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Human resources for health

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

Report by the Director-General

1.   In 2010, following six years of deliberation, the Sixty-third World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel in resolution WHA63.16.[1]

2.   The Code is a comprehensive, multilateral framework that advances cooperation and information sharing on health worker migration. It establishes ethical principles and practices for the international recruitment of health personnel and the strengthening of health systems. Although non-binding in nature, it includes a robust monitoring framework.

3.   In 2016, the Sixty-ninth World Health Assembly noted the second report on implementation of the Code.[2] By the completion of the second round, 74 Member States had submitted national reports – a substantial increase compared with the first round, during which 56 Member States reported.

4.   This report on the third round of national reporting is submitted in line with the requirements of Articles 9.2 and 7.2(c) of the Code. The content will form the basis for the second review of the Code's relevance and effectiveness in 2019, as called for by the Health Assembly in decision WHA68(11) (2015).

5.   An important context for this report is the adoption of the Global Compact for Safe, Orderly and Regular Migration at the Intergovernmental Conference to Adopt the Global Compact for Safe, Orderly and Regular Migration, held in Marrakech, Morocco, 10 and 11 December 2018. The final text of the document includes important linkages to the Code. Of note, also, the United Nations Secretary-General's report on International Migration and Development,[3] highlights the importance of the Code and health workforce-related data to the broader migration agenda.

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[1] In resolution WHA57.19 (2004), on International migration of health personnel: a challenge for health systems in developing countries, the Health Assembly requested the Director-General to develop a code of practice on the international recruitment of health personnel.

[2] See document WHA69/2016/REC/3, summary records of Committee B, fourth meeting, section 2.

[3] United Nations General Assembly document 73/286.

Progress on implementation of the Code

6.   Within the resources available, the Secretariat has supported the Code's implementation and monitoring, including technical cooperation and provision of support to Member States, and facilitating the third round of national reporting by the designated national authorities.

Third round of national reporting: process and results

Designated national authorities

7.   As at 4 October 2018, 113 Member States have provided contact information for their designated national authorities with responsibility for exchanging information on health personnel migration and Code implementation during the third round (see Table 1 and Fig. 1); 24 Member States did so for the first time.

Table 1. Number of designated national authorities, by WHO region

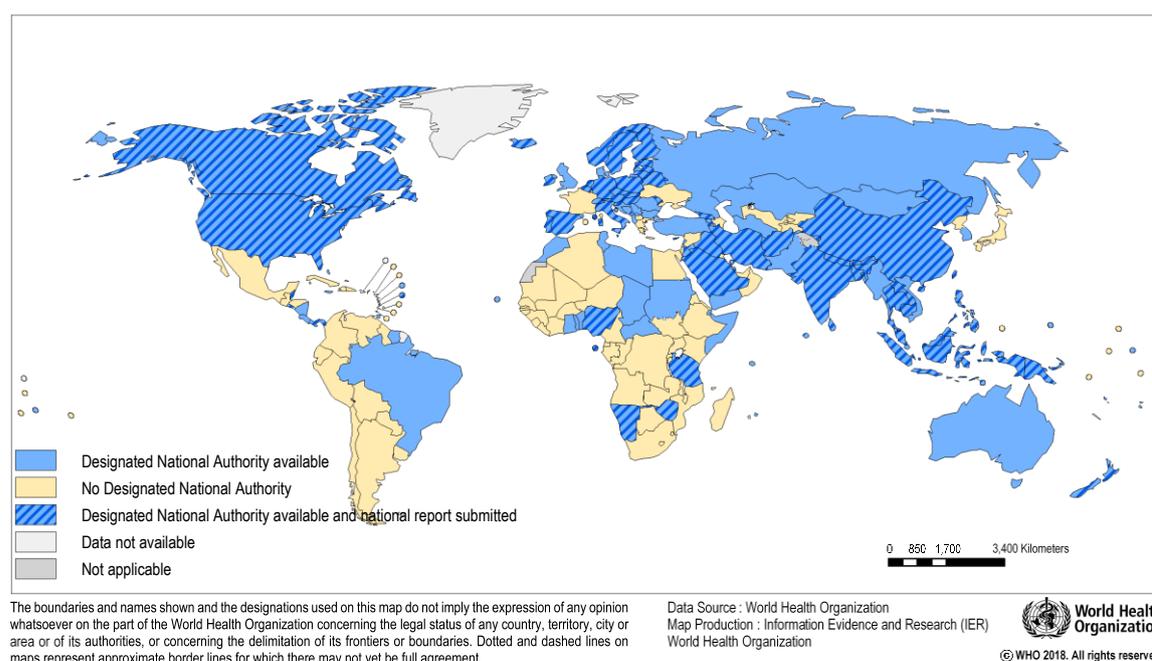| Region	First round of reporting (2012–2013)	Second round of reporting (as at 30 September 2015)	Third round of reporting (as at 4 October 2018)
African	13	12	13
The Americas	11	15	14
South-East Asia	4	7	10
European	43	43	42
Eastern Mediterranean	8	13	16
Western Pacific	6	24	18
Total	85	114[a]	113

