CHA
Catholic Health Association of the United States

The Future of Health Workforce Discussion Paper

INSIGHTS AND OPPORTUNITIES TO TRANSFORM INTERNATIONAL HEALTH WORKFORCE RECRUITMENT AND CAPACITY

2025 UPDATE

This update includes a checklist and practical applications for health systems and facilities involved in recruitment of foreign trained professionals.

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

As a Catholic ministry, we are called to global solidarity, rooted in human dignity and the common good. For more than a century, CHA has worked to advance justice, peace, and health equity. Today's workforce crisis challenges us to renew that commitment—especially to those who are poor, underserved, and most vulnerable.

As workforce challenges persist, the report calls for renewed leadership and, in the spirit of CHA's strategic plan, calls for Catholic Health and relevant Catholic and secular organizations to "Unite for Change" as we redefine ethical recruitment, strengthen global partnerships, and uphold the right to health for all.

Informed by the continued engagement with global experts and Catholic social thought, the updated report integrates ethical guidance from Daniel J. Daly, Ph.D., Executive Director of the Center for Theology and Ethics in Catholic Health sponsored by CHA. Daly emphasizes that international recruitment must consider the well-being of three constituencies: patients in U.S. Catholic facilities, recruited workers, and health systems in sending nations. Catholic health care is called to uphold human dignity, promote the common good, practice solidarity, and foster a culture of encounter—principles that should help guide recruitment from nations with low health worker densities.

The report aligns with WHO Standards referenced in the WHO Global Code of Practice, which provides a **voluntary framework of ethical principles and practices** for the international recruitment of health workers. It also incorporates references to the *WHO Health Workforce Support and Safeguard List*, which identifies countries facing critical shortages, discourages active recruitment from these countries, and encourages targeted support from development partners.

We hope this paper helps CHA and the Catholic health ministry continue to respond in a way that highlight our continued commitments, encourages us to a culture of encounter, and leads us towards global solidarity, peace, justice, and the common good.

Bruce Compton
Senior Director, Global Health
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 – CHA Accenture Research

Insights and Opportunities to Transform International Health Workforce Recruitment and Capacity

This updated discussion paper, originally published in 2023, was developed in collaboration with Accenture Development Partnerships and CHA's Working Group on the Global Health Workforce for the Future. It explores the ongoing global health workforce shortage and its implications for health systems worldwide. It highlights the leadership role of U.S. Catholic health care in advancing ethical, sustainable, and globally responsible workforce strategies.

The report is intended for Catholic health ministry leaders—including Sponsors, C-suite executives, CHROs, CNOs, and global health leaders—and offers actionable insights to strengthen talent pipelines and international recruitment practices.

Drawing on a comprehensive literature review and interviews with over 30 global stakeholders across income settings, as well as ongoing interactions with international experts on the global health workforce, the report identifies key challenges such as:

- Workforce attrition due to burnout, violence, and aging demographics
- Limited local recruitment capacity and overreliance on international hiring
- The ethical and systemic consequences of brain drain

The report outlines a framework for ethical international recruitment, emphasizing:

- Investment in health workforce development in low- and middle-income countries
- Ethical recruitment practices aligned with global standards
- Advocacy for improved working conditions and pipeline development
- Systemic reforms to build long-term global health capacity

As workforce challenges persist in 2025, the report calls for renewed leadership to redefine ethical recruitment, strengthen global partnerships, and uphold the right to health for all. By implementing these recommendations, Catholic health leaders can help transform international recruitment and contribute to a more equitable and resilient global health system.

