

## **Health and care workforce**

### **WHO Global Code of Practice on the International Recruitment of Health Personnel**

#### **Report by the Director-General**

#### **Background and overview**

1. The Health Assembly in 2004, in resolution WHA57.19, requested the Director-General to develop, in consultation with Member States and all relevant partners, a code of practice on the international recruitment of health personnel.
2. A six-year consultation process followed, including Member State engagement at the Fifty-eighth World Health Assembly, the 124th session of the Executive Board and the six regional committee meetings held in 2009. In resolution WHA63.16 (2010), the Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereinafter the “Code”).
3. The Seventy-eighth World Health Assembly marks the 15-year anniversary of the Code’s adoption. The present report includes findings from the fifth round of national reporting on the Code’s implementation<sup>1</sup> and an interim report from the Director-General’s Expert Advisory Group addressing Article 9.5 on the Code’s relevance, effectiveness and text.<sup>2,3</sup>

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<sup>1</sup> The reporting is conducted every three years. The previous reports are contained in documents A66/25, A69/37, A72/23 and A75/14.

<sup>2</sup> Article 9.5: “The World Health Assembly should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text that should be brought up to date as required”.

<sup>3</sup> Reports are produced every five years. See documents A68/32 Add.1 and A73/9.

## Fifth round of reporting: Process and results

4. The fifth round of reporting commenced in November 2023. As at 30 September 2024, 173 Member States (89%) had notified the Secretariat of their designated national authorities (see Table 1).

**Table 1. Number of designated national authorities, by WHO region as at 30 September 2024**

Region	First round (2012–2013)	Second round (2015–2016)	Third round (2018–2019)	Fourth round (2021–2022)	Fifth round (2024–2025)
Africa (n=47)	13	14	17	24	32
The Americas (n=35)	11	15	15	28	34
South-East Asia (n=11)	4	7	10	9	10
Europe (n=53)	43	43	42	49	50
Eastern Mediterranean (n=21)	8	14	20	21	20
Western Pacific (n=27)	6	24	18	26	27
<b>Total (n=194)<sup>a</sup></b>	<b>85</b>	<b>117</b>	<b>122</b>	<b>157</b>	<b>173</b>

<sup>a</sup> The totals represent the consolidated number of designated national authorities that were nominated during the current and/or previous rounds of reporting.

5. As at 30 September 2024, 86 countries, representing 35% of the world's population and comprising eight of the 10 major destination countries, submitted a national report, a record level of Member State engagement (see Table 2). Twenty-eight countries submitting a report in 2021–2022 did not do so in 2024, while 34 countries not reporting in 2021–2022 did so in the fifth round. The reporting rate by countries in the WHO Health Workforce Support and Safeguards List 2023 remains low (16 of 55 countries (29%)).

**Table 2. National designated authorities reporting to the Secretariat, by WHO region and World Bank income group as at 30 September 2024**

	First round (2012–2013)	Second round (2015–2016)	Third round (2018–2019)	Fourth round (2021–2022)	Fifth round (2024–2025)
<b>By WHO region</b>					
Africa (n=47)	2	9	7	8	15
The Americas (n=35)	4	9	8	13	17
South-East Asia (n=11)	3	6	9	6	3
Europe (n=53)	40	31	31	24	31
Eastern Mediterranean (n=21)	3	7	15	17	12
Western Pacific (n=27)	4	12	10	12	8

	First round (2012–2013)	Second round (2015–2016)	Third round (2018–2019)	Fourth round (2021–2022)	Fifth round (2024–2025)
<b>By World Bank income group<sup>a</sup></b>					
High-income countries (n=62)	30	35	39	38	36
Upper middle-income countries (n=54)	17	17	18	15	21
Lower middle-income countries (n=49)	7	17	18	17	21
Low-income countries (n=26)	2	4	5	9	7
<b>Total</b>	<b>56</b>	<b>74</b>	<b>80</b>	<b>80</b>	<b>86</b>

<sup>a</sup> World Bank Group country classification by income level for the fiscal year 2025.

6. The Member State reports provide valuable insights into international mobility and migration (Figs. 1, 2 and 3). Of note:

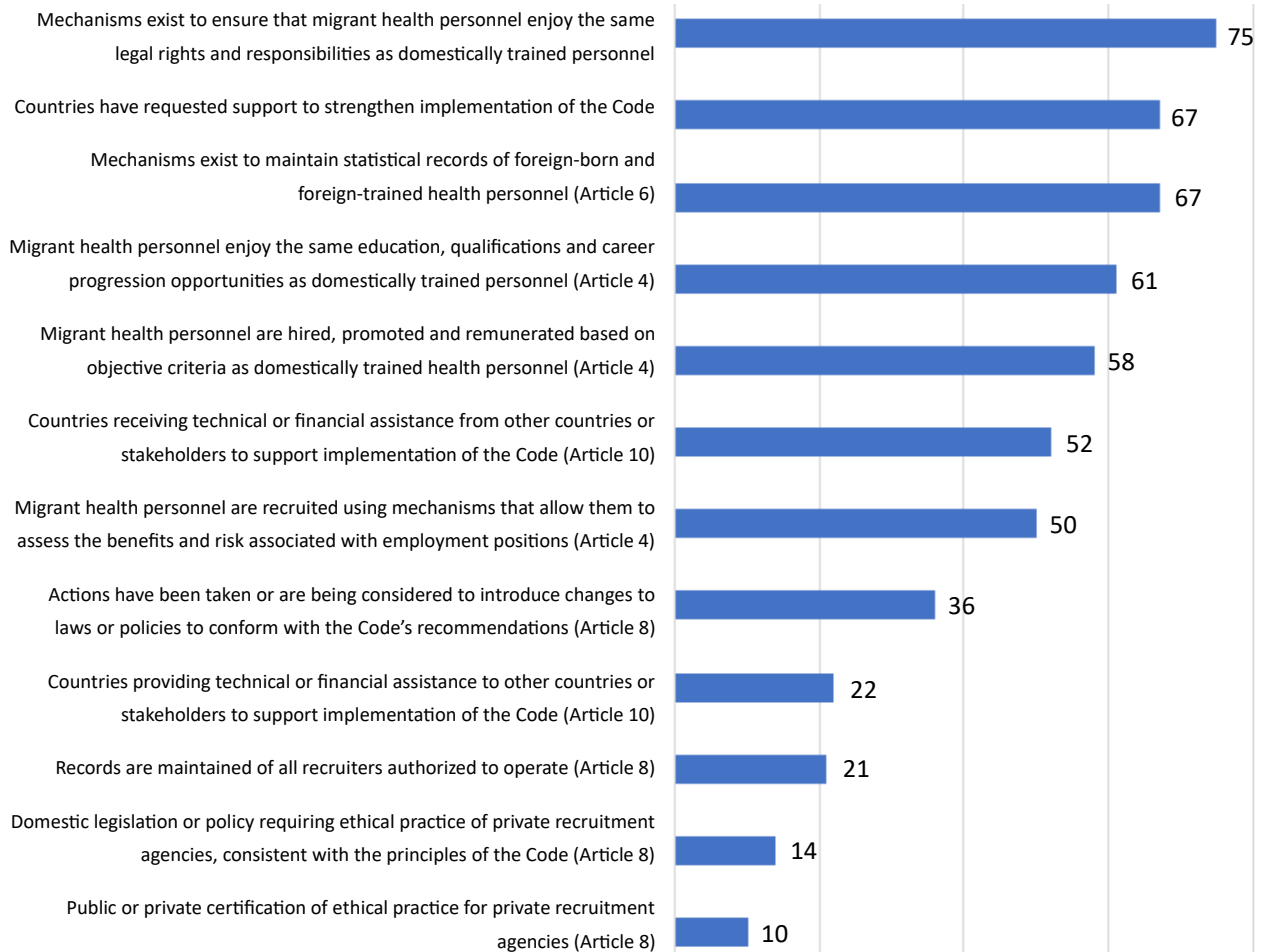
- (a) 81 of 86 Member States (94%) stated they were taking measures for health workforce sustainability and to address the geographical maldistribution and retention of health and care workers;<sup>4</sup>
- (b) 66 of 85 Member States (78%) indicated that international recruitment of, or reliance on, foreign-trained health personnel is an issue of national concern;
- (c) 48 of 85 Member States (56%) indicated that migration has been increasing in intensity in the past three years;
- (d) 33 of 86 Member States (38%) indicated they had entered into bilateral agreements related to health personnel migration and mobility; 94 bilateral agreements were reported, with six countries having at least 10 agreements.<sup>5</sup> However, quantitative data on health worker migration through such agreements are available for fewer than 40 agreements;
- (e) the perceived effect of international recruitment of health personnel varies from positive to neutral and negative in terms of implications on health service delivery. Some source countries, even those outside the Support and Safeguards List, face challenges in delivering services. In parallel, large-scale international recruitment of health workers from developing countries facing shortages by high-income countries without explicit focus on mutuality of benefits runs counter to the provisions of the Code;
- (f) concerns from low- and middle-income countries include: targeted international recruitment and difficulties in replacing specialists; the need to resort to international recruitment as nationally trained graduates emigrate; and the recruitment of practising nurses to other countries as care workers; and

<sup>4</sup> Among the reporting countries, 91% of the small island developing States, 81% of the countries in the Support and Safeguards List 2023 and 80% of OECD countries responded that the international migration of health personnel was an issue of concern.