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

Submission of national reports: status as at 4 October 2018

8.   Member States and the Secretariat collaborated to simplify the National Reporting Instrument while maintaining consistency with its previous iterations. Data elements were harmonized with the tool and reporting on national health workforce accounts (as urged on Member States by the Health Assembly in resolution WHA69.19 (2016)). The Independent Stakeholders Reporting Instrument and outreach were also strengthened to improve engagement with "relevant stakeholders" in the reporting process.

9.   As at 4 October 2018, 63 Member States (see Table 2) had submitted a national report.[1] The 63 Member States concerned represent almost two thirds of the world's population, and 16 of the 63 countries were reporting for the first time.

Fig. 1 Status of designated national authorities and submitted national reports, by Member States – as at 4 October 2018

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization 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 : World Health Organization
Map Production : Information Evidence and Research (IER)
World Health Organization

Table 2. National authorities that reported to the Secretariat, by WHO region

Region	First round of reporting (2012–2013)	Second round of reporting (as at 30 September 2015)	Third round of reporting (as at 4 October 2018)		
	Report submitted	Report submitted	Report submitted	Report in process	Submitted/ in process
African	2	5	5	2	7
The Americas	4	8	7	2	9
South-East Asia	3	6	9	0	9
European	40	25	29	4	33
Eastern Mediterranean	3	5	6	5	11
Western Pacific	4	11	7	3	10
Total	56	60	63	16	79

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[1] The following Member States reported during the current round: Afghanistan, Armenia, Austria, Bangladesh, Belarus, Belgium, Belize, Bhutan, Cambodia, Canada, China, Cyprus, Czechia, El Salvador, Estonia, Finland, Georgia, Germany, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jordan, Lao People's Democratic Republic, Latvia, Lithuania, Malaysia, Maldives, Malta, Monaco, Montenegro, Namibia, Nepal, Netherlands, New Zealand, Nigeria, Norway, Panama, Papua New Guinea, Philippines, Poland, Portugal, Qatar, Republic of Moldova, Saint Lucia, Sao Tome and Principe, Saudi Arabia, Slovakia, Slovenia, Spain, Sri Lanka, Sweden, Switzerland, Thailand, Timor-Leste, Trinidad and Tobago, United Republic of Tanzania, United States of America, and Zimbabwe.

10. Strong engagement is particularly evident in the South-East Asia Region, where more than three quarters of its Member States have submitted a national report.

Selected results from submitted national reports (n = 63)

11. Altogether 57 Member States provided quantitative data, with 52 Member States providing data on the five health professions (dentist, midwife, nurse, pharmacist and physician) that represent the largest share of regulated health professions and which are most associated with international migration. A total of 42 Member States provided data on the share of foreign-born and/or foreign-trained health workers, with disaggregated data by country of training available for 26 Member States. This figure is an improvement from the second round of reporting in 2016.