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
Qaanaaq (Thule)
Greenland Sea
Longyearbyen
Svalbard (NORWAY)
Beaufort Sea
Banks Island
Kaujuitoq (Resolute)
Baffin Bay
Greenland (DENMARK)
Barrow
Victoria Island
Baffin Island
Jan Mayen (NORWAY)
Norwegian Sea
Arctic Circle (66°33')
Fairbanks
Great Bear Lake
Iqaluit (Frobisher Bay)
Davis Strait
Nuuk (Godthåb)
Denmark Strait
ICELAND
Reykjavik
NORWAY
SWEDEN
Yellowknife
Great Slave Lake
Whitehorse
Hudson Bay
Churchill
Tórshavn (DEN.)
Faroe Islands (DEN.)
Bergen
Oslo
Stockholm
Helsinki
Tallinn
Riga
Juneau
CANADA
Labrador Sea
Rockall (U.K.)
UNITED KINGDOM
North Sea
DENMARK
Copenhagen
RUSSIA
Vilnius
Edmonton
Happy Valley-Goose Bay
Glasgow
Belfast
Dublin
IRELAND
Manchester
London
Amsterdam
NETH.
Hamburg
POLAND
Warsaw
Lake Winnipeg
Island of Newfoundland
Celtic Sea
Brussels
BELGIUM
Luxembourg
GERMANY
Berlin
Cologne
Prague
Vancouver
Calgary
Winnipeg
Seattle
Lake Superior
Lake Huron
Québec
Ottawa
Montréal
Gulf of St. Lawrence
Paris
FRANCE
Munich
Vienna
AUSTRIA
Budapest
Portland
Minneapolis
Lake Michigan
Toronto
Lake Ontario
Halifax
St. Pierre and Miquelon (FRANCE)
Bay of Biscay
Lyon
Bern
Ljubljana
Milwaukee
Detroit
Boston
Bordeaux
Milan
Zagreb
Salt Lake City
Chicago
Lake Erie
Cleveland
New York
Philadelphia
Bilbao
ANDORRA
Marseille
ITALY
Rome
Naples
Sarajevo
Denver
Indianapolis
Columbus
Baltimore
Washington, D.C.
St. Louis
UNITED STATES
NORTH ATLANTIC OCEAN
PORTUGAL
Lisbon
SPAIN
Madrid
Barcelona
Valencia
Seville
Gibraltar (U.K.)
Algiers
Tunis
MALTA
Valletta
TUNISIA
Mediterranean Sea
Los Angeles
San Diego
Phoenix
Dallas
Atlanta
Bermuda (U.K.)
AZORES (PORT.)
MADEIRA ISLANDS (PORT.)
Casablanca
Rabat
Marrakech
Tripoli
Benghazi
Ciudad Juárez
El Paso
Houston
New Orleans
Jacksonville
San Antonio
MOROCCO
CANARY ISLANDS (SP.)
ALGERIA
LIBYA
Laayoune (El Aaiún)
Western Sahara
Monterrey
Matamoros
Gulf of Mexico
Miami
THE BAHAMAS
Nassau
Havana
Medellín
MEXICO
León
Cancún
México
CUBA
Guadalajara
Veracruz
Mexico
Puebla
Cayman Is. (U.K.)
Port-au-Prince
DOMINICAN REPUBLIC
British Virgin Islands (U.K.)
Anguilla (U.K.)
ST. KITTS AND NEVIS
ANTIGUA AND BARBUDA
Guadeloupe (FR.)
Puerto Rico (U.S.)
JAMAICA
Kingston
HAITI
Santo Domingo
Nouakchott
MAURITANIA
MALI
Tombouctou
NIGER
CHAD
Oaxaca
BELIZE
Belmopan
Acapulco
Caribbean Sea
Aruba (NETH.)
Neth. Antilles (NETH.)
Montserrat (U.K.)
DOMINICA
Martinique (FR.)
ST. LUCIA
BARBADOS
ST. VINCENT AND THE GRENADINES
GRENADA
Port-of-Spain
TRINIDAD AND TOBAGO
CAPE VERDE
Praia
Dakar
SENEGAL
Banjul
THE GAMBIA
Bissau
GUINEA-BISSAU
GUINEA
Conakry
Freetown
SIERRA LEONE
Monrovia
LIBERIA
Bamako
BURKINA FASO
Ouagadougou
Niamey
Kano
N'Djamena
NIGERIA
Abuja
Lagos
Cotonou
BENIN
TOGO
Accra
Lomé
Porto-Novo
CÔTE D'IVOIRE
Yamoussoukro
GHANA
Abidjan
GUATEMALA
HONDURAS
Guatemala
Tegucigalpa
San Salvador
EL SALVADOR
NICARAGUA
Managua
Barranquilla
Cartagena
Maracaibo
Caracas
Cozumel
Ibadan
Kumasi
Cayman Islands (U.K.)
San José
Colón
COSTA RICA
Panamá
PANAMA
Isla del Coco (COSTA RICA)
VENEZUELA
Georgetown
Paramaribo
GUYANA
French Guiana (FRANCE)
SURINAME
Cayenne
Medellín
Bogotá
COLOMBIA
Cali
Isla de Malpelo
PENEDOS DE SÃO PEDRO E SÃO PAULO (BRAZIL)
Equator
Gulf of Guinea
EQUATORIAL GUINEA
Malabo
SÃO TOMÉ AND PRINCIPE
São Tomé
Libreville
GABON
Annobón (EQUA. GUI.)
CAMEROON
Douala
Yaoundé
Bangui
CENTRAL AFRICAN REP.
REP. OF THE CONGO
DEMO REPU
Brazzaville
Kinshasa
OF THE
ANGOLA
Luanda
Quito
ECUADOR
GALAPAGOS ISLANDS (ECUADOR)
Guayaquil
Iquitos
Manaus
Belém
São Luís
ARQUIPELAGO DE FERNANDO DE NORONHA (BRAZIL)
Teresina
Fortaleza
Natal
Recife
Maceió
Salvador
Trujillo
PERU
BRAZIL
Ascension (St. Helena)
Lima
Cusco
Lago Titicaca
La Paz
BOLIVIA
Arequipa
Santa Cruz
Sucre
Goiânia
Brasília
Belo Horizonte
Martin Vaz (BRAZIL)
Trindade (BRAZIL)
SOUTH ATLANTIC OCEAN
St. Helena (St. Helena)
Namibe
ANGOLA
NAMIBIA
Windhoek
Walvis Bay
PARAGUAY
Asunción
Curitiba
São Paulo
Rio de Janeiro
Antofagasta
Isla Sala y Gómez (CHILE)
Isla San Félix (CHILE)
Isla San Ambrosio (CHILE)
San Miguel de Tucumán
Easter Island (CHILE)
Porto Alegre
St. Helena (U.K.)
CHILE
Córdoba
Mendoza
Rosario
URUGUAY
Santiago
Buenos Aires
La Plata
Montevideo
ARCHIPIÉLAGO JUAN FERNÁNDEZ (CHILE)
Concepción
ARGENTINA
Bahía Blanca
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
Scotia Sea
South Georgia and the South Sandwich Islands (administered by U.K., claimed by ARGENTINA)
Bouvet Island (NORWAY)
Drake Passage
SOUTH ORKNEY ISLANDS
Antarctic Circle (66°33')
SOUTHERN OCEAN
SOUTHERN OC
Bellingshausen Sea
Weddell Sea
Amundsen Sea
Ross Sea
Ronne Ice Shelf
Ross Ice Shelf
Antarctica