<sup>5</sup> Cuba, Germany, the Philippines, the Russian Federation, Saudi Arabia and the United Kingdom of Great Britain and Northern Ireland.

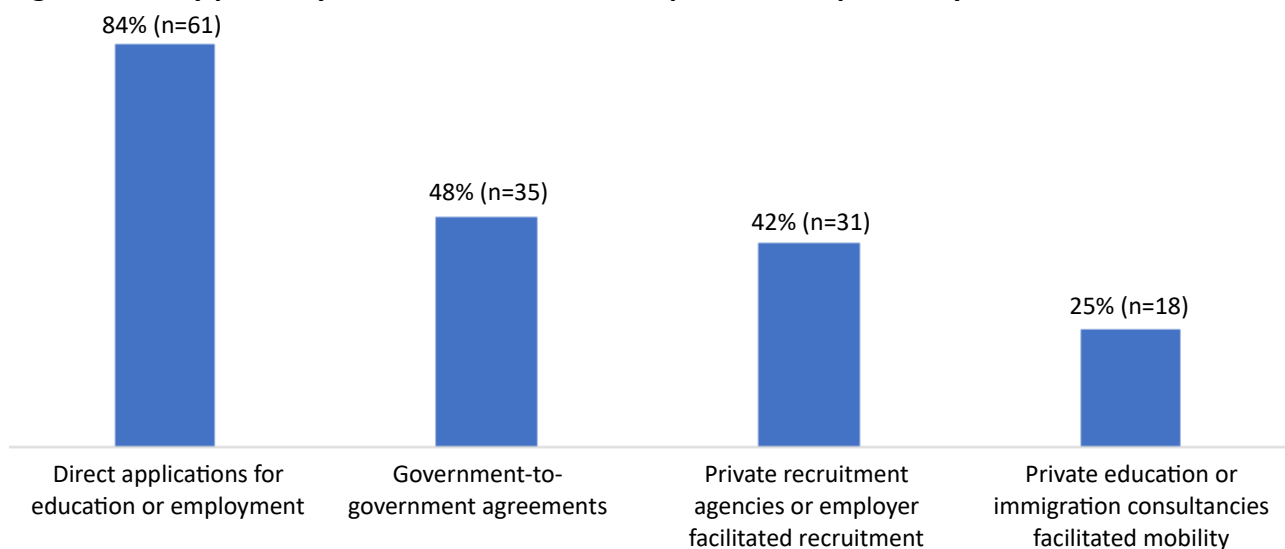
(g) 10 Member States – predominantly source countries – recommended that the Code should be updated to improve data sharing, including on return migration, incorporate lessons from the coronavirus disease (COVID-19) pandemic, and address the escalating recruitment drives for care jobs, and emerging issues such as technological advances in health.

**Fig. 1. Key findings from national reports of 86 Member States as at 30 September 2024**

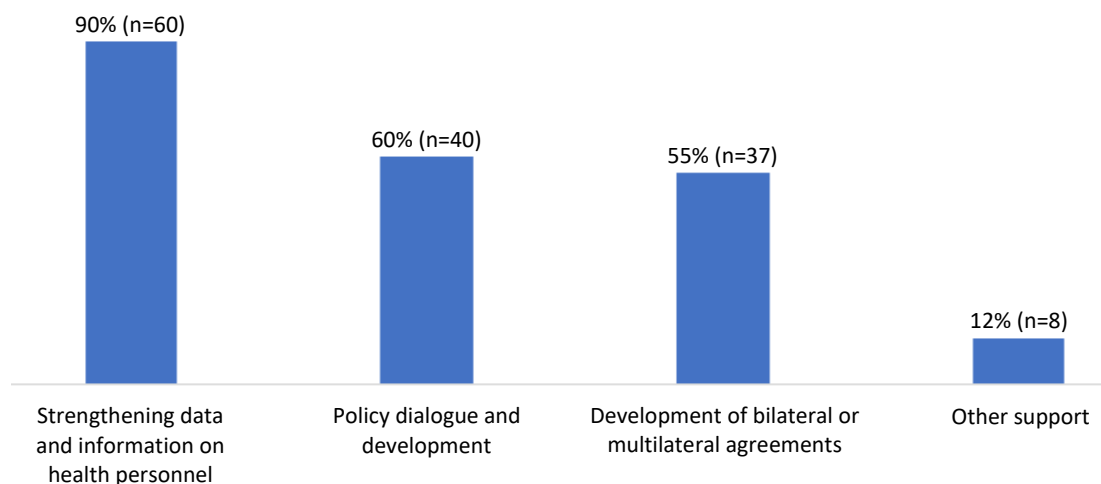


Note: Responses to the National Reporting Instrument are voluntary. The number of countries responding to each question may vary.

**Fig. 2. Mobility pathways for international health personnel reported by 73 Member States**



Note: Of the 73 Member States, 40 indicated the existence of more than one mobility pathway for international health personnel to their country.

**Fig. 3. Support requested by 67 Member States to strengthen implementation of the Code**

Note: Of the 67 Member States, 46 requested more than one type of support to strengthen Code implementation.

7. The number of independent stakeholders reporting (academic institutions, civil society organizations, professional associations), mostly from high-income countries, has remained stable (13). Consistent with Member State reports, non-State actors' reports suggest an increase in the international recruitment of health personnel.

8. Reports from 38 private recruiters referred to recruitment from 44 source countries to six destination countries in 2023. Some 84% of responding private recruiters indicated awareness of the Code and 87% of responding private recruiters reported awareness of the Support and Safeguards List. Also, 89% of the responding private recruiters expressed commitment to implementing the Code. Further, 63% of respondents stated that formal authorization is required for international recruitment in some or all countries from where they recruit, while 45% indicated the need for such authorizations in destination countries.

### Migration data through national health workforce accounts

9. In parallel to the fifth round of reporting, 130 Member States reported data through the national health workforce accounts 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 2013–2023; 69 have done so in the past three years. This is an 11% increase since the fourth round of reporting.

10. The data reveal stark differences in the global distribution of health workers and complex mobility patterns:

(a) 23% of the world's doctors, nurses and midwives are based in 10 high-income countries that comprise 9% of the world's population, compared with only 5% in the 55 countries in the Support and Safeguards List 2023, representing 21% of the world's population;

(b) in selected high-income countries reporting data pre and post the COVID-19 pandemic, although the share of foreign-trained health workers remained stable during 2018 to 2021, the total number of foreign-trained physicians and nursing personnel increased substantially (range: 2–57%);

(c) in 79 destination countries, approximately 72 000 of the foreign-trained physicians and 164 000 of the foreign-trained nurses originated from the countries in the Support and Safeguards List 2023, representing 11% of the stock from these source countries; and

(d) the distinction between source and destination countries is becoming increasingly blurred. Two of the major destination countries for foreign-born or -trained nurses and physicians are also key source countries. Meanwhile, in 28 low- and middle-income countries, more than one in five health workers of at least one health occupation is foreign trained.<sup>6</sup>

## Other selected Code-related activities

11. Pursuant to the recommendations of the Expert Advisory Group's second review, the Secretariat undertook additional activities to support implementation of the Code, including:

- (a) an update of the Support and Safeguards List 2023, identifying countries needing additional support and safeguards for the ethical management of international recruitment; and
- (b) publication, in consultation with ILO, of guidance on the design and implementation of bilateral agreements on health worker migration and mobility.

12. The third review of the Code's relevance, effectiveness and text, in accordance with resolution WHA63.16 and Article 9.5, commenced in March 2024. The Expert Advisory Group is composed of representatives from 12 Member States, two per WHO region, alongside 14 international experts. It will continue to report to the Health Assembly until 2026.

13. The Director-General extends his appreciation to the Expert Advisory Group and has the pleasure of submitting its interim report to the Board (Annex). The Group's interim report highlights the complexity of international migration and mobility, calling for a renewed consensus among Member States and partners that the full implementation of the Code is a global health imperative. The Group's interim proposals include measures to strengthen the effectiveness of the Code's implementation in the next five years and updates to its text.

14. The Group's interim report will be transmitted to the Seventy-eighth World Health Assembly. Regional consultations, in the second half of 2025, would be in line with the procedure agreed on by the Board at its 124th session in January 2009.<sup>7</sup> The outcome of the regional discussions would inform the Group's final report.