12. The data submitted by Member States provides new insights into the international mobility of dentists, midwives and pharmacists.

13. Data on foreign-born and/or foreign-trained health workers provide evidence of a blurring of the distinction between source and destination countries. The inference is that a simplistic binary narrative of source/destination or sending/receiving countries is outdated. Countries that may previously have been identified as source countries are themselves reliant on foreign-trained health workers.[1]

14. Member States also reported on policies and processes consistent with the Code. About 70% of Member States (44 out of 63) identified that they had taken steps to implement the Code. Of these 44 Member States, 27 identified laws and policies, consistent with the Code, being introduced or currently under consideration, and 23 identified good practices, consistent with the Code, being encouraged and promoted among recruitment agencies.

15. Nearly half the Member States (29 out of 63) reported the use of bilateral, regional or multilateral arrangements with respect to the international recruitment and migration of health personnel. Of these 29, 23 identified that the Code's recommendations were incorporated in the arrangements. Notably, 55 separate bilateral, multilateral and regional arrangements with respect to international recruitment and migration were notified to the Secretariat,[2] and text and Internet links to 30 bilateral, multilateral and regional arrangements were shared with the Secretariat.

16. This information complements the findings of the Secretariat's analysis of trade in service agreements notified to WTO and available through its Integrated Trade Intelligence Portal, which identified 12 additional agreements with a health worker mobility component.

17. More than three quarters of Member States, 50 out of 63, requested technical support from the Secretariat to strengthen implementation of the Code. Requests included support in the areas of strengthening data, policy dialogue and development, and the development of bilateral agreements. Member States also requested the Secretariat to enhance work of relevance to all countries, including: the development, negotiation and implementation of bilateral agreements; the review of both the criteria

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[1] For example, the following percentages of health workers were reported as having been foreign trained: 83% of medical doctors in Bhutan; 12% of medical doctors in El Salvador; 10% of dentists in the Islamic Republic of Iran; 70% of medical doctors in Jordan; 11% of medical doctors, 9% of pharmacists and 7% of nurses in the public sector in Lao People's Democratic Republic with numbers rising to 40% in the private sector; and 17.5% of medical doctors and 50% of pharmacists in Zimbabwe.

[2] China additionally identified health personnel-related arrangements for government-to-government cooperation with 56 countries.

and the list of countries with critical health workforce shortages; and the strengthening of the network of designated national authorities to further facilitate information exchange.

Independent stakeholders' reports

18.   As at 4 October 2018, 14 independent stakeholders' reports have been submitted to the Secretariat. This figure is an improvement from the second round when there was only one such submission. The 14 submissions in the third round were received from diverse stakeholders including academia, civil society, national regulatory bodies and international federations. They included country case studies, progress reports and recommendations for implementation of the Code, description of and perspective on bilateral agreements, and requests for technical support.

Targeted support for implementation of the Code at country and global levels

Support from the European Union and Norway

19.   Financial support from the European Union and Norwegian Agency for Development Cooperation enabled the Secretariat to provide targeted support for advancing implementation of the Code in five countries – India, Ireland, Nigeria, South Africa and Uganda – and at the global level. The work has provided a more dynamic understanding of health worker migration, with substantial intraregional, South–South and North–South movement. It has also informed policy dialogue and development.[1]

Establishment of the International Platform on Health Worker Mobility

20.   In 2016, responding to the increasing volume and complexity of health professional migration, the United Nations Secretary-General's High-Level Commission on Health Employment and Economic Growth called on ILO, OECD and WHO to establish an international platform on health worker mobility in order to advance dialogue, knowledge and international cooperation in the area, including support to strengthening of implementation of the Code. In 2017, the Seventieth World Health Assembly in resolution WHA70.6 on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth adopted the five-year action plan on health employment and inclusive economic growth (2017–2021) with the United Nations General Assembly also supporting its operationalization in resolution 71/159.

