An honest account of the benefits and costs of international health worker recruitment

A report by The All-Party Parliamentary Group on Global Health & Security

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FOREWORD
Why this Inquiry? Why now?

Health workers are the foundation of every health system.

They are the professionals that patients rely on in moments of vulnerability and the individuals whose expertise and performance are central to delivering care that is accessible, safe and effective. Increasingly, they are also part of a global workforce, moving across borders in search of opportunity, professional development and better conditions.

This mobility has brought immense benefit to the United Kingdom. It has also created responsibilities that we can no longer afford to ignore, responsibilities grounded not only in strategic self-interest, but in the values that have long shaped the UK's approach to global health and development.

For decades, the National Health Service (NHS) has depended on the skills and commitment of internationally-trained doctors, nurses and allied health professionals. Their contribution is not peripheral; it is central to the functioning of our health and care system. Yet the global context in which this reliance exists has changed profoundly.

The COVID-19 pandemic exposed the fragility and interdependence of health systems worldwide, while persistent workforce shortages have intensified competition for skilled professionals. The result is a growing tension between domestic workforce needs and the consequences of international recruitment for countries whose health systems are already under severe strain.

This Inquiry was launched to confront that tension honestly. The question is not whether international recruitment should continue – it will remain a necessary component of the NHS workforce for the foreseeable future.

Rather, the question is how it should be conducted: whether through a reactive and extractive model driven by short-term pressures, or through deliberate partnerships that deliver mutual benefit, strengthen health systems globally and support long-term health workforce sustainability in the UK and globally. At its heart lies a deeper question about fairness: how the UK balances its legitimate domestic needs with its responsibility to ensure that the pursuit of those needs does not undermine the capacity of others to deliver care to their own populations.

The evidence we heard leaves little doubt.

International recruitment has been a lifeline for the NHS, delivering operational resilience, specialist expertise and significant fiscal value.

At the same time, unmanaged or poorly governed recruitment can impose real costs elsewhere – particularly in countries with fragile health systems, where the loss of experienced health workers and educators can undermine service delivery, training capacity and health outcomes. Ignoring this reality risks deepening global inequities and weakening the collective foundations of global health security.

These findings reinforce a broader moral and political imperative: the UK benefits from a global health workforce, therefore it must invest in sustaining it.

That means aligning ongoing international recruitment with investment that grows skills, capacity and employment opportunities, particularly in fragile health systems that are critically understaffed. Health-related overseas development assistance is not a "nice to have" – it is vital to building and retaining the global workforce on which the NHS also depends.

At a time when development budgets are under pressure, prioritising health investment is both ethically justified and strategically wise.

Stronger health systems save lives, advance equity and contribute directly to global stability and preparedness – outcomes that reflect both the UK's humanitarian values and its long-term national interest. Reaffirming a principled commitment to global health cooperation signals that the UK remains a country prepared to act with solidarity as well as pragmatism.

This report argues that honesty is the starting point for better policy. We propose a shift from reliance to responsibility: predictable government-to-government partnerships, enforceable ethical standards and proportionate co-investment across the health worker cycle. Done well, this strengthens source country health systems, particularly the most fragile, and UK health security.

The UK has an opportunity to demonstrate global leadership in 2027 as it assumes the responsibility of chairing the G20 for the first time since 2009.

As health workforce shortages intensify worldwide, a model based on partnership rather than extraction offers a path that aligns moral responsibility with national interest. Strengthening the global health workforce ultimately strengthens the NHS itself but it also reflects a broader choice about who we are as a country and the role we wish to play in the world.

The recommendations that follow set out a practical roadmap for moving from reliance to responsibility, from a system shaped by short-term necessity to one guided by long-term strategy, fairness and shared resilience. Getting this right matters not only for the future of our health service, but for the credibility of the UK's leadership on global health and security.

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Executive Summary

Health workforce capacity is a global public good.

Strong, sufficiently staffed health systems do not benefit only the countries that train or employ those workers – they enhance global health security, pandemic preparedness and the stability of interconnected health economies. The UK benefits from a global health workforce, therefore it must invest in sustaining it.

The NHS could not function without internationally-educated health workers.

Today, around one in five NHS workers in England report a nationality other than British. One in three doctors were trained overseas. For nursing, about one in four registrants on the UK register were educated internationally in 2025, and nearly half of new nursing joiners in 2023/24 were internationally educated. International recruitment is not a marginal feature of the system – it is structural.

That reliance has delivered significant benefit to the UK. Based on a conservative calculation, this equates to approximately £14 billion in saved training costs across NHS doctors (including GPs) and nurses, with approximately £1.1 billion saved in the most recent year alone. Internationally-trained staff fill persistent vacancies, sustain services in underserved regions and bring specialist skills that strengthen patient care.

Their contribution – fiscal, operational and clinical – has been foundational to the NHS for decades.