## Conclusion

15. Some 15 years after its adoption, the Code is a mature instrument benefiting from five rounds of Member State reporting and three rounds of Expert Advisory Group review. In the face of growing migration trends, data indicate increasing awareness and uptake of selected Code recommendations and related instruments.

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<sup>6</sup> See [National Health Workforce Accounts Data Portal](#). Geneva: World Health Organization; 2023 (accessed 27 September 2024).

<sup>7</sup> See document EB124/2009/REC/2, eleventh meeting, section 1.

16. At the same time, challenges persist, including uneven implementation of the Code in countries in the Support and Safeguards List as well as destination and other source countries.

17. The continuing Expert Advisory Group third review presents an important opportunity for Member States to reaffirm their commitment to the Code, strengthen the Code's implementation and refine it for both the current context and the next five years.

### **Action by the Executive Board**

18. The Board is invited to note the report and consider the following draft decision regarding the Expert Advisory Group interim report:

The Executive Board, having considered the report by the Director-General<sup>8</sup> and the annexed interim report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel,

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following decision:

The Seventy-eighth World Health Assembly,

Having considered the report of the Director-General and the interim report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel,

Decided to request the Director-General to facilitate regional consultations with Member States to review the interim report of the Expert Advisory Group in advance of its finalization and submission to the Seventy-ninth World Health Assembly through the Executive Board at its 158th session.

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<sup>8</sup> Document EB156/14.

## **Annex**

# **WHO Expert Advisory Group's Interim Report on the Third Review of the WHO Global Code of Practice on the International Recruitment of Health Personnel**

**December 2024**

*The full implementation of the Code is a global health imperative.*

## Executive summary

The Director-General, responding to decision WHA73(30) (2020), convened an Expert Advisory Group (“EAG”) with the mandate to conduct the third review of the WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”). The EAG is tasked with (1) advising the Director-General of evidence on the relevance and effectiveness of the Code; and (2) providing guidance on measures needed to ensure and strengthen the Code’s relevance and effectiveness, including updates to the Code as required.

The work of the EAG is taking place from March 2024 to May 2026, producing an interim (December 2024) and final (December 2025) report. This interim report benefits from a review of 14 evidence briefs, including access to the results of the fifth round of national reporting on the Code’s implementation in the period 2023–2024, and two EAG meetings.

The EAG agreed that the full implementation of the Code is a global health imperative. The increasing market-driven mobility of health workers can widen health inequalities and increase risk to global health security unless proactive actions are taken by both source and destination countries, in alignment with the Code’s principles.

To this end, the EAG recommends:

- (a) specific measures for Member States, the WHO Secretariat and other stakeholders to ensure the effective application of the Code over the next five years (see Box 1 below);
- (b) additional elements to be included in the Code (see Box 2 below);
- (c) regional consultations with Member States in 2025 to review this interim report and provide written responses to inform the EAG’s work.

**Relevance:** The Code retains its full relevance in the context of growing international mobility and migration, ever more complex threats to health security and the increasing interconnectedness of health systems linked through a globalized health labour market. However, its continued relevance in the future is dependent on the extent to which the Code can address emerging global health workforce challenges through its uptake by Member States and other stakeholders in the post-coronavirus disease (COVID-19) world, which is increasingly interconnected, with the education and mobility of health workers contributing to the interdependency of health systems. Its continued relevance is also dependent on the economic context in countries.

**Effectiveness:** The implementation of the Code has been a major contributor in raising awareness among Member States, recruitment agencies and independent stakeholders, and has demonstrated effectiveness in increasing the availability of health workforce data, the reporting of bilateral agreements, the availability of tools and the dissemination and adoption of some of the Code’s provisions in national and international policies.

However, the Code and its implementation needs to be strengthened to incorporate health personnel working in the care sector, more effectively foster proportionality of mutual health system benefits from migration, facilitate the ethical management of international recruitments during emergencies, enhance the effective regulation of private recruiters, address passive recruitment from vulnerable countries, catalyse investments in health systems and health workforce in countries of origin, advance health workforce sustainability of both source and destination countries, and address evolving threats to health security.

### Box 1. Recommendations to strengthen the implementation of the Code over the next five years

#### To Member States

1. **Health workforce sustainability:** Member States with high reliance on international health personnel should strive for sustainable health workforce policies, planning, investments and practices that reduce dependency on international recruitment and, in parallel, support the strengthening of the health workforce in less-resourced countries that supply them with health personnel.
2. **International recruitment during emergencies:** Since any country can face sudden vulnerabilities at times of crises (e.g. emergencies and pandemics), while undertaking international recruitment during such times, Member States and their delegated agents should consult with source countries to ensure the adequate domestic supply of health personnel and provide possible support in the priority areas of these countries.
3. **Data on internationalization of health professional education:** Member States should gather and share data on international flows of students and trainees in health professional education during the period of training.
4. **Research and funding:** Research on health and care workforce migration is lacking, limiting the generation of critical knowledge to manage migration more equitably and efficiently, and should be prioritized at both the national and international levels.

#### To the WHO Secretariat and other stakeholders

5. **Clarity and advocacy on the Code and the WHO Health Workforce Support and Safeguards List:**
  - (a) Provide clear and, as applicable, operational definitions of specific aspects and terms related to the Code (active recruitment, ethical recruitment, sustainable health workforce, co-investment, etc.) through information products tailored to different audiences.
  - (b) Provide greater clarity on the objective, use and impact of the WHO Health Workforce Support and Safeguards List. The aim of the List is to identify countries facing health workforce vulnerabilities that would benefit from support and safeguards measures, including strengthening health systems and health workforce investments and developing bilateral agreements.
  - (c) The WHO Health Workforce Support and Safeguards List should explore options for countries that: are in the List but do not require the recommended safeguards; and countries that are not in the List but that could benefit from the safeguards in order to communicate individual national policies on international recruitment with destination countries and recruiters. The Expert Advisory Group recommends that there should be some flexibility in its application through a process whereby Member States may communicate, to the Secretariat, willingness to allow international recruitment under certain circumstances (e.g. as part of a bilateral agreement or in the case of oversupply documented by a health labour market analysis) to be considered in line with domestic health workforce and/or migration policy.
  - (d) Promote the dissemination and uptake of the Code by identifying champions, creating pledging mechanisms and annual celebration of the Code's adoption at the regional and global levels.
6. **Support for bilateral agreement development and evaluation:**
  - (a) Facilitate and support the development of bilateral agreements on health worker migration and mobility in alignment with the Code's principles and recommendations, when requested by Member States.
  - (b) Strengthen the review and evaluation of bilateral agreements reported through the Code reporting mechanisms and provide guidance on good practices.
7. **Capacity development:**
  - (a) Provide technical support to develop core capacity in source and destination countries to monitor the dynamics of health workforce flows and measures on health workforce education, employment and retention to address the drivers of health workforce migration.
  - (b) Convene source and destination countries to strengthen capacity and negotiation processes and skills to promote co-investment dialogues on the health workforce, including measures to address the drivers of migration in source countries.
  - (c) Provide country support on the dissemination of the Code, its application and reporting process.

8. **Engagement with non-State actors, regulators and other stakeholders:**
- (a) Strengthen advocacy efforts on the Code among non-State actors, including private sector recruiters and education institutions.
  - (b) Encourage professional associations, regulators and civil society to share data and information related to the health workforce and international recruitment practices.
9. **Research:** Support a research agenda for health and care workforce migration, including but not limited to the following priority areas:
- (a) spectrum of international health worker recruitment in the private sector and through recruitment agencies, including health workers working as care workers;
  - (b) regulation of private recruitment agencies;
  - (c) performance of bilateral agreements;
  - (d) perspectives and experiences of migrant health workers;
  - (e) co-investment: volumes, modalities and best practices;
  - (f) value and enablers of the health diaspora in ensuring health equity in source and destination countries;
  - (g) economic impacts of health worker migration on source countries; and
  - (h) enablers of safe, effective and equitable provision of telehealth services across jurisdictions, ensuring that such practices comply with ethical recruitment standards and do not inadvertently exacerbate health workforce imbalances.

**Box 2. Additional elements to be included in the WHO Global Code of Practice (2010)**

**Nature and scope**

1. The provisions of the Code also apply to health personnel who migrate and take up employment positions as care workers<sup>1</sup> in destination countries.
2. The recommendations of the Code are applicable in all countries also during pandemics and other health emergencies, environmental disasters and humanitarian, economic or crises situations that require additional or surge support to manage health service delivery.

**Health system sustainability**

3. Member States with a high reliance on international health personnel, irrespective of the pathway of mobility or type of recruitment, could consider modalities of support focused on mutually beneficial approaches, such as targeted co-investments in partnership with source countries in specific areas of the health workforce and health systems in the source countries.

