

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

Report by the Secretariat

1. In 2010, the Sixty-third World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel in resolution WHA63.16. The Code is a comprehensive, multilateral framework for strengthening the health workforce, which places emphasis on the international mobility of health professionals.
2. In 2013, the Secretariat presented the Sixty-sixth World Health Assembly with the first report on progress made in implementing the Code.¹ At that time, 85 Member States had designated national authorities and 56 had submitted reports using the national reporting instrument.
3. In 2015, the Sixty-eighth World Health Assembly reviewed the report of the Expert Advisory Group on the Relevance and Effectiveness of the Code.² In its deliberations, the Group had concluded that the Code remains relevant and that evidence of its effectiveness is emerging. It had also concluded that the work to develop, strengthen and maintain the implementation of the instrument should be viewed as a continuing process.
4. The present report, on the second round of national reporting, is being submitted in line with the requirements of Articles 9.2 and 7.2(c) of the Code.

SUPPORT TO MEMBER STATES IMPLEMENTING THE CODE

5. The Secretariat has been providing support in three areas of work, as discussed below.

Designated national authorities

6. Working with regional offices, the Secretariat has maintained its efforts to promote the designation by each Member State of a national authority responsible for exchanging information regarding health personnel migration and the implementation of the Code. Designated national authorities have been established in 114 countries, which represents a 34% increase since the first

¹ Document A66/25.

² Document A68/32 Add.1.

round of reporting, in 2012–2013 (see Table 1). Of these authorities, 85% are based in health ministries, 9% are based in public health institutes and 6% are based in other institutions (such as health authorities, health boards or human resources for health observatories).

7. The overall coverage of designated national authorities has improved considerably. There have been major improvements in certain regions, including a fourfold increase in the number of designated national authorities in the Western Pacific Region.

Table 1. Number of designated national authorities, by WHO region, and number of designated national authorities that reported to the Secretariat using the national reporting instrument as at 30 September 2015

WHO region	First round of reporting (2012–2013)		Second round of reporting (2015–2016)			
	Number of designated national authorities	Number of designated national authorities that reported to the Secretariat	Number of designated national authorities	Number of designated national authorities that reported to the Secretariat	Number of reports to be completed	Number of designated national authorities from which no response was received
African	13	2	12	5	5	2
The Americas	11	4	15	8	4	3
South-East Asia	4	3	7	6	1	0
European	43	40	43	25	9	9
Eastern Mediterranean	8	3	13	5	5	3
Western Pacific	6	4	24	11	4	9
Total	85	56	114	60	28	26

National reporting instrument

8. In consultation with Member States and the relevant stakeholders, the Secretariat has enhanced the national reporting instrument as a country-based self-assessment tool, by:

(a) extending the instrument to cover health workforce development and sustainability, as well as legal rights of migrants, bilateral agreements, research on health personnel mobility, statistics, regulation of authorization to practice, partnerships and technical cooperation;

(b) developing, in cooperation with OECD and Eurostat and through coordination with regional offices, a module on health workforce migration and introducing it to the national reporting instrument, in accordance with Articles 6 and 7 of the Code. This module is aligned

with the questionnaire on joint data collection on non-monetary health care statistics¹ and facilitates data collection on the stock and annual inflow of physicians and nurses by country of their first professional qualification.² It provides new disaggregated data on foreign-trained health personnel;

(c) adding to the national reporting instrument, pursuant to Article 9.4 of the Code, a new part for other stakeholders that wish to provide information related to the implementation of the Code.

9. By 30 September 2015, 60 of the 114 designated national authorities (53%) had completed and submitted a report using the national reporting instrument for the second round of national reporting (see Table 1). Compared with the first round, this represents an increase for all regions except for the European Region. The vast majority of countries that have submitted reports in the second round are those that are the known source and destination countries for the international migration of health personnel.

Collaboration

10. The Secretariat has been fostering multistakeholder collaboration involving government and academic institutions, and civil society organizations and networks, in order to support the advocacy and analytical work called for by the Code. Particular achievements include: Member States' efforts to make the Code available in their official languages (including Catalan, Dutch, Finnish, German, Indonesian, Italian, Japanese, Polish, Romanian and Thai); the incorporation of the Code's provisions into national legislation (for example, in Germany) and bilateral agreements (specifically in source countries such as the Republic of Moldova and Philippines); and the use of the Code to promote multisectoral dialogue on health system sustainability (in El Salvador, Indonesia, Maldives, Philippines and Uganda).