They also bring something less easily measured but equally important: experiences from different health systems, new clinical approaches and global insight. A globally-mobile health workforce – where skills, knowledge and people move responsibly across borders – strengthens care in the UK and abroad. In an era of pandemics, antimicrobial resistance and shared health threats, strong international workforce links are not simply a staffing issue; they are a pillar of global health security.

But this model has consequences.

The World Health Organization (WHO) projects a global shortfall of 11 million health workers by 2030.

Many of the countries from which the UK recruits already face critical workforce shortages. Evidence to this Inquiry – including from lower-income country governments and frontline health workers – described the loss of experienced health workers, educators and specialists, with knock-on effects on training capacity, service delivery and patient outcomes, particularly in those with the most understaffed health systems. While outmigration can bring benefits – employment, remittances, skills exchange – the system-level impacts in fragile health settings can be profound.

The UK government has set an ambition to reduce reliance on international recruitment to approximately 10% by 2035. However, the evidence to this Inquiry questions the delivery of such a rapid shift without unprecedented domestic investment in training expansion alongside materially-improved retention; historically the UK has not fallen to 10% or less reliance on international nurses since 1990.

Between 2024-2025, around 30% of new NHS appointments were recruited internationally. Reducing this reliance - even by training enough domestic staff to replace just 20% of those posts - would have required an additional £700 million in government investment.

Fiscal restraint, falling domestic nursing applications and an ageing workforce, illustrate the scale of the challenge ahead: the government's 10-Year Health Plan aims to reduce international recruitment to less than 10% by 2035, a significant shift from today's levels.

The choice, therefore, is not between recruitment and no recruitment. It is between a reactive, extractive model and a fair, predictable, partnership model.

Many of the bilateral agreements that the UK has with source countries solely manage the mechanics of mobility. They do not link recruitment to sustained investment in workforce production, employment and retention in lower- and middle-income countries (LMICs) – to offset the impact of recruitment. In practice this means mobility is structured; workforce strengthening is not.

A more sustainable approach requires **"proportionate co-investment"**, which is a predictable, rules-based, fair contribution that all countries recruiting health workers internationally make, including the UK, to strengthen the most fragile and understaffed health systems of the countries these health workers come from.

The UK should recommit to restoring development spending to a level that upholds its reputation as a reliable global health partner and reaffirms its longstanding commitment to global health; by ensuring that when it benefits from international health workers, it also strengthens the most fragile and critically understaffed health systems in their countries of origin. In line with the scale of international recruitment, the UK should invest in training and retaining health workers in these countries in a stable and predictable way, demonstrating responsible recruitment and its global health leadership.

This is not about restricting mobility. It is about ensuring mobility works for both sides. Health workforce capacity underpins recognised global public goods – universal health coverage, pandemic preparedness and health security – with specific health workforce functions (e.g. surveillance, outbreak response) delivering cross-border benefit that no country can secure alone. The resilience of the NHS is directly linked to the strength and stability of source countries' health systems.

The Inquiry concludes that the UK must move from reliance to responsibility. The UK benefits from a global health workforce, therefore it must invest in sustaining it.

That means recognising international recruitment as a structural element of NHS workforce planning in the medium term, while investing to reduce dependence over time.

It means replacing ad-hoc recruitment drives with transparent government-to-government partnerships aligned with national health workforce plans and priorities. It means embedding co-investment alongside international recruitment and moving beyond voluntary ethical codes towards enforceable standards and greater transparency. It also means consistent induction, skills recognition (to avoid deskilling), fair progression and pastoral support for internationally-recruited staff, backed by enforceable worker protections (e.g. fee bans, parity of conditions, accessible redress), so they can stay and thrive in the NHS.

Fairness and self-interest align. A connected, responsibly-governed global health workforce strengthens the NHS, supports partner countries and enhances global health security.

The UK has the opportunity to set a new global standard.

A model based on ethical mobility, shared investment and long-term partnership would strengthen the NHS, support the most fragile source country health systems and enhance global health security. The UK should use upcoming opportunities – the 79th World Health Assembly (2026) and the UK's G20 Presidency (2027) – and its strategic leadership role within the Commonwealth to launch this partnership model and commit to transparent co-investment compacts with priority countries.

The path is clear.

Leadership now will shape the health workforce resilience of the future.

Recommendations in brief

The UK should:

- Restore development spending to a level that reflects and reinforces the UK's long-standing leadership in global health while ensuring stable and predictable co-investment is proportionate to the benefits gained.
- Invest in a robust future for the NHS by directing reliable, predictable long-term co-investment aligned with partner country priorities for the training, employment and retention of health workers, especially in countries with fragile or severely understaffed health systems.
- Give source countries predictability by setting out clear, long-term workforce plans that include realistic expectations for international recruitment and retention, avoiding sudden rises and falls.
- Ensure that UK support increases when UK recruitment increases, so that countries most affected by UK recruitment also benefit from additional investment in their health workforce.
- Establish co-investment mechanisms (time-limited evidence-based global training and skills pathways that address locally-identified priorities – e.g. the UK Medical Training Initiative and Global Skills Partnerships), supported by ethical and transparent government-to-government agreements that strengthen health systems and