

Human resources for health

WHO Global Code of Practice on the International Recruitment of Health Personnel: fourth round of national reporting

Report by the Director-General

BACKGROUND AND OVERVIEW

1. Member State implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel is reviewed on a three-year basis, as per Articles 6.2, 7.2, 9.1 and 9.2 of the Code adopted by the Health Assembly in resolution WHA63.16 (2010).
2. To facilitate the periodic review, the National Reporting Instrument is distributed to all Member States via their respective designated national authority (or focal point) one year before the item is taken up at the Health Assembly.
3. Three previous rounds of reporting have been undertaken and the relevant reports noted by the Sixty-sixth, Sixty-ninth and Seventy-second World Health Assemblies.¹
4. In addition, Article 9.4 of the Code establishes a five-year mechanism to review the Code's relevance and effectiveness. The reports produced by the Expert Advisory Group established for that purpose were discussed at the Sixty-eighth and Seventy-third World Health Assemblies.²
5. This fourth round of national reporting was launched in May 2021 amid the global response to the coronavirus disease (COVID-19) pandemic, widespread disruptions to essential health services and reports of increasing reliance on the recruitment of international health and care personnel to fill employment vacancies, especially in upper middle- and high-income countries.
6. The rising demand for health personnel has prompted contrasting government measures. While some countries have introduced a moratorium on the outward migration of health personnel during the COVID-19 pandemic, a far greater number has simplified the process for inward migration and professional licensure to facilitate rapid recruitment of international personnel. Additionally, many

¹ See documents A66/25 and WHA66/2013/REC/3, summary records of Committee B, fifth meeting, section 2; documents A69/37 and WHA69/2016/REC/3, summary records of Committee B, fourth meeting; and documents A72/23 and WHA72/2019/REC/3, summary records of Committee B, eighth meeting, section 1, respectively.

² See documents A68/32 Add.1 and WHA68/2015/REC/3, summary records of Committee B, fourth meeting, section 2; and documents A73/9 and WHA73/2020/REC/3, summary records of Committee B, fourth meeting, section 3, respectively.

countries have imposed generalized entry bans and travel restrictions that have limited traditional migration pathways. The combined impact on the mobility and migration of health professionals will have to be monitored and analysed as more data become available. A process for doing so is presented in the final section of this report.

FOURTH ROUND OF REPORTING: PROCESS AND RESULTS

7. Pursuant to the recommendations made by the Expert Advisory Group following its second review of the Code's relevance and effectiveness,¹ the Secretariat undertook additional activities to support the fourth round of reporting and implementation of the Code:

- streamlining the National Reporting Instrument;²
- developing tools to enable private recruitment agencies to engage in the process;
- drawing up the Health Workforce Support and Safeguards List 2020³ to identify countries where additional support and safeguards are needed for the ethical management of international recruitment;
- updating the guidance on the design, implementation and monitoring of bilateral agreements on health personnel mobility;⁴ and
- supporting 25 Member States in the implementation of the Code.

8. As at 2 March 2022, 158 Member States (81%) had notified the Secretariat of their designated national authorities, up from 122 (63%) in 2019 (see Table 1).

¹ See document A73/9.

² The fourth round of reporting leverages strengthened synergies with National Health Workforce Accounts.

³ Available at https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_10 (accessed 25 February 2022).

⁴ Bilateral Agreements on Health Worker Mobility: Maximizing benefits through ethical international recruitment. Geneva: World Health Organization; forthcoming.

Table 1. Number of designated national authorities, by WHO region as at 24 March 2022

Region	First round of reporting (2012–2013)	Second round of reporting (2015–2016)	Third round of reporting (2018–2019)	Fourth round of reporting (as at 24 March 2022)
Africa	13	14	17	24
The Americas	11	15	15	28
South-East Asia	4	7	10	9
Europe	43	43	42	49
Eastern Mediterranean	8	14	20	22
Western Pacific	6	24	18	26
Total	85	117^a	122^b	158

^a Consolidated figure of designated national authorities confirmed during the first and second rounds of reporting.

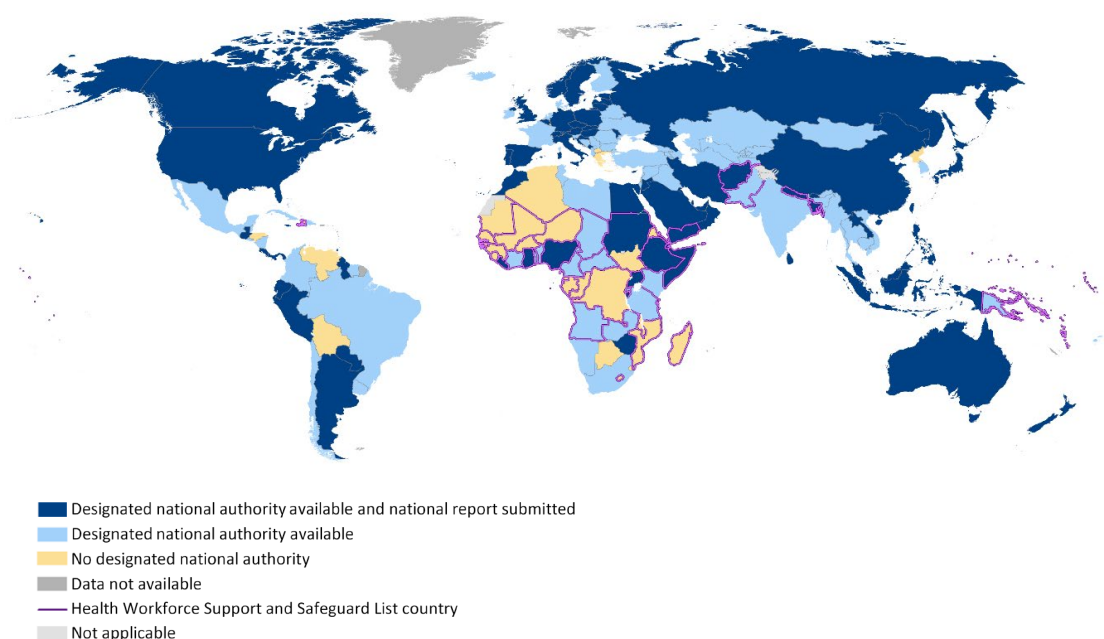
^b Consolidated figure of designated national authorities confirmed during the first three rounds of reporting.