11. At the regional level, the Secretariat has supported a range of activities and intercountry initiatives promoting the implementation of the Code, including: the organization by the Arab Administrative Development Organization of the Thirteenth Arab Conference on New Trends in Hospital Management, which resulted in a declaration calling for efforts to promote accountability for the progressive implementation of the Code in the countries of the Arab League, the Gulf Cooperation Council and the Eastern Mediterranean Region; the efforts of Ibero-American ministers of health to strengthen human resources for health information systems in relation to the monitoring of the migration of health professionals in line with the Code; and the efforts of the Council of Central American Ministers of Health to define a regional policy for migratory flow management. Similarly, WHO has upheld its commitment to and support for the European Union's Joint Action on Health Workforce Planning and Forecasting, and is looking forward to the recommendations for joint action that will be made following a report on the applicability of the Code in the European Union context, with a view to promoting a sustainable health workforce in the medium to longer term. The Secretariat has supported a range of activities in the South-East Asia Region, including the organization of ministerial round-table discussions on strengthening the health workforce during the Sixty-eighth session of the Regional Committee for South-East Asia. The decade of health workforce strengthening

¹ See OECD and WHO Regional Office for Europe. Joint Action Plan, at http://www.euro.who.int/__data/assets/pdf_file/0019/232426/OECD-Joint-statement_09013_FINAL.pdf (accessed 20 October 2015).

² Further details will be provided in an addendum to the report by the Secretariat to the Sixty-ninth World Health Assembly in 2016.

(2015–2024), an initiative launched by the Regional Office for South-East Asia, is considered to be a critical platform for the implementation of the Code.

RESULTS FROM THE SECOND ROUND OF NATIONAL REPORTING

12. Of the 60 countries that submitted a report, 40 (67%) indicate that steps have been taken towards the implementation of the Code. Of these, half report to have conducted a needs assessment for the implementation of the Code at the national, subnational and local levels. A clearer picture is provided of the challenges experienced at the national level than of those at the subnational and local levels.

13. A number of major themes emerge. The first concerns requests for technical assistance for incorporating the Code's provisions into national legislation and regulations; strengthening regulation in both the private and the public sectors; and promoting intersectoral collaboration, specifically between ministries of health and ministries of labour and social affairs. At the regional and global levels, a common challenge faced by countries is that of establishing a link between the regulations that have been put in place to guide their work at the national level and those that form part of bilateral agreements. A third common theme concerns the poor quality of available data and the need to build capacities and make funds available to standardize, collect and exchange mobility data that would serve to strengthen health workforce planning and the effective monitoring of the implementation and impact of the Code.¹

