest in the role of international legal instruments for global health cooperation for almost twenty years, international law has traditionally been neglected as a tool of global health policy.²² Of course, the contemporary reality is altogether different. Over the last decade or so, the field of global health has undergone transformations that have been widely described as revolutionary. Aggressive globalization, among other factors, has lifted global health from an issue of political neglect to one of political prominence among state and non-state actors. As health has emerged on the foreign policy agenda, so has interest in international law as a tool for health policy.

Today there is an evolving array of binding and non-binding instruments in global health governance. Notably, however, consistent with other international legal realms, the pattern that is beginning to emerge is a marked preference for binding global health law instruments. This preference for expanding treaty law appears among state actors, civil society, and academia and is reflected in the proliferation of proposals for new global health treaties over the last decade. The rising demand for treaties may reflect, in part, the perceived credibility of treaties and the widely held view that non-binding instruments are weak and ineffective.

Undoubtedly, there is no alternative to treaties when states want to make credible commitments. However, treaties are not the only source of norms in the international system. It is increasingly recognized that the challenges of global governance demand faster and more flexible approaches to international cooperation than can be provided by traditional and heavily legalized strategies. Consequently, in other realms of international concern, ranging from the environment to arms control, the world community is increasingly turning to the creation of non-binding international norms.

Like binding international instruments, non-binding instruments have important strengths and limitations as international legal tools. Chief amongst the limitations of non-binding instruments is that such voluntary agreements are not subject to the international law of treaties and, in particular, the fundamental principle of *pacta sunt servanda*. There are no rules of international law like the Vienna Convention on the Law of Treaties that regulate or supplement non-binding instruments. Moreover, many non-binding instruments are purposefully designed as way stations or even permanent detours from hard, binding legal commitments. Consequently, many if not most non-binding instruments are purely rhetorical and have no impact on state practice.

However, non-binding instruments have important advantages as mechanisms for international cooperation and can, at times, make an important contribution to shaping state behavior. The experience negotiating the WHO Global Code evidences some of the key advantages of non-binding instruments. For example, a core characteristic of non-binding instruments is their flexibility. Flexibility is an essential component of international negotiations. Non-binding agreements can facilitate compromise and agreement may be easier to achieve than binding instruments, especially when states jealously guard their sovereignty because non-binding standards do not involve formal legal commitments. Notably, the FCTC was negotiated in six separate rounds of two-week negotiation sessions open to all WHO Member States over five years, while the WHO Global Code was negotiated in just a fraction of that time. In addition, by removing concerns about legal non-compliance, non-binding instruments may, at times, promote deeper commitments with stricter compliance mechanisms than comparable binding instruments. Notably, the WHO Global Code incorporates procedural mechanisms to advance implementation that are more potent than those incorporated in the FCTC. While both the FCTC and the WHO Global Code set forth a shallow substantive framework, the WHO Global Code sets forth a deep legal and institutional framework.

The strength of the WHO Global Code as an international legal instrument and the effectiveness of the Code negotiation process evidence that non-binding instruments deserve greater attention in future global health diplomacy efforts.

CONCLUSION

The summer of 2010 witnessed adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel. As identified earlier, this is only the second instrument of its kind promulgated by the WHO—almost three decades after adoption of its predecessor, the International Code of the Marketing of Breast Milk Substitutes. The adoption of the WHO Global Code evidences both the gauntlet of a process associated with negotiating global health law at WHO and suggests evolution in the capacity of the WHO Secretariat, Member States, and civil society to engage in global health “law-making.”

Spurred by the urgency of the problem and the increased global attention on strengthening health systems, WHO Member States have come together to make available a unique and potentially powerful instrument to begin addressing the challenges associated with the international recruitment and migration of health workers. Various factors contributed to the successful development and adoption of the WHO Global Code, including an innovative partnership between the WHO Secretariat, GHWA, and Realizing Rights, the choice of a simple negotiating text, the sequencing of negotiations, and political leadership from both Member States and individuals. Of particular note, the choice of a non-binding instrument to address these challenges may reflect recognition of the political realities and complexities associated with the issue, as well as an understanding of the role of such instruments in shaping state behavior.

Long ignored, the issue of health worker migration is and, thanks to the Code’s reporting requirements, will remain on the global health agenda for the foreseeable future. In particular, African governments, underrepresented in global negotiations, played a key role in addressing an issue of significant concern to African health systems. Reflecting on the adoption of the WHO Global Code, one African government representative at the World Health Assembly stated that the issue of health worker migration long “under the table, is now squarely on the table.”

It should also be recalled that the WHO Global Code was adopted in the context of a strong spirit of multilateralism and goodwill amongst Member States. Despite the goodwill and multilateral spirit exhibited, there is real danger that the norms articulated in the WHO Global Code may not be reflected in national and international laws, policies, and programs. This is due in significant part to the scarcity of resources made available for WHO Secretariat support for implementation as a consequence of the general reform process underway at WHO. Though heralded as a “real gift to public health everywhere,” the success of the WHO Global Code will ultimately be judged by whether its norms are implemented and lead to the tangible improvement in the lives of individuals and communities of those most affected. Work to this end is underway and must immediately be supported and intensified. Nothing less than progress towards the health-related MDGs and donor credibility is at stake.