**Partnerships, technical collaboration and financial support**

4. Development banks, donor agencies and financial and development institutions and countries with responsibility for emergency financing, should develop emergency financing modalities to mitigate the risk of excessive health workforce depletion during crises arising from a variety of causes.
5. Donor agencies, global health initiatives, and international financial institutions are encouraged to co-invest in priority areas of health systems identified by countries as requiring support, with investments across the entire health worker life cycle (education, employment and retention) to optimize the management and performance of the health workforce and improve population health.

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<sup>1</sup> Care workers provide direct personal care services in the home, in healthcare and residential settings, assisting with routine tasks of daily life, and performing a variety of other tasks of a simple and routine nature. Source: [Health Workforce-related terminology](#) (accessed 11 December 2024).

## Background

1. Building on policy discussions initiated at the Fifty-seventh World Health Assembly in 2004,<sup>2</sup> after six years of negotiations, the Sixty-third World Health Assembly, through resolution WHA63.16, adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (“the Code”) in 2010.<sup>3</sup>
2. Since the Code’s adoption, there has been significant progress in global health, as evidenced by the steady increase in life expectancy (temporarily reversed by the COVID-19 pandemic), reductions in maternal and child mortality and control of priority infectious diseases. Yet, since 2016 progress towards the health-related targets of the Sustainable Development Goals has stagnated; further, large health inequities between and within countries are persistent and widening, owing to the disparities in access to health services, the rising burden of chronic diseases, emerging health and increasing climate-related threats, the rise in conflict and humanitarian crises, and the social determinants of health.
3. The COVID-19 pandemic served as a reminder that the health and care workforce is crucial for all health system operations, public health goals, health security and the global economy. As health workers represent an invaluable resource, increasing levels of international migration of health personnel is a priority issue, both for the countries that rely on international recruitment to meet their health system needs, and especially for countries where the availability of health workers is insufficient to meet universal health coverage goals and substantial numbers of already scarce health workers are lost to international migration. The growing migratory flows of health workers demonstrates the existence of a global health labour market and the growing interdependence and interconnectedness of health systems and national labour markets in this respect.
4. The Code is the main global framework to promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel. The Code benefits from robust review mechanisms for its implementation, monitoring and effectiveness, features that are more commonly associated with binding instruments. So far, there have been four rounds of national reporting<sup>4</sup> and two independent Member State-led reviews of the Code’s relevance and effectiveness.<sup>5</sup> The fifth round of national reporting and the third review of the Code are in progress at the time of writing of this report.

## Expert Advisory Group: constitution, mandate and process

5. Article 9.5 of the Code, reinforced by resolution WHA63.16, stipulates that “the World Health Assembly should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text that should be brought up to date as required”.

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<sup>2</sup> See [resolution WHA57.19 \(2004\)](#), International migration of health personnel: a challenge for health systems in developing countries (accessed 10 December 2024).

<sup>3</sup> [Resolution WHA63.16 \(2010\)](#), WHO Global Code of Practice on the International Recruitment of Health Personnel (accessed 10 December 2024).

<sup>4</sup> See documents A66/25, A69/37, A69/37 Add.1, A72/23, and A75/14.

<sup>5</sup> See documents A68/32 Add.1 and A73/9.

6. The third review of the Code, which is the subject of this interim report, adopted the same mechanisms as applied for the previous two reviews. Responding to decision WHA73(30) (2020), the Director-General convened the EAG with the mandate to prepare and conduct the third review.
7. The EAG is tasked with (1) advising the Director-General of evidence on the relevance and effectiveness of the Code; and (2) providing guidance on measures needed to ensure and strengthen the Code's relevance and effectiveness, including updates to the Code as required.
8. The EAG is composed of 26 individuals, including 12 representatives from Member States (two Member States from each WHO region), 11 individual experts and three representatives from international organizations (see Appendix), supported by the WHO Secretariat.
9. The EAG's proceedings commenced in March 2024 and its operations will continue until the Seventy-ninth World Health Assembly in May 2026. The EAG is issuing an interim report to inform deliberations at the 156th session of the Executive Board in January 2025 and support consultations across the six WHO regions in 2025. It will submit its final report to the Director-General for onward transmission to the 158th session of the Executive Board and subsequently to the Seventy-ninth World Health Assembly in 2026.
10. The EAG met in June and November 2024. At the first meeting, the Group's members elected by consensus Dr Kenneth Ronquillo, Undersecretary, Department of Health, the Philippines, and Ms Susan Weston, Assistant Director, Health Policy Branch, Health Canada, Canada, as Co-Chairs of the Expert Advisory Group.
11. The EAG's review was informed by 14 technical evidence briefs and a briefing from the WHO Secretariat on the governance procedure for updating the Code as required. The technical briefs analysed migration levels and trends, reports submitted by Member States and non-State actors on the Code's implementation, the legal nature of the Code, pathways to international mobility and return migration, practices and ethical oversight of private recruiters, policy options to strengthen implementation of the Code and the economics of health workforce migration to both source and destination countries.
12. Recommendations from other international and regional forums on international health worker migration were also considered, including, amongst others, the Bucharest Declaration on the health and care workforce (March 2023), the Prince Mahidol Award Conference (January 2024), the high-level meeting on migration and mobility of healthcare workers in the Region of the Americas (October 2024), the G20 Health Ministerial Declaration (October 2024) and the Philippine–Pacific Partnership on Sustainable Health Workforce for Health Security (November 2024).

## Summary of evidence reviewed by the Expert Advisory Group

13. The evidence considered by the EAG is grouped in two parts: (1) relevance; and (2) effectiveness. Consistent with the first and second reviews of the Code, the following definitions were used:

- (a) **Relevance:** the extent to which the objectives, principles and articles of the Code continue to be pertinent and can inform solutions related to the global challenge of the migration of health personnel and health system strengthening.

- (b) **Effectiveness:** the extent to which the implementation of the Code's objectives, principles and articles have influenced actions and policies concerning health workforce strengthening at the country, regional and global levels.

## Relevance

14. Marked inequalities persist in health workforce distribution globally: based on WHO national health workforce accounts data, 23% of the world's doctors, nurses and midwives are based in 10 high-income countries, which comprise 9% of the world's population. In sharp contrast, only 5% of health workers in these three occupations are based in the 55 countries in the WHO Health Workforce Support and Safeguards List 2023, which comprise 21% of the world's population. Uneven distribution across countries is compounded by geographical maldistribution within countries and gender disparities.<sup>6</sup>

15. In certain high-income countries<sup>7</sup> reporting pre- and post-COVID-19 data, while the share of foreign-trained health workers remained stable during the period 2018–2021, the total number of foreign-trained medical doctors and nursing personnel increased, often substantially (by between 2% and 57%), suggesting an acceleration in international mobility fuelled by rising demand as a result of the pandemic, continued changing demographics, and the growing interdependence of health systems and labour markets (particularly in terms of high-skilled workers), which are increasingly interconnected through the global health labour market.

16. In the past two decades, while the cluster of major destination countries has remained mostly unchanged,<sup>8</sup> the number of source countries has expanded. Health worker mobility is also increasing among physiotherapists, health laboratory workers and personal care workers.

17. The distinction between "source" and "destination" countries is increasingly blurred: among the top 10 high-income destination countries, two are also key source countries for other destination countries; and among 28 low- and middle-income source countries, 20% of the health workers in at least one health occupation are foreign trained.<sup>9</sup> Further, some countries act as "transit" countries for health workers in their mobility pathways. In addition to South to North movements, South to South and North to North movements are increasingly recognized as phenomena of substantial magnitude.

18. The growing number of international migrant health workers is the result of multiple factors, in addition to conventional drivers such as better remuneration, career prospects, working environment and job satisfaction in destination countries.<sup>10</sup> Language and geographical proximity and bilateral and multilateral collaborative structures and mechanisms operating between

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<sup>6</sup> [Fair share for health and care: gender and the undervaluation of health and care work](#). Geneva: World Health Organization; 2024 (accessed 10 December 2024).

<sup>7</sup> Belgium, Canada, Finland, France, Germany, Hungary, Israel, Italy, Switzerland, and the United Kingdom of Great Britain and Northern Ireland.

<sup>8</sup> Available national health workforce accounts data suggest that these are Australia, Canada, France, Germany, Saudi Arabia, Switzerland, the United Kingdom of Great Britain and Northern Ireland and the United States of America for medical doctors, and the United Kingdom of Great Britain and Northern Ireland and the United States of America for nurses.

<sup>9</sup> Evidence brief No. 3: The WHO Global Code of Practice on the International Recruitment of Health Personnel: key findings from national reports (2013–2024).