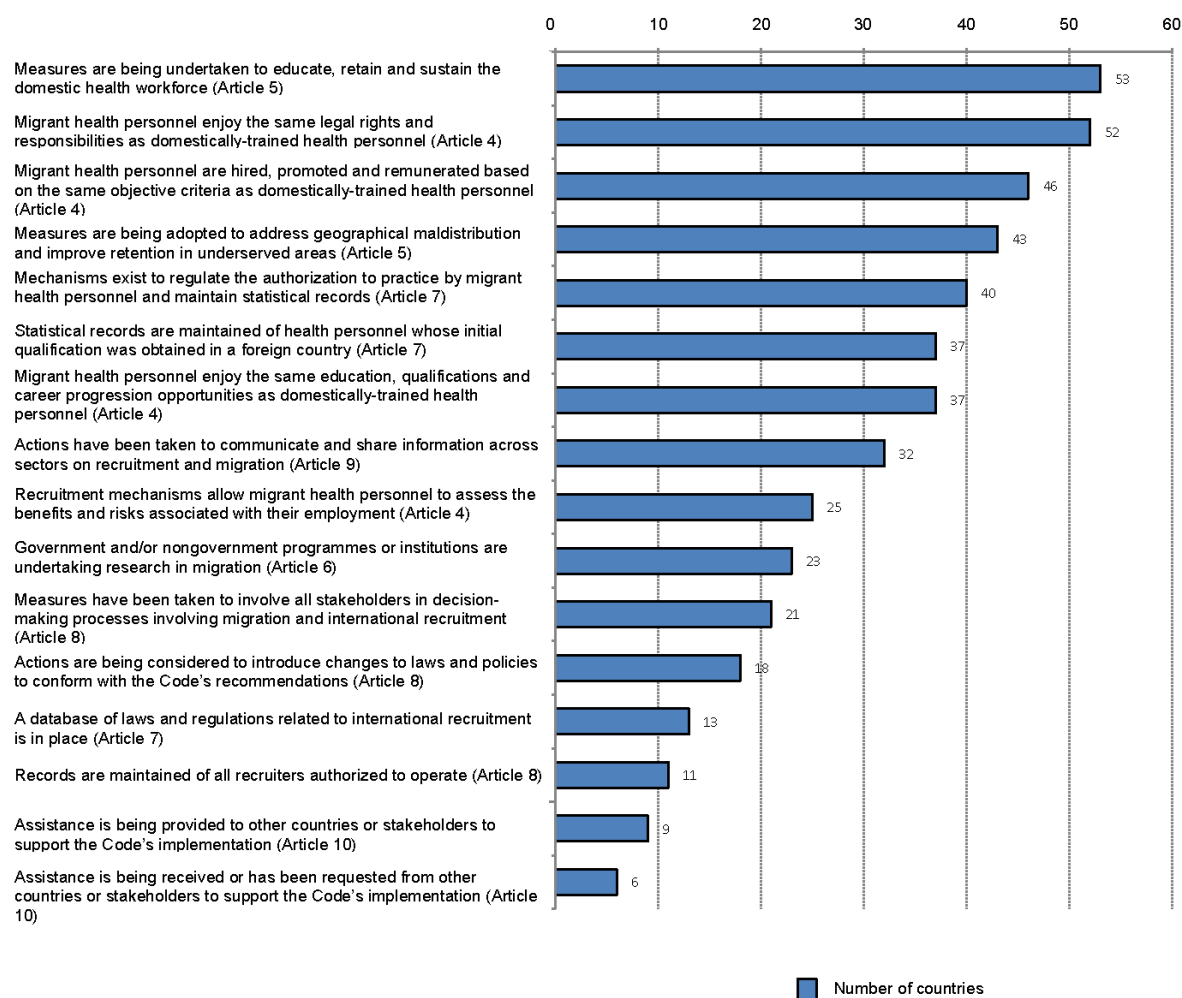
Health workforce development and health systems sustainability

14. The Code is a comprehensive framework for health workforce development that extends beyond labour migration. This point is highlighted in the reports submitted by Member States: 88% of the reports received provide details of measures taken to meet health workforce needs with domestically-trained personnel. Solutions included increasing the number of available positions of assured quality, with more attention being paid to newer skills and competency needs, continuing professional development and improved pay and working conditions.

15. Of the 60 countries that submitted a report, 43 (72%) stated that measures had been taken to address the geographical imbalance in workforce distribution in their countries. The results of these measures will require further analysis and synthesis. The situation of the migrant workforce in terms of legal rights, recruitment and regulation of practice is presented in the figure below. Information on statistical records and on the authorization to practice of foreign-trained health personnel covers mostly physicians and nurses, and to a lesser extent midwives.

¹ Further details will be provided in an addendum to the report by the Secretariat to the Sixty-ninth World Health Assembly in 2016.

Figure. Highlights of the information obtained from 60 designated national authorities using the national reporting instrument (by Article in the Code), as at 30 September 2015



16. Although there would seem to be little sign of intercountry support in the implementation of the Code, close to half of the countries reporting (28) are engaged in bilateral, regional or multilateral agreements on the recruitment of health personnel, which is evidence of the interconnected nature of health labour markets and labour market mobility. The majority of those agreements, predominantly concerning physicians and nurses, preceded the adoption of the Code and remain valid. New evidence of agreements reached at a regional level (specifically concerning ASEAN, the Nordic countries and Middle Eastern countries) was provided by 10 countries with respect to dentists, and three countries with respect to pharmacists.

17. Twenty-five countries opted to provide some information on the profile of the entity submitting the report and some information on other stakeholders and international organizations taking part in the reporting process.

Gathering new evidence on health workforce mobility

18. In accordance with the recommendations of Articles 6 and 7, new information on the scale of international mobility has been obtained from the health workforce migration module in the national reporting instrument (see Table 2 for information on the data obtained). Of the 60 countries that completed the instrument, optional information was provided by 31 on the stock of foreign-trained physicians; by 22 on the annual inflow of foreign-trained physicians; by 27 on the stock of foreign-trained nurses; and by 19 on the annual inflow of foreign-trained nurses. Countries also provided information on the different approaches taken by destination countries to professional registration and recertification. While there were differences between countries in terms of the availability of yearly data, overall there was a strong potential for continued improvements in data collection.