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Chapter 1: Introduction

What Is the Purpose of This Report?

The global shortage of health care workers remains a critical challenge, affecting countries across all levels of socioeconomic development. This report aims to examine the current landscape of international health workforce practices, spotlight innovative case studies, and explore the role of U.S. Catholic health leaders and global health care leaders in advancing a more equitable, ethical, and resilient global health workforce. The goal is to safeguard health care workers, strengthen health systems, and improve patient outcomes in communities worldwide.

Who Is the Intended Audience of This Report?

This report is intended for health care leaders engaged in the recruitment, development, and strategic planning of health workforce initiatives. It offers insights and recommendations for shaping sustainable and ethical talent pipelines. The report is designed to be shared broadly across the Catholic health ministry, including sponsors, executive leadership, Chief Human Resource Officers (CHROs), Chief Nursing Officers (CNOs), global health leaders, and policy influencers.

Methodology

Accenture conducted independent research for this report in collaboration with the Catholic Health Association's Working Group on the Future of the Health Workforce. The scope was shaped through iterative feedback and consultation.

- Secondary research included a comprehensive review of over 70 publications, articles, and reports.
- Primary research involved interviews with more than 30 global stakeholders, representing high-, middle-, and low-income countries. Many participants were affiliated with the Catholic health ministry, while others included health care executives, physicians, policy experts, and advocates.

A full list of stakeholders engaged in the development of the initial report is available in the Appendix.

Framework for Future Discernment

This report introduces a strategic framework for ministry leaders, emphasizing an ethical and sustainable approach to international health workforce recruitment. The framework includes four key pillars:

1. INVEST: Strengthen health workforce capacity in low- and middle-income countries (LMICs) through pre-service education, infrastructure development, and reciprocal partnerships.
2. PRACTICE: Ensure recruitment agencies adhere to ethical standards and protect LMIC health systems from depletion.
3. ADVOCATE: Support domestic workforce development and advocate for improved working conditions and global policy safeguards.
4. LEAD: Empower Catholic health leaders to drive systemic change, promote equity, and enhance global health capacity.

This framework promotes ethical recruitment, equitable workforce practices, and the protection of vulnerable health systems, contributing to global health equity and the realization of 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].

Global Health Partnerships (formerly 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.
4. **LEAD:** Catholic health 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

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 Global Health Partnerships (formerly 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. In 2025 CHA provided comments at a UK All-Party Parliamentary Group looking into workforce issues.