<sup>10</sup> Evidence brief No. 1: Global health worker mobility – trends and patterns.

countries and regions, as well as the social networks of the diaspora, influence mobility patterns, as part of broader globalization trends. The growing internationalization of health professional education is also affecting mobility. The changing dynamics of international recruitment pathways have also enabled the increasing mobility and migration of health workers. There are multiple modalities of mobility that enable health workers to move from one country to another, facilitated by immigration policies, bilateral and regional agreements, regulatory flexibilities (including streamlined licensing requirements), employment mechanisms, academic programmes and private recruitment agencies or consultancies.<sup>11</sup> Furthermore, with the rapid advance in technology, the dissemination of recruitment opportunities abroad is increasingly enabled by social media, and the provision of telehealth services by health personnel based in other countries has expanded substantially, adding opportunities, challenges and complexity to international recruitment and international service delivery.

19. The Code and the associated WHO Health Workforce Support and Safeguards List have been recognized across different sectors of government, international agencies and civil society. At the country level, they have influenced domestic workforce policies and practices on ethical recruitment and facilitated the safeguarding of the rights of health workers and the development of bilateral agreements and policy dialogues within and across countries.<sup>12</sup>

20. The United Nations Secretary-General's 2024 report on international migration and development to the seventy-ninth session of the United Nations General Assembly emphasized the application of the Code's principles for the benefit of health systems in source and destination countries, as well as health workers themselves.<sup>13</sup>

21. The Code influenced health-related trade policy<sup>14</sup> and the United Nations Network on Migration guidance on bilateral agreements and was highlighted by various international and regional forums that have committed to the Code's principles and recommendations to inform solutions to address health workforce challenges and promote ethical recruitment.<sup>15</sup>

## Effectiveness

22. This section differentiates "legal" effectiveness (adoption of the Code in national, bilateral and international legal and policy frameworks, compliance with procedural and reporting requirements, data availability, etc.) and "behavioural" effectiveness (the extent to which the Code provisions are implemented through corresponding policy and investment decisions).

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<sup>11</sup> Evidence brief No. 4: Modes of international recruitment: A rapid review of evolving pathways, emerging issues, and key concepts.

<sup>12</sup> Evidence brief No. 3a: Key findings from the fifth round of national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

<sup>13</sup> [Report of the Secretary-General on international migration and development](#), document A/79/323 (accessed 11 December 2024).

<sup>14</sup> [Trade Therapy: Deepening cooperation to strengthen pandemic defenses](#). Washington, DC: World Bank; 2022 (accessed 11 December 2024).

<sup>15</sup> Prince Mahidol Award Conference (2024), Bangkok; high-level meeting on migration and mobility of healthcare workers in the Region of the Americas (2024), Washington, DC; G7 Health Ministers' Communiqué (2024), Ancona, Italy; and G20 Health Ministerial Declaration (2024), Rio de Janeiro, Brazil.

## Legal effectiveness

### Reporting compliance (Article 7)

23. A record level of Member State engagement was observed in the fifth round of reporting on the Code's implementation.<sup>16</sup> A total of 173 Member States (89%) notified the Secretariat of their designated national authority responsible for the exchange of information; about half of these (86 designated national authorities) had submitted a report by 30 September 2024.<sup>17</sup> Compared with the fourth round, this represents a 10% and 8% increase in nominations of designated national authorities and report submissions, respectively. The reporting rate among OECD member countries remains high, while the reporting rate among countries in the WHO Health Workforce Support and Safeguards List and small island developing States remains low. The reporting from the African Region and the Region of the Americas has increased significantly compared with previous rounds.

24. The Code is a voluntary instrument with no dedicated funding. Reporting compliance is lower for voluntary instruments than for legally binding instruments, which can be attributed to the compulsory reporting requirements and availability of dedicated financial resources and secretariats. After 15 years, national reporting on the Code has reached close to 50%;<sup>18</sup> 74% of Member States have reported at least once. By comparison, reporting on the International Health Regulations (2005) had reached 99%, 18 years after its adoption.<sup>19</sup> Reporting compliance from the Parties to the WHO Framework Convention on Tobacco Control reached 74% after 18 years.<sup>20</sup>

25. The Code also encourages non-State actors to participate in reporting on implementation. In the fifth round, 13 independent stakeholders and 38 private recruitment agencies submitted a report providing valuable insights on the Code's implementation through the reporting process. The non-State actors were national or global entities predominantly based in high-income countries and representing professions (particularly nurses) or trade unions. The recruitment agencies participating in the Code reporting were also predominantly based in high-income countries and recruited health workers from 44 source countries to six high-income countries.

### Data on health personnel (Articles 6, 7 and 9)

26. The quality of national reporting on Code implementation has also improved. Data reporting through the Code, the national health workforce accounts, the OECD/Eurostat/WHO European Region joint questionnaire and the regular data collection by the OECD on foreign-born doctors and nurses by countries of origin since 2000 have led to the establishment of a comprehensive international database on the health workforce. As a result, WHO has consolidated more data on the health workforce now than ever before, enabling analysis, policy dialogue, communications and advocacy at the global, regional and national levels.

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<sup>16</sup> Evidence brief No. 3a: Key findings from the fifth round of national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

<sup>17</sup> By 5 December 2024, 90 designated national authorities had submitted a report.

<sup>18</sup> This is based on reporting until 30 September 2024; additional reports are expected to be submitted and incorporated into the Secretariat report before submission to the Seventy-eighth World Health Assembly.

<sup>19</sup> See document A77/8, Implementation of the International Health Regulations (2005).

<sup>20</sup> [2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control](#). Geneva: World Health Organization; 2023 (accessed 11 December 2024).

27. In parallel to the fifth round of reporting on the Code, 130 Member States reported data through the national health workforce accounts on the number of foreign-born or foreign-trained health personnel in at least one of the five major health occupations (dentist, midwife, nurse, pharmacist and physician) at least once in the 10-year period 2013–2023 and 69 in the past three years (2020–2023), an 11% increase since the fourth round of reporting.<sup>21</sup> Provisions to maintain statistical records of foreign-born and foreign-trained health personnel and to monitor the inflow and/or outflow of health personnel to/from the country are high among OECD/high-income countries and low among the respondents from low-income countries and countries in the WHO Health Workforce Support and Safeguards List.

28. Reliable and timely data on the mobility of health workers are essential to enable countries to understand, measure, monitor and plan health workforce education, employment and management. Monitoring health worker migration requires a multipronged approach and cannot be measured by a single metric. Despite the progress in global data availability through the national health workforce accounts, the availability of migration-specific statistics continues to be a challenge and requires the diversification of data sources, including health ministry and regulatory databases, professional associations and council registries, population censuses and labour force surveys data, and their triangulation. This requires investments to strengthen human resources for health information systems and national health workforce account implementation.<sup>22</sup>

### **Bilateral agreements**

29. The reporting on bilateral agreements related to health worker migration and mobility has also strengthened. In the first four rounds of reporting, 49 Member States had reported the existence of 283 separate bilateral agreements related to international mobility and migration of health workers. In the fifth round of reporting, 94 bilateral agreements were reported, with six countries having at least 10 agreements.<sup>21</sup> For the first time, countries reported on the implementation of the agreements, although quantitative data on the movements of health workers as a result of such agreements was reported only for 33 agreements.

### **Adoption in national policy and legislation (Article 8)**

30. Some high-income countries have adopted the Code's provisions in national policy and legislation. For instance, Germany has a law that proscribes active international recruitment of health personnel from countries in the WHO Health Workforce Support and Safeguards List and the United Kingdom of Great Britain and Northern Ireland has adopted a national code of practice on international recruitment of health personnel, which mirrors the provisions of the Code and supports its implementation by holding a registry of recruitment firms upholding its provisions. The National Health and Interaction Plan 2024–2027 of Norway indicates that Norway will not recruit health personnel from countries that have an unmet need for these professionals themselves. In October 2024, Ireland committed to align recruitments through bilateral agreements with the Code's recommendations.<sup>23</sup> However, the fundamental drivers of

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<sup>21</sup> Evidence brief No. 3a: Key findings from the fifth round of national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

<sup>22</sup> Evidence brief No. 1: Global health worker mobility – trends and patterns.

<sup>23</sup> [Minister for Health signals his intention to develop a bi-lateral labour agreement for nursing and midwifery with Kenya](#). Department of Health, Ireland. 28 October 2024 (accessed 6 December 2024).

international migration continue to determine large and growing migratory flows, even when countries take deliberate action to align their policies with the Code.

31. The Expert Advisory Group notes the actions taken by the WHO Secretariat to strengthen implementation of the Code, as recommended by the Group following the second review of the Code:

(a) Reporting mechanisms have been strengthened. The synergy between Member States reporting processes on the Code and the national health workforce accounts has improved the availability of quantitative data. Reporting instruments have been revised and streamlined to better capture input from non-State actors. Independent stakeholders and private recruitment agencies have provided valuable insights on the Code's implementation through the reporting process.