19. Comparison with international databases¹ confirms that seven of the top 10 destination countries for international migrants took part in the second round of national reporting.² Comparison with OECD data on the migration of health professionals confirms that the reports submitted by Australia, Canada, France, Germany, Ireland, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America account for close to 75% of the foreign-trained physicians reported across 26 OECD countries. In this respect, there was a qualified improvement in the second round of reporting in terms of the involvement of the major destination countries.

Table 2. Information on the data obtained on foreign-trained physicians by 60 designated national authorities using the national reporting instrument – as at 30 September 2015

WHO Region	Number of reports received by the Secretariat	Stock of foreign-trained physicians		Annual inflow of foreign-trained physicians	
		Number of countries for which data are available	Median number of years (data availability)	Number of countries for which data are available	Median number of years (data availability)
African	5	1	3	0	–
The Americas	8	4	5.5	2	13
South-East Asian	6	3	7	2	15
European	25	17	7	15	7
Eastern Mediterranean	5	0	–	0	–
Western Pacific	11	6	7	3	2
Total	60	31	7	22	8

¹ United Nations Department of Economic and Social Affairs (2013). Trends in international migrant stock: the 2013 revision (United Nations database, POP/DB/MIG/Stock/Rev.2013).

² These countries, and the percentage of all international migrants in the world living in those countries, are: United States of America (19.8%); Germany (4.2%); United Kingdom of Great Britain and Northern Ireland (3.4%); France (3.2%); Canada (3.2%); Australia (2.8%); and Spain (2.8%).

THE WAY FORWARD WITH SUSTAINED IMPLEMENTATION

20. The quantity and the quality of reporting by Member States on the implementation of the Code has improved considerably in the second round. There has been an increase of 34% in the number of designated national authorities, which will have a significant impact on the implementation of the Code in those Member States. In addition, the engagement of major destination countries (accounting for more than 75% of all physician migration to OECD countries) not only legitimizes the Code and its articles, but explains the increasing quantity and quality of reporting.

21. The 34% increase is a positive response to the reiterated affirmation by the Expert Advisory Group on the Relevance and Effectiveness of the Code of the importance of Member State designation of a national authority, as called for in Article 7.3 of the Code, to facilitate national dialogue, support implementation, and coordinate information exchange and reporting.¹

22. To date, 53% of designated national authorities have submitted a report. The Secretariat is working with the remaining Member States with designated national authorities who have yet to do so as part of the second round of national reporting (47%) and will submit a report with an addendum including additional information to the Sixty-ninth World Health Assembly, in 2016.

23. Member States have conveyed clear messages on their needs to integrate the implementation of the Code and its monitoring into broader national health workforce analysis and planning. In 2015, the Health Assembly requested the Secretariat (at the global, regional and country levels) to expand its capacity to raise awareness, provide technical support and promote effective implementation and reporting of the Code.² The draft global strategy on human resources for health: workforce 2030 incorporates this request³ and places emphasis on continuing implementation of the Code. The draft strategy highlights the increasing demand for health workers due to population growth and demographic and epidemiological transitions. This demand will generate new employment opportunities, mostly in upper-middle and high income countries. A continuing reliance on foreign-trained health professionals is therefore likely. Financial support from the European Commission and the Norwegian Government has permitted WHO to implement a small-scale programme to support the implementation of the Code across five countries; responding to new requests by Member States will be subject to the availability of financial and technical resources in 2016–2017.

24. The new aspects of health workforce development and sustainability assessed to date in the second round of reporting testify to: the beneficial effects of the Code in terms of drawing policy attention to employment, education and retention; the increasing awareness of the global nature of health labour mobility, which requires improved bilateral and multilateral links; and the need for whole-of-government responses with the involvement of health, education, labour and other ministries. Future efforts in this regard must be focused on promoting broader understanding of health workforce sustainability in support of health systems strengthening and the attainment of universal health coverage. Policy options to guide these efforts are included in the draft global strategy on human resources for health: workforce 2030.

ACTION BY THE EXECUTIVE BOARD

25. The Board is invited to note the report.

¹ See document A68/32 Add.1.

² See decision WHA68(11) on the WHO Global Code of Practice on the International Recruitment of Health Personnel (2015).

³ See document EB138/36.