Tine Hanrieder Leon Janauschek June 16th, 2025

Is the managed migration of health workers "ethics washing" or something more?

Many countries across the world struggle with the emigration of health workers. But do frameworks for ethically managing healthcare worker emigration make a real difference? **Tine Hanrieder** *and* **Leon Janauschek** *argue that while these approaches can provide some benefits, they have far too many shortcomings to be considered good practice.*

Health services in developing countries are deeply impacted by the aid freezes and cuts imposed by high-income countries – of which the shutdown of USAID is only the most dramatic instance.

One recent estimate, covering the 32 member states of the Development Assistance Committee of the OECD, projects that the reduction in development assistance for health in these countries will increase the projected health and care workforce shortage in Africa by 600,000 workers by 2030, compared to previous projections. This only adds to a dire lack of health workers worldwide, which the World Health Organization estimated to amount to 14.7 million in 2024, before the latest wave of announced aid cuts.

In parallel, many of the countries that are slashing their development aid have become ever more aggressive when it comes to poaching poorer countries' health workers. The UK's Royal College of Nursing found that countries on the WHO's safeguards list (those facing the most critical workforce shortage) have suffered major cuts in UK aid – while at the same time, nurses from these countries filled some twenty thousand vacancies in the UK between 2020 and 2024.

The managed migration of health workers

Many countries in Africa, as well as in Latin America, the Caribbean and Asia, struggle with health worker emigration. They seek to mitigate its impact but often cannot offer jobs and conditions that would retain a workforce that has taken years to train, often with public resources.

To mitigate the health workforce brain-drain, but also to make migration journeys less risky and vulnerable to exploitation, global health policy makers promote standards in line with the broader "managed migration agenda". They refer to key documents such as the United Nations' 2018 Global Compact for Migration and, most importantly, the WHO's 2010 Global Code of Practice on the International Recruitment of Health Personnel, which sets soft standards for "ethical recruitment".

In a future where aid is expected to become more transactional, and where the rise of anti-migration discourses across the "West" makes migratory pathways ever more erratic and hazardous, managing health worker migration "ethically" might seem desirable. But do these approaches simply amount to "ethics washing" by making the emigration of healthcare workers appear superficially ethical without addressing any of the underlying harms caused?

The short answer is that while ethical recruitment can have a positive impact, it has too many shortcomings to be considered good practice. The longer answer, drawing on our recent in-depth research on Germany – one of the "model countries" for ethical recruitment – is that there are four main areas where current practice falls short.

Insights from Germany

Germany promotes its ethical recruitment of nurses internationally, is praised as a best practice recruiter by global policy bodies and is celebrated as the shining counterexample to the UK's recruitment practices in newspapers such as *The Guardian*. Through myriad initiatives, including the public nurse recruitment scheme Triple Win and a voluntary fairness certificate for private recruiters, the country aims to fill gaps in its health system with foreign-trained workers in an "ethical" way.

It does so by making nurse migration journeys more predictable, letting employers pay for the costs of migration, reining in the use of binding clauses that would tie workers to certain employers, and ensuring equal treatment of immigrant nurses in German workplaces. While this does set some good examples, especially for nurses joining well-resourced university hospitals, the win-win-win rhetoric of "ethical recruitment" leaves major inequities unaddressed.

First, even "well-managed" cases of nurse migration to Germany are burdensome and exploitative. The administrative limbos, Kafkaesque paperwork, and arbitrary decision-making regarding visa decisions and skill recognition test the endurance of immigrant nurses for months, often years.

The gap between arriving in Germany with a "certificate of deficits" and finally working as a professional nurse takes up to one and a half years, sometimes longer. While waiting, the nurses

who are already professionals work for lower pay as nurse aides – a classic case of deskilling discussed amply in the migration literature.

Second, the postulated "win" for the sending countries is not enough. The WHO urges countries to manage health workforce migration through bilateral agreements that specify a benefit for the sending country, and stresses that this benefit must go beyond (assumed or real) remittance payments to folks back home. Yet, German players in the growing recruitment industry deflect demands for mutual benefit or compensation.

The country's bilateral agreements – which we obtained through freedom of information requests – do not entail any such compensation, and are rarely inclusive of relevant health sector voices that might put such demands forward. The same holds for almost all other bilateral health worker migration agreements on record. If you consider the cost of training health workers – training a nurse in Kenya, for example, requires some $43,000 in education costs – nurse migration from poor to rich countries remains a highly unequal exchange, if not a neo-colonial extractivist practice, that inhibits source countries' push for universal health coverage.

Third, "red lists" only create illusions of protection. The WHO's Health workforce support and safeguards list accompanies the Global Code of Practice. It is periodically updated to indicate in which countries no "active recruitment" should take place. Yet, the line between active recruitment – for example by recruitment agencies – and mere openness to applications from candidates is becoming ever blurrier as information about job and migration opportunities circulates online and through migrant and professional networks.

German regulators and recruiters all point to respecting the red list and consider this a satisfactory response to the brain drain problem. However, even countries that are "not red" such as the Philippines or Colombia struggle with health worker shortages. The safeguards list thus provides a false sense of assurance that these countries are safe to recruit from and employers need not be concerned about compensation and health equity trade-offs. Additionally, governments and workers in countries that *are* on the list have criticised it since, for unemployed workers, even if living in a country with shortages, safe and managed emigration might be the only alternative to leaving their profession altogether.

Fourth and finally, even ethical recruitment practices such as, for example, paying for migration costs or offering support with integration after arrival in the new country, do not address ingrained problems in the (German) healthcare industry. This includes work intensification and early burnout.

Hundreds of thousands of nurses in Germany are reported to have left the profession due to the conditions in the sector, conditions that migrants are expected to cope with on top of all the investments they have to make to try and thrive in Germany. Furthermore, discrimination and racist aggressions, which can come from colleagues as well as from patients, are impacting the work and

wellbeing of many migrant nurses. Flagship projects in ethical recruitment do not address such underlying issues.

The need for change

In sum, ethical recruitment is more than ethics washing when migrants are protected against deception or against visas tied to certain employers. Its ideals in terms of worker protection should be more fully and more bindingly implemented. But using this discourse as a legitimation for unfettered health workforce extraction from the Global South is unjust.

Countries of origin should receive compensation for their qualified workers that goes beyond the illusions of remittance alchemy. At least, in the next generation of bilateral health workforce recruitment agreements, health sector stakeholders should be more systematically included and enabled to negotiate a health dividend for their countries and most underserved regions.

For more information, see the authors' accompanying paper in the Review of International Political Economy.

Note: This article gives the views of the authors, not the position of EUROPP – European Politics and Policy or the London School of Economics. Featured image credit: Sutipond Somnam / Shutterstock.com

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