21.   At the first meeting of the International Platform (Dublin, 14 November 2017), on the margins of the 4th Global Forum on Human Resources for Health, Member States, representatives of regional organizations and international organizations shared information on the challenges and opportunities to maximize the benefits from health worker mobility.[2]

22.   Thirty Member States attended the following meeting of the International Platform (Geneva, 13 and 14 September 2018). Participants discussed promising policy measures and proposed strategic actions to strengthen the management and governance of health worker mobility. As in the third round

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[1] See A dynamic understanding of health worker migration (www.who.int/hrh/HWF17002_Brochure.pdf, accessed 29 October 2018).

[2] See http://www.who.int/hrh/news/2017/high_level-dialogue-int-health-worker-migration-meeting-summary.pdf?ua=1 (accessed 29 October 2018).

of reporting, Member States requested the Secretariat to strengthen information sharing; to support the development, implementation and monitoring of bilateral agreements; to review the criteria and list of countries with critical shortages as part of the second review of the Code's relevance and effectiveness; to strengthen information and policy at the national level; and to maintain knowledge repositories in relevant areas (containing, for example, the texts of bilateral agreements, national competency frameworks and mapping of qualifications across jurisdictions).[1]

The way forward

23.   In collaboration with Member States and independent stakeholders the Secretariat will seek to further strengthen the reporting on the third round ahead of the Seventy-second World Health Assembly.

24.   The Secretariat will seek to provide support in response to all requests for technical assistance from Member States and independent stakeholders. Member States' requests rose to 50 in 2018 – a significant increase. In order to service this level of demand, the Secretariat, together with ILO and OECD, will continue dialogue with Member States, bilateral, multilateral and philanthropic agencies to identify financial resources for the Working for Health Multi-Partner Trust Fund, which serves as a pooled mechanism to implement the Code and the International Platform on Labour Mobility.

25.   As called for by the Health Assembly in decision WHA68(11) (2015) on the Code and as indicated in the timeline shown in Fig. 2, the Secretariat is preparing for the further assessment of the Code's relevance and effectiveness. The findings of the second review, scheduled to be undertaken during the period May–October 2019, will be submitted to the Seventy-third World Health Assembly.

Fig. 2 Timeline for further assessment of the Code

October 2018	January 2019	March 2019	May 2019	May – October 2019	January 2020	May 2020
Report on the Third Round of National Reporting on the Code	144th session of the Executive Board	Report on the Third Round of National Reporting on the Code – Updated	Seventy-second World Health Assembly	Second review of Code's relevance and effectiveness	146th session of the Executive Board	Seventy-third World Health Assembly – 10 Year Anniversary of WHO Global Code
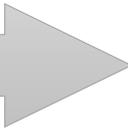
26.   The process for the second review of the Code's relevance and effectiveness will adopt the mechanism successfully applied in the first review.[2] As was done in the first review, the Director-General will convene an expert advisory group with the task of preparing and conducting the review. The expert advisory group will consist of 20 members, comprising 12 representatives of Member States (two nominated from each WHO region) and eight representatives of organizations with institutional knowledge of the Code's development, negotiation and implementation and individual experts. The group shall elect, from among its members, two co-chairpersons. The Secretariat will provide support for the work of the expert advisory group.

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[1] See http://www.who.int/hrh/migration/InternationalPlatformHealthWorkerMobilityMeetingNotes.pdf?ua=1 (accessed 29 October 2018).

[2] As described in document EB136/28, noted by the Executive Board at its 136th session (see document EB136/2015/REC/2, summary records of the eighth meeting, section 3).

ACTION BY THE EXECUTIVE BOARD

27.   The Board is invited to note this report and request the Secretariat to submit an updated version to the Seventy-second World Health Assembly; to encourage all Member States to designate a national authority and to report during the third round of national reporting; and to request the Director-General to proceed with the second review of the Code's relevance and effectiveness.

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