(b) The Secretariat published the WHO Health Workforce Support and Safeguards List 2020 to identify countries with the most pressing health workforce vulnerabilities to achieve universal health coverage. In recognition of the additional vulnerabilities brought about by the COVID-19 pandemic, the List was updated in 2023<sup>24</sup> and is scheduled for update every three years. The List has gained wide recognition and awareness among both recruiters and Member States although its correct interpretation and application represent an area that requires continued attention and focus.

(c) WHO and the OECD, in collaboration with ILO, published guidance<sup>25</sup> on bilateral agreements on health worker migration and mobility to help Member States to develop a new generation of agreements that bring proportionate benefits to health systems of both source and destination countries. Multiple countries have approached the Secretariat for technical assistance and cooperation on bilateral agreements.

## Behavioural effectiveness

### Responsibilities, rights and recruitment practices (Article 4)

32. In the fifth round of reporting, most destination countries responded that they have established legal safeguards or other mechanisms for the support and integration of migrant health personnel. This was highest among the responding countries from the OECD. Most of these countries have safeguards related to provisions regarding equal opportunities for professional education and career progression, as well as objective criteria for recruitment, promotion and remuneration. However, very few countries had measures to promote circular migration.

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<sup>24</sup> [WHO Health Workforce Support and Safeguards List 2023](#). Geneva: World Health Organization; 2023 (accessed 11 December 2024).

<sup>25</sup> [Bilateral agreements on health worker migration and mobility](#). Geneva: World Health Organization; 2024 (accessed 11 December 2024).

33. In contrast, less than half of source countries reported measures to ensure fair recruitment and employment, safe migration, return and diaspora utilization. Most of the measures taken were on the return of health personnel and their reintegration into the source countries' health labour markets, while very few reported the existence of arrangements for safe mobility of migrant health personnel.

### **Health workforce development and health systems sustainability (Article 5)**

34. Out of 81 reporting countries, 75 indicated that they had taken steps to ensure health workforce sustainability and 61 reported taking measures to address the maldistribution and retention of health workers through measures related to education, regulation, incentives and/or support to health workers. Some countries offer pathways for permanent residency or citizenship for international health workers as incentives for working in rural areas.

35. There are multiple and overlapping modes of international health personnel recruitment, and these are difficult to identify and track, calling for clearer definitions and boundaries between active and other forms of international recruitment, as well as for suitable policy responses for passive and non-active modalities of recruitment.<sup>26</sup> While few high-income countries have provisions to minimize *active* recruitment from countries in the WHO Health Workforce Support and Safeguards List in alignment with Article 5.1, recruitment from these countries can take place, mostly through individuals' direct application to employers or education institutions.<sup>27</sup> This contributes to the recruitment of a substantial number of health personnel from countries in the List.<sup>28</sup>

36. The evidence brief on the modes of international recruitment finds that the notion of "active recruitment", as stated in the Code, is increasingly difficult to interpret, as the term itself might appear almost outdated considering the streamlining of mobility pathways, recruitment, regulation and integration processes in some countries, which is also enabled by technology and social media. Moreover, other policy levers, such as streamlining requirements for entry through regulatory interventions, could yield the same effects while stopping short of being "active" recruitment policies. If one defines active recruitment as systematic and proactive approaches by employers or recruitment agencies to recruit health workers (from targeted countries) and non-active recruitment as policies adopted by destination countries to enable entry for students and health workers through more flexible admission, licensing and regulatory requirements (e.g. streamlined processes), then the latter policies, which intentionally enable health worker migration through various pathways, predominate.<sup>26</sup>

37. The use of bilateral agreements for health worker migration has increased, with elements that advance health worker rights and welfare and fill human resource gaps in high-income countries, as reported by Member States to WHO. However, the analysis of evidence leading to the development of WHO guidance on bilateral agreements showed that this approach has not

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<sup>26</sup> Evidence brief No. 4: Modes of international health personnel recruitment: A rapid review of evolving pathways, emerging issues, and key concepts.

<sup>27</sup> Evidence brief No. 3a: Key findings from the fifth round of national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

<sup>28</sup> [The NMC register UK mid-year update 1 April – 30 September 2024](#). London: Nursing and Midwifery Council; 2024 (accessed 11 December 2024).

yielded proportionate benefits to the health systems of source countries, as envisioned by the Code.<sup>29</sup>

38. A deeper understanding of the economics of health workforce migration, and the economic value of migrant health personnel, along with clear guidance on assessing its impacts and achieving proportional benefits, is essential for fostering constructive dialogue between source and destination countries.<sup>30</sup> Unlike other labour markets, the health sector has unique characteristics that make it particularly vulnerable to market failures, which migration may or may not exacerbate, depending on how it is managed. Health workforce migration is also distinct from other types of labour migration due to the high entry barriers to regulate practice and service delivery, given the impacts on public health, quality of care and societal well-being. Therefore, recognizing the essential role played by regulators to ensure regulatory aspects (such as the mechanisms for the timely and effective recognition of professional qualifications and licensing) is essential.

39. While circular migration among health personnel is promoted by the Code and is envisioned in some bilateral agreements, there is limited evidence on its size and it is typically a small-scale phenomenon.<sup>31</sup> Although circular migration may remain limited in numbers and policy significance, policy enablers can be identified to enhance mobility and harness the role of the health diaspora in a positive way to meet the specific needs in source countries. However, neither circular migration nor the health diaspora contribution is likely to offset in a significant way the challenges posed by excessive unplanned migration on the health systems of source countries in the WHO Health Workforce Support and Safeguards List, which requires multisectoral collaboration.

40. The Code encourages (Article 5.4) all countries “to strive to meet their health personnel needs with their own human resources for health, as far as possible”. A sustainable health workforce can be understood to be a sustainable stock of health workers (supply) to meet defined service requirements (needs) at an adequate funding level (demand), where stock incorporates broader elements such as retention, distribution, mix, quality and efficiency. Avoiding dependency on international migration may be achieved through a bundle of coordinated intersectoral policy approaches under the health labour market domains of production (educating and training the current and future health workforce); flows (improving the recruitment, retention and utilization of health personnel and the management of international migration); and addressing maldistribution and inefficiencies.<sup>32</sup>

41. While these policies need to be tailored to individual country contexts and priorities, strengthened application of the Code is essential to support progress towards universal health coverage in Member States so as to “support rather than compromise similar achievement in others”,<sup>33</sup> especially those with weaker health systems. Evaluation of country policies and

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<sup>29</sup> [Bilateral agreements on health worker migration and mobility](#). Geneva: World Health Organization; 2024 (accessed 11 December 2024).

<sup>30</sup> Evidence brief No. 11: Better understanding the economics of international migration of health and care workers to move towards a win-win situation.

<sup>31</sup> Evidence brief No. 6: Circular migration of health workers and diaspora contributions to health systems in source countries: A scoping review report.

<sup>32</sup> Evidence brief No. 7: Health workforce sustainability, the WHO Code, and the international migration of health workers.

<sup>33</sup> See document A73/9.

mechanisms used to ensure health workforce availability during the COVID-19 pandemic can inform medium- and long-term policies and approaches for health workforce sustainability as well as for future emergencies.<sup>34</sup>

### **Implementation of the Code (Article 8)**

42. In the fifth round of reporting, 57 Member States indicated taking steps to implement at least one of the following Code recommendations: adoption of measures to consult stakeholders in decision-making processes, introduction of changes to laws or policies consistent with the Code, and information sharing across sectors and publicizing the Code among relevant stakeholders. The adoption of such measures was lower among countries in the WHO Health Workforce Support and Safeguards List compared with other countries. However, only a few countries reported maintaining records on all authorized private recruitment agencies, or promoting good practices among these agencies, as called for by the Code.

43. Thirty-six countries reported having laws or policies on health personnel aligned with the Code's recommendations. These range from legal prohibition of recruitment of health personnel from countries in the WHO Health Workforce Support and Safeguards List, adoption of the Code and the associated List in a country's own code for ethical recruitment, increasing domestic production of health workers, sustainable reintegration programmes for health workers, incorporation of human resource development, decent work and equal opportunities in the development of government-to-government bilateral agreements, and application of the Code's recommendations in the development of national policies on the health workforce and health worker migration.

44. Recognizing the role of private recruitment agencies, some countries have well-established mechanisms in place requiring them to manage their practice in alignment with the Code's principles. In some high-income destination countries, there are mechanisms for the recognition of recruitment agencies that commit to comply with the Code or to support recruitment from agencies that adhere to the ethical recruitment principles of the Code. Frameworks for ethical recruitment and country codes on ethical recruitment have incorporated some of the Code's principles. However, the application of these principles is uneven across countries and recruitment agencies. Although less common, in source countries, a government entity can be responsible for the licensing of recruitment agencies as well as for overseeing all deployed migrant workers.

45. Private recruitment agencies' participation in the Code reporting process in the fourth and fifth rounds, while limited in coverage and scope, has added to the understanding of their practices and challenges. While private recruitment agencies play a key role in the international recruitment of health personnel in the major destination countries, their awareness and uptake of and commitment to the Code is variable and often contingent upon laws and regulations of individual countries where they work. The analysis of private sector recruiters suggested that, going forward, it may be beneficial to further clarify how best to engage with them in the context of the Code.