9. Seventy-seven countries, representing 55% of the world's population and comprising most of the major destination economies, submitted a national report, a similar proportion as that recorded in the third round of reporting (see Table 2 and Fig.). The reporting rate in respect of the Support and Safeguards List 2020 is however lower, with only 13 of 47 countries identified therein (28%) participating.

Table 2. National authorities reporting to the Secretariat, by WHO region as at 24 March 2022

Region	First round of reporting (2012–2013)	Second round of reporting (2015–2016)	Third round of reporting (2018–2019)	Fourth round of reporting (as at 24 March 2022)
Africa	2	9	7	8
The Americas	4	9	8	12
South-East Asia	3	6	9	6
Europe	40	31	31	24
Eastern Mediterranean	3	7	15	15
Western Pacific	4	12	10	12
Total	56	74	80	77

Fig. Status of designated national authorities and submitted national reports, by Member States as at 24 March 2022



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source : WHO
 Map Production : WHO GIS Centre for Health
 Map Creation Date: 30 March 2022



10. The Member State reports provide valuable insights into international mobility and migration across the global health economy:

- 29 Member States reported the use of 60 bilateral agreements for international recruitment of health personnel, most of which reflect the Code's principles. This is a positive indicator of compliance with the Code, even though most of the bilateral agreements (62%) had not been co-signed by the relevant health ministries.
- 20 Member States reported measures to ease the entry or integration of foreign-born or -trained health personnel.¹ Conversely, 17 reported limiting the exit of health personnel during the COVID-19 pandemic and most had no mechanism to monitor movements.
- 58 Member States specifically requested technical support to implement the Code, predominantly to strengthen data and information, enhance policy dialogue and develop bilateral agreements.
- 14 Member States reported requiring private recruitment agencies to be certified for ethical practice.

¹ Note: this is a share of the 77 reports. The actual volume of regulatory changes during the pandemic to ease entry and licensing of foreign-trained health personnel is considerably higher.

11. The number of independent stakeholders reporting has remained stable (14) and private recruitment agencies contributed to the reporting for the first time (188 submitted reports).¹ The agencies work in all WHO regions, although most operate in the source and destination countries² where migration of health personnel is highest.

12. From this new source of reporting, it is encouraging to note that most private recruitment agencies reported awareness of the Code (61%) and the Support and Safeguards List 2020 (76%). More work is needed, however, in terms of good governance models, as only 36% of the agencies reported having a government authorization (or equivalent) in source countries to offer ethical international recruitment services.

13. Most independent stakeholders identified the following policy priorities: strengthen data on health workforce migration; promote bilateral agreements with wider stakeholder engagement and ensure benefits to source countries; and strengthen collaboration with the private sector.

14. In parallel to the fourth round of reporting, Member States have continued to collaborate with the Secretariat on the annual reporting of data through their National Health Workforce Accounts. In all, 117 Member States reported data on the number of foreign-born or -trained health personnel in one of the five major health occupations (dentist, midwife, nurse, pharmacist and physician) at least once in the 10-year period 2011–2020; 87 have done so in the last three years.

15. Analysis of the data reveals complex global and regional mobility patterns. For instance:

- Approximately 15% of health and care workers globally are working outside their country of birth or first professional qualification.
- The percentage of foreign-born or -trained health personnel varies by region and occupation. In eight high-density OECD countries, the proportion of foreign-trained physicians increased from 32% in 2010 to 36% in 2020. The proportion is 70 to 80% for nurses and physicians in six high-density Gulf countries.
- Two of the top five destination markets for foreign-born or -trained nurses and physicians are also among the top 10 source countries for health workers.
- Among the source countries exporting the largest numbers of health workers, some also have percentages of foreign-born or -trained nurses or physicians as high as 18 or 20%.
- In a sub-sample of 48 destination countries, approximately 10% of the foreign-trained physicians and 12% of the foreign-trained nurses originated from countries on the Support and Safeguards List 2020.

16. While the historic patterns of mobility (e.g. south to north, low-income to high-income) are still evident, the distinction between source and destination countries is becoming increasingly blurred.

¹ The Secretariat acknowledges the support of the United Kingdom of Great Britain and Northern Ireland, which conducted a survey of recruitment agencies and published an updated national policy aligned with the WHO Global Code of Practice.

² A list of 28 destination countries and 74 source countries was identified thanks to the reports.

CONCLUSION AND WAY FORWARD

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

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

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

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

21. The Secretariat will respond to the requests for technical support from 58 Member States, develop evidence and guidance on bilateral agreements, and review ethical governance models with private recruitment agencies.

22. The Seventy-eighth World Health Assembly will consider the fifth round of reporting and the findings of the third review of the Code's relevance and effectiveness in May 2025.

ACTION BY THE HEALTH ASSEMBLY

23. The Health Assembly is invited to note this report.

= = =