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: According to the WHO's Global Health Observatory, as of the latest reporting year (2023–2025), the Philippines has approximately 20 health workers (including nurses and midwives) per 10,000 population, well below the WHO's recommended threshold of 44.5 per 10,000.

The Philippines Department of Health (DOH) encourages ethical and sustainable global health recruitment while addressing domestic workforce gaps. It advocates for alignment with the WHO Global Code of Practice on the International Recruitment of Health Personnel. The DOH also promotes bilateral agreements to ensure mutual benefits, including co-investment in the workforce, and opposes wholesale recruitment that harms local systems.

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 can lead as we implement ethical practices for international recruitment. International health care workers will always be a valued resource, and while we must protect the freedom of individuals to migrate, we must also ensure that recruitment does not worsen shortages in countries that cannot afford to lose their long-trained workforce.

Guided by Catholic Social Teaching, our approach is grounded in these principles outlined by Dan Daly of the Center for Theology and Ethics in Catholic Health Care:

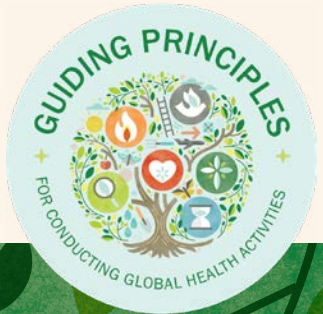
- **Human Dignity:** Every person possesses intrinsic worth and should never be treated as an object of production. Recruitment must enable workers to flourish physically, mentally, spiritually, and relationally.
- **The Common Good:** We are called to create social conditions that promote the flourishing of all communities touched by our actions—including sending nations—not just receiving systems.
- **Solidarity:** A firm determination to promote the common good and bear the burdens of those who suffer. In recruitment, this means mitigating harm to source countries and partnering to strengthen their health systems.
- **Culture of Encounter:** Pope Francis urged us to meet others, build bridges, and plan projects that include everyone. For Catholic health, this means co-designing solutions with sending nations rather than imposing unilateral strategies.

As Catholic health leaders, we have a powerful opportunity to **invest** in global workforce capacity, **practice** and promote inclusive ethical recruitment, and **advocate** for new standards that reflect these values. At the heart of this, Catholic health can lead bold systemic change, and center the voices of countries most affected and partner with them to shape sustainable solutions. The international recruitment crisis will not be solved by one system alone; it requires shared responsibility and a renewed vision of health equity that safeguards the right of all people to health.

CHA
Catholic Health Association of the United States

Global Health Workforce Research & Discussion Paper

OVERVIEW, CHECKLIST, AND PRACTICAL APPLICATIONS



Global Health Workforce Research & Discussion Paper

OVERVIEW, CHECKLIST, AND PRACTICAL APPLICATIONS

Overview

The Catholic Health Association (CHA) developed the full discussion paper to raise awareness and promote discernment among Catholic health leaders regarding the global health workforce crisis. The discussion paper emphasizes the ethical implications of international recruitment and the need for solidarity, sustainability, and justice in workforce development.

Key challenges identified through the research highlight the opportunity to educate ourselves more fully and develop recruitment and retention practices that improve care for all in our local communities and in the communities and countries from which we recruit workers. Ultimately, ensuring that we are improving the quality and expanding the supply of workers in source countries while also assisting with our shortages.

Key Challenges

Global Imbalance: High-income countries increasingly recruit from low- and middle-income countries (LMICs), often inadvertently worsening shortages in fragile health systems.

Ethical Tensions: Recruitment practices often lack transparency and may unintentionally harm countries with less financial resources.

Catholic Concerns: Catholic health care is called to uphold human dignity, promote the common good, practice solidarity, and foster a culture of encounter — principles that should help guide recruitment from nations with low health worker densities. The right to migration, especially for those who are seeking safety and opportunity, is one to be protected and respected.

Call to Action

Ethical recruitment doesn't mean we won't recruit. It does mean that when we recruit, we do so in ways that strengthen, not weaken, health systems in the countries of origin. This means we prioritize transparency, mutual benefit, and long-term investment in the health workforce both at home and abroad. Catholic health ministries are urged to:

- Reflect on their role in the globalworkforce ecosystem.
- Avoid exploitative recruitment.
- Build reciprocal partnerships.
- Advocate for ethical policies.
- Educate staff and monitor impact.

CHA's Global Workforce Ethics & Strategy Checklist

1 Ethical Recruitment Practices

Avoid harm to source countries; ensure transparency and respect.