The opinions expressed herein are those of the authors alone and do not necessarily reflect the views of the World Health Organization or Realizing Rights.

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¹ Organisation for Economic Co-operation and Development, "Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration," pt. III in *International Migration Outlook 2007* (Paris: OECD, 2007), 161-228.

² Mary Robinson and Peggy Clark, "Forging Solutions to Health Worker Migration," *The Lancet* 371, no. 9613 (February 28, 2008): 691-693.

³ Sixty-Third World Health Assembly Agenda Item 11.5, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, WHA63.16 (May 21, 2010). Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

⁴ World Health Organization, *Working Together for Health: The World Health Report 2006* (Geneva: World Health Organization, 2006). Available at: <http://www.who.int/whr/2006/en/>

⁵ World Health Organization, "Global Atlas of the Health Workforce," last updated December 2010. Available at: <http://apps.who.int/globalatlas/>

⁶ American Association of Medical Colleges, "AAMC Releases New Physician Shortage Estimates Post-Reform," news alert. Available at: <https://www.aamc.org/newsroom/newsreleases/2010/150570/100930.html>

⁷ Mona Mourshed, Viktor Hediger, and Toby Lambert, McKinsey & Co., *Gulf Cooperation Council Health Care: Challenges and Opportunities*, ch. 2.1 in McKinsey & Company Report. Available at: http://www.weforum.org/pdf/Global_Competitiveness_Reports/Reports/chapters/2_1.pdf

⁸ World Bank Human Development Department, Caribbean Country Management Unit, Latin America and the Caribbean Region, *The Nurse Labor & Education Markets in the English-Speaking CARICOM: Issues and Options For Reform*, Report No. 48988-LAC, (June 2009). Available at: http://siteresources.worldbank.org/INTJAMAICA/Resources/The_Nurse_Labor_Education_Market_Eng.pdf

⁹ Fifty-Seventh World Health Assembly, *International migration of health personnel: a challenge for health systems in developing countries*, WHA57.19 (May 22, 2004). Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf

¹⁰ Ibadat S. Dhillon, Margaret E. Clark, and Robert H. Kapp, *Innovations in Cooperation: A Guidebook to Address Health Worker Migration* (Washington, DC: Realizing Rights/Global Health & Development at the Aspen Institute, May 3, 2010). Available at: <http://www.aspeninstitute.org/publications/innovations-cooperation-guidebook-bilateral-agreements-address-health-worker-migration>

¹¹ Annie Willetts and Tim Martineau, Liverpool School of Tropical Medicine, United Kingdom, *Ethical international recruitment of health professionals: Will codes of practice protect developing country health systems?* (January 2004). Available at: http://medact.org/content/health/documents/brain_drain/Martineau%20codesofpracticereport.pdf

¹² Allyn L. Taylor, "The Proposed WHO Code of Practice on Health Worker Migration: Issues of Form, Substance and Negotiation" (paper presented at *Health Worker Migration Global Policy Advisory Council Meeting*, Geneva, Switzerland (May 18, 2008) (copy on file with author).

¹³ Allyn L. Taylor, The Draft WHO Code of Practice on the International Recruitment of Health Personnel, *American Society of International Law Insights* 12, no. 23 (November 11, 2008). Available at: <http://www.asil.org/insights081111.cfm>

¹⁴ Sixty-Third World Health Assembly Provisional Agenda Item 11.5, *International recruitment of health personnel: draft global code of practice, Report by the Secretariat*, WHA A63/8 (April 15, 2010). Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_8-en.pdf

¹⁵ Sixty-Third World Health Assembly Provisional Agenda Item 11.5, *International recruitment of health personnel: draft global code of practice*, A63/INF.DOC./2 (April 15, 2010). Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_ID2-en.pdf

¹⁶ Sixty-third World Health Assembly, World Health Organization, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, WHA 63.16 (May 2010). Available at: http://www.who.int/hrh/migration/code/code_en.pdf.

¹⁷ Margaret Chan, "Agreements at World Health Assembly a gift to public health," Closing remarks at the Sixty-Third World Health Assembly (May 21, 2010). Available at: http://www.who.int/dg/speeches/2010/WHA_closing_20100521/en/index.html

¹⁸ Ruth Roemer, Allyn Taylor, and Jean Laraviere, "Origins of the WHO Framework Convention on Tobacco Control," *American Journal of Public Health* 95, no. 6 (June 1, 2005), 936-938.

¹⁹ Framework Convention on Tobacco Control, *opened for signature* June 16, 2003, 2302 U.N.T.S. 166.

²⁰ Allyn L. Taylor, "Global Health Law," in *Textbook on Global Health Diplomacy*, ed. Ilona Kickbusch et al. (New York: Springer, forthcoming).

²¹ Allyn L. Taylor, Douglas W. Bettcher, and Richard Peck, "International law and the international legislative process: The WHO Framework Convention on Tobacco Control," in *Global Public Goods for Health*, ed. Richard Smith, Robert Beaglehole, David Woodward, and Nick Drager (Oxford, United Kingdom: Oxford University Press, 2003), 212-230.

²² Allyn Lise Taylor, "Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health," *American Journal of Law & Medicine* 18, no.4 (1992): 301-46.