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<sup>34</sup> [Health practitioner regulation: design, reform and implementation guidance](#). Geneva: World Health Organization; 2024 (accessed 11 December 2024).

## Partnerships, technical collaboration and financial support (Article 10)

46. Countries have reported providing or receiving financial support for health systems strengthening or health workforce development. However, it is not possible to assess the volumes, nature and alignment with national mechanisms and priorities of co-investments made by high-income destination countries and multilateral agencies on the health workforce in countries in the WHO Health Workforce Support and Safeguards List or other low- and middle-income countries, nor to identify the linkage between such investments and international recruitment. The limited overseas development assistance for health workforce development identified by the EAG in the second review of the Code continues to be an area of concern; this finding was reinforced by a 2022 analysis that identified overseas development assistance for human resources for health as limited in size (averaging less than 5% of overseas development assistance for health over the past two decades) and poorly directed in scope (largely focusing on short-term, issue-specific training).<sup>35</sup>

47. There have been mixed responses on health worker migration from countries in the WHO Health Workforce Support and Safeguards List. These ranged from overseas recruitment not being perceived as a problem to opening avenues for engagement with major destination countries for mutually beneficial practices. In this regard, the recommendations of the Prince Mahidol Award Conference 2024 included to consider understanding the countries' unique contexts, establishing a platform for countries to appeal or request review of their WHO Health Workforce Support and Safeguards List status and ensuring clear communication about the List's use and impacts.<sup>36</sup>

48. Conversely, other countries had expressed support (for instance, at the Fifth Global Forum on Human Resources for Health, convened at WHO headquarters in 2023) for their inclusion in the WHO Health Workforce Support and Safeguards List, and other countries not currently in the List have expressed interest in being considered for the same safeguards and support, including being more protected from international recruitment of their health personnel.

49. While reports point to countries in the WHO Health Workforce Support and Safeguards List not receiving the recommended investment, Member States reporting on the Code also point to the health workforce vulnerability of countries that are not in the List, especially in periods of crisis (e.g. pandemics and economic, political or humanitarian emergencies). During the COVID-19 pandemic, when all countries required surge capacity, mechanisms were put in place both to facilitate the entry of international health workers, including through active international recruitments, and to restrict exit of health workers to meet health workforce needs.<sup>37</sup> Some countries not in the List have raised concerns that active recruitment of specific types of health workers by high-income countries has affected their service delivery. In particular, the small size of the health workforce in small island developing States can amplify the large effect that the loss of relatively few health workers can have on health services.

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<sup>35</sup> Micah AE, Solorio J, Stutzman H, Zhao Y, Tsakalos G, Dieleman JL. Development assistance for human resources for health, 1990–2020. *Human Resources for Health*. 2022;20(1):51. doi: 10.1186/s12960-022-00744-x.

<sup>36</sup> Placing Local Health Systems of Asia-Pacific at the Centre of International Governance on Health Worker Migration. Report of the side meeting on Strengthening Local Health Systems in Asia-Pacific Nations to Address the Impact of International Migration of Health Workforces. Prince Mahidol Award Conference 2024. 22–23 January 2024, Bangkok, Thailand.

<sup>37</sup> Evidence brief No. 3: The WHO Global Code of Practice on the International Recruitment of Health Personnel: key findings from national reports (2013–2024).

### **Need for revision of the text for effective application in future (Article 9 and paragraph 3(4) of resolution WHA63.16)**

50. In the fifth round of reporting, 10 Member States, predominantly low- and middle- income countries, mentioned in their reports the need to update the Code. Areas indicated as warranting modifications included: the criteria for vulnerability, incorporating emerging issues such as telehealth, artificial intelligence and other evolving areas of health, advocating for the Code to be mandatory and acquire a legally binding nature, strengthening data and including data on return migration and expanding the scope of the Code to the social care sector, which also recruits health workers.

51. Twenty-three Member States suggested updating the process of reporting on Code implementation to include clarification on the definition of terms; streamlining the national reporting instrument to make it shorter and tailored to specific groups of countries; use of the submitted national reporting instruments by WHO to provide necessary support; and a separate data set of international students pursuing health professional education who mostly return to their country after completion of training.

52. Sixty-seven Member States requested support to strengthen Code implementation, most of which related to strengthening data and information on health personnel, policy dialogue on the health workforce and migration, and the development of bilateral agreements.

### **Summary of the Expert Advisory Group's interim findings on relevance, effectiveness and measures needed for the Code's effective application**

53. This section presents the EAG's interim findings on the Code's relevance and effectiveness, followed by measures needed for its effective application.

#### **Relevance**

54. The EAG members reached consensus on the continuing and growing relevance of the Code. This consensus recognizes a multitude of converging trends including: the widening inequities of global health workforce challenges; the rising and increasingly complex mobility patterns compounding them; the consolidation of the interdependence of health systems bound together in a globalized health labour market; and the increasing engagement in, and demand for, technical assistance on the Code by Member States.

55. The key drivers of the international migration of health workers comprise various "push" factors in source countries, including unemployment and underemployment; substandard working conditions and low salaries; lack of security arising from conflicts, instability and unrest; systematic understaffing leading to unmanageable professional workloads, unsafe working environments, burnout and deterioration of quality of care; and the erosion of labour rights, often linked to efficiency targets and contractualization of staff or security concerns. These factors are further compounded by "pull" factors in high-income countries, where the ageing of the population alongside an ageing health workforce, coupled with inadequate production capacity and fewer potential entrants into the health workforce, results in increasing demand for international recruitment.

56. In the face of broader socioeconomic, health, demographic, security, climate-related and technology trends, the global health workforce represents a global public good that cannot be left entirely to market forces or to bilateral dynamics between Member States. Interconnectivity, globalization and interdependency mean that attaining global health objectives, including global health security, requires a collective response. The development of artificial intelligence, digital health and cross-border service delivery presents enormous challenges and opportunities to advance health equity goals in the next decades. This can benefit from global guidance, governance and cooperation on ethical management of cross-national challenges.

57. To maintain its relevance in the next five and 15 years, the Code's effectiveness needs to be strengthened, including how it can inform responses to prospective global health challenges and emerging health system needs that are fuelling demands for the international mobility of health workers.

58. The relevance of the Code is also contingent on positioning the international recruitment discourse and the dynamics of the health labour market as critical components of every country's health workforce governance and stewardship functions, without siloing migration and international recruitment issues. Further, by recognizing that there is a gap between the adoption of the Code's provisions in international and national policies and their actual application in delivering mutual benefits to health systems, the relevance of the Code can be further enhanced if enablers of its effective implementation are identified, and barriers addressed to overcome the implementation constraints.

## **Effectiveness**

59. The Code has demonstrated considerable effectiveness in raising awareness (Article 2) and in improving the availability of health workforce data (Article 6), the reporting of bilateral agreements (Article 5), the availability of tools (Article 7) and the dissemination and adoption of some of its provisions in national and international policies (Article 8), even though these are uneven across countries. While these gains have been prominent in relation to some of the stakeholders and target audience of the Code (such as ministries of health, professional associations and civil society actors), there are opportunities for broader and deeper awareness and uptake among other constituencies, such as regulators and private sector recruiters.

60. Although the need for the Code to be binding to improve compliance has been suggested by some Member States and independent stakeholders, the EAG finds that the effectiveness of the Code does not depend on its legal force. The successful adoption by the World Health Assembly in 2010 may not have been possible if it had been proposed as a binding instrument. Rather, the EAG considers the voluntary nature of the Code a strength.

61. There are multiple areas where the EAG recommends the Code can be further strengthened: (see Box 2), based on the following findings and observations.

(a) Article 2.2: The scope of the Code is relevant to the international recruitment of health personnel as care workers, since – irrespective of employment sector in the destination country – the impacts for the health systems of the source country are the same.

(b) Articles 3.2, 3.3, 3.4 and 5.1: The benefits of international health worker migration for the health systems of higher-income destination countries are disproportionately large compared with those for source countries' health systems, undermining the Code's equity aspirations. This is not just an issue of concern for source countries, but, as demonstrated by

the COVID-19 pandemic, weaker health systems ultimately pose a risk to global health security and the global economy. Greater mutuality and proportionality of benefits is therefore required.

(c) Articles 3.3 and 7.2: The role of education institutions in international migration is prominent. The internationalization of health professional education has emerged as a pathway for the international recruitment of health workers. However, quantitative and qualitative data to understand the extent of the internationalization of education and subsequent employment pathways across disciplines and occupations are scarce and need strengthening.