Checklist:

- ☐ Ensure recruitment does not harm source countries with low health worker density.
- ☐ Avoid aggressive or exploitative recruitment from fragile health systems.
- ☐ Prioritize transparency in contracts, compensation, and expectations.
- ☐ Respect cultural and professional norms of recruited workers.

Practical Applications:

- Audit current recruitment practices for ethical alignment.
- Adopt the WHO Code of Practice.
- Partner only with ethical recruitment agencies.
- Develop culturally sensitive onboarding materials.

2 Support for Recruited Workers

Holistic support, integration, and retention.

Checklist:

- ☐ Provide holistic support: physical, mental, spiritual, and relational.
- ☐ Offer orientation and integration programs tailored to international recruits.
- ☐ Ensure access to pastoral care and community-strengthening opportunities.
- ☐ Monitor well-being and retention through regular feedback mechanisms.

Practical Applications:

- Create support teams for international staff (HR, chaplaincy, peer mentors).
- Offer tailored orientation and community-strengthening programs.
- Monitor well-being through feedback and wellness check-ins.

3 Partnership with Source Nations

Mutual benefit, capacity strengthening, and avoiding dependency.

Checklist:

- ☐ Engage with source countries (Ministry of Health, Church, and secular institutions) to understand their workforce needs and ability to retain needed resources.
- ☐ Build mutually beneficial agreements that include capacity strengthening.
- ☐ Include source country leadership in planning and evaluation.
- ☐ Avoid creating dependency or draining local health systems.

Practical Applications:

- Establish formal agreements with LMIC institutions.
- Co-develop training and exchange programs.
- Invest in infrastructure to educate as well as retain talent in source countries.

4 Investment in Workforce Pipelines

Strengthen domestic and global training systems.

Checklist:

- ☐ Strengthen domestic training and retention programs.
- ☐ Support global workforce development initiatives.
- ☐ Collaborate with educational institutions and professional associations.
- ☐ Promote career pathways and leadership development.

Practical Applications:

- Expand partnerships with U.S. educational institutions.
- Fund scholarships for underserved populations.
- Support faculty development in LMICs.
- Create leadership pathways for all staff.

5 Advocacy & Policy Engagement

Influence ethical recruitment standards and legislation.

Checklist:

- ☐ Advocate for ethical international recruitment standards.
- ☐ Influence policy at local, national, and global levels.
- ☐ Align with WHO guidelines and CHA principles.
- ☐ Support legislation that protects migrant health workers.

Practical Applications:

- Join CHA-led advocacy efforts.
- Engage policymakers on immigration and labor protections.
- Share organizational experiences to inform policy.

6 Education & Awareness

Staff education and ministry-wide engagement.

Checklist:

- ☐ Educate staff and stakeholders on global workforce ethics.
- ☐ Share best practices and case studies across the ministry.
- ☐ Use global health observances (e.g., World Health Day) for awareness campaigns.
- ☐ Engage HR and ethics teams in ongoing training.

Practical Applications:

- Launch internal campaigns on global workforce ethics.
- Host webinars and share case studies.
- Celebrate global health observances with storytelling and events.

7 Monitoring & Accountability

Track impact, report transparently, and include diverse voices.

Checklist:

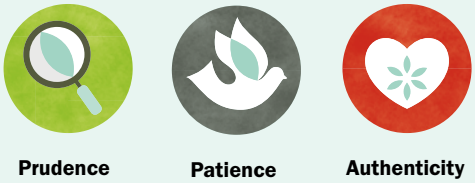
- ☐ Establish metrics to evaluate recruitment impact and equity.
- ☐ Track retention, satisfaction, and integration outcomes.
- ☐ Report transparently on workforce strategies and results.
- ☐ Include diverse voices in evaluation and oversight.

Practical Applications:

- Develop dashboards to monitor recruitment and retention.
- Conduct annual reviews with input from global partners.
- Form advisory groups to oversee workforce initiatives.

Guiding Principles for Global Engagement

CHA outlines six foundational principles for conducting global health workforce activities. Learn more at chausa.org/guidingprinciples.



Prudence **Patience** **Authenticity**

Excellence **Honesty** **Humility**

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List of Abbreviations

- AHC: Americas Health Corps
- CHA: Catholic Health Association
- CHW: Community health workers
- CNO: Chief Nursing Officer
- CHRO: Chief Human Resources Officer
- GHP: Global Health Partnerships (formerly THET)
- 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
- 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

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