(d) Articles 4.7, 8.5 and 8.6: Stronger engagement with private recruitment agencies in supporting the implementation of the Code, with reinforced scrutiny by regulators in all Member States, is warranted. Greater clarity on what is considered to be active recruitment, and what constitutes ethical recruitment, could help recruitment agencies, employers and governments align their practices with the Code.

(e) Article 5.1: While some countries have limited “active” recruitment of health personnel from countries facing critical shortages of health workers, supportive measures to address the drivers of migration in source countries are missing. Without meaningful co-investment and support in these countries, the WHO Health Workforce Support and Safeguards List may be of limited use. Further, “non-active” or passive means of international recruitment may equal or exceed the international flows arising through active recruitment. The multiple modes of non-active international recruitment require greater policy attention aligned with the Code.

(f) Article 5.1: There are differing opinions on the WHO Health Workforce Support and Safeguards List. Some countries in the List indicated that they wish to increase opportunities for international employment of their health personnel and may not require the recommended safeguards, while some countries outside of the List could derive greater benefit if its recommendations were applied. The health workforce vulnerability status is dynamic and can rapidly change during times of crisis, but the Code’s principles and recommendations are relevant to all countries and the need for its application is even greater during emergencies and pandemics. The relevance and applicability of the List’s provisions should be considered in the context of each country’s national socioeconomic and health labour market conditions.

(g) Articles 3.3 and 5.2: Use of bilateral agreements for international recruitment has increased but with only partial consideration of the needs of developing countries, with limited returns on health systems strengthening. Leadership of ministries of health, alongside participation of other health sector stakeholders (e.g. regulators and professional associations) during the development of the agreements, is required to achieve proportionality of benefits between source and destination countries, greater transparency on their contents, monitoring of implementation status and evaluation of the subsequent impact on health systems. Such agreements should also include policy enablers and incentives built into receiving countries to enable circular migration.

(h) Articles 3.6 and 5.4: “Effective measures to educate, retain and sustain” the health workforce and to strive “to meet their health personnel needs with their own human resources for health” have only partly been achieved. Some high-income countries have yet to respond to the post-COVID-19 dynamics and longer-term demographic and

epidemiological trends with the necessary scale-up of education pipelines to offset increasing population needs, economic demands and exits from the workforce. The estimated shortage of more than 3 million health workers in OECD countries is one of the most significant pull factors globally. This “demand” should be met first through investment in domestic supply as well as improvements in retention policies and, secondly, through innovative approaches and models for global health professional education and mobility, underpinned by the principle of mutual benefits and co-investment to support health personnel employment and retention in low- and middle- income countries, where unemployment and underemployment contribute to the “push” factors. The conditions under which the international mobility and migration of health personnel can contribute to health workforce sustainability in compliance with the principles of the Code should be identified.

(i) Articles 5.4, 5.5 and 5.7: There are social and economic benefits of international health worker migration accruing to migrant health workers themselves and to different actors; at the same time, there are also concerns that lower-resourced countries, despite investments in the development of human capital as recommended in Articles 5.5 and 5.7, are facing challenges in health service delivery due to pre-existing shortages and the maldistribution of health workers, which are compounded by outward migration. These concerns can be more acute during pandemics and other emergencies, when all countries may be facing health worker challenges and the loss of health workers can affect countries not otherwise characterized as vulnerable. As such, countries with greater reliance on international health workers should strive to meet, as far as possible, their health personnel needs with their own human resources for health; and recognizing that international recruitments will continue to take place at some level, they should co-invest in education, employment and retention in source countries to ensure adequate quantity and quality of health workers to meet service delivery needs.

(j) Article 8.2: The effectiveness of the Code could be further enhanced by implementation of its principles and recommendations through national laws and policies. However, the capacity to translate Code provisions into policy and implementation decisions can vary. In both source and destination countries, health workforce governance and stewardship capacity need to be strengthened to make strategic use of health workforce intelligence; address the drivers of migration through education, employment and recruitment policies, which requires capacity to effectively steward an intersectoral health workforce agenda in collaboration with other relevant sectors and line ministries and negotiate, develop and implement mutually beneficial agreements.

(k) Articles 3.8 and 8.7: Despite limited evidence on, and the small scale of, return migration among health personnel, many diaspora health workers show commitment to supporting health systems in source countries. While some countries have incentives for the health diaspora to return or contribute through different means, notably on knowledge and skills transfer, others are initiating international telehealth services from their health diaspora in selected areas. Policy actions and incentives from governments of both source and destination countries are necessary to utilize the potential of the health diaspora to meet the specific health needs of the health systems in source countries.

(l) Articles 9.3(b) and 10.2: The support provided by “international organizations, international donor agencies, financial and development institutions and other relevant organizations” to assist the implementation of the Code has not been adequate to meet the

objectives of the Code. Direct financial investments to strengthen the health workforce should be increased and improved in scope and in alignment with national priorities and mechanisms. Support for policy dialogue and development of bilateral agreements can benefit from additional technical support and coordination by the WHO Secretariat, which also requires dedicated financing and support.

## **Recommended measures for the Code's effective application**

62. The Code remains relevant and represents an important tool in global health policy. However, its relevance in the next five and 15 years is also dependent on the extent to which the Code addresses the existing and emerging global health workforce challenges and on its uptake by Member States as well as all other stakeholders in the post-COVID-19 world, which is increasingly interconnected, with health workers representing a growing dimension of the interdependency of health systems.

63. The movement of health workers can advance the right to health for all people across national boundaries, especially those who are underserved. However, market-led drivers of mobility can contribute directly or indirectly to unintentional consequences that widen health inequities and increase risk to global health security unless proactive actions are taken by both source and destination countries in alignment with the Code's principles.

64. To this effect, the EAG identified a range of measures that should be considered to ensure the continued relevance of the Code and enhance its effectiveness, comprising both operational recommendations within the existing scope of the Code and proposed revisions that should be added to the Code.

65. The measures outlined in Box 1 are recommended in order to strengthen the implementation of the Code over the next five years.

66. To strengthen its relevance and effectiveness, and in keeping with the Code's original provision that it should be a dynamic text, the EAG recommends that the Director-General should consider the proposals in Box 2.

67. Lastly, the EAG requests the Director-General to adopt a similar process to the 2009 preparations for the Code's adoption by facilitating regional consultations with Member States in 2025, and in advance of the EAG's meeting in November 2025. The Secretariat should prepare a process whereby all Member States can review the recommended measures needed for the Code's effective application and each WHO region can report on their deliberations within two weeks of their regional committee meetings in 2025.

68. The reports from regional consultations will be reviewed by the Expert Advisory Group at its meeting in November 2025 and inform its final report, to be transmitted to the Director-General in December 2025 for consideration by the Executive Board at its 158th session in 2026 and the Seventy-ninth World Health Assembly in 2026.

## Appendix

### Expert Advisory Group Members

#### Member States representatives

1. Erlend Aasheim, Norwegian Directorate of Health, **Norway**
2. Yao Badié and Yao Kouadio Abissa, Ministère de la Santé et de l'Hygiène Publique et de la Couverture Maladie Universelle, **Côte d'Ivoire**
3. Teodor Blidaru, Ministry of Health, **Romania**
4. Assegid Samuel Cheru, Ministry of Health, **Ethiopia**
5. Jiosefa Draunidalo, Ministry of Health and Medical Services, **Fiji**
6. Maitham Husain, Ministry of Health, **Kuwait**
7. Kenneth G. Ronquillo, Department of Health, **Philippines (Co-Chair)**
8. Mariyum Sarfraz, Ministry of National Health Services, **Pakistan**
9. Mohammad Nora Alam Siddique, Ministry of Health and Family Welfare, **Bangladesh**
10. Narine Singh, Ministry of Health, **Guyana**
11. Sridharan Sathasivam, Ministry of Health, **Sri Lanka**
12. Susan Weston, Health Canada, **Canada (Co-Chair)**

#### Independent experts

1. Balkiss Abdelmoula, **Junior Doctors Network**
2. Gloria Lamela Beriones, **Philippine Nurses Association of America, Inc.**
3. James Buchan, **University of Technology**, Sydney, Australia/**Health Foundation**, United Kingdom of Great Britain and Northern Ireland
4. Yoswa Mbulalina Dambisya, **East, Central and Southern Africa Health Community**
5. Timothy Grant Evans, **McGill University**
6. Martin Fletcher, **Australian Health Practitioner Regulation Agency**
7. Titilola Banjoko Osiyemi, **Global Health Partnerships**, United Kingdom of Great Britain and Northern Ireland
8. Maha El Rabbat, **Cairo University**
9. Srinath Reddy, **Public Health Foundation of India**
10. Laetitia Rispel, **University of the Witwatersrand**
11. Julia Tainijoki, **World Health Professions Alliance/World Medical Association**

#### Partner agencies

1. Edson Araujo, **World Bank**
2. Jean-Christophe Dumont, **Organisation for Economic Co-operation and Development**
3. Manjula Luthria, **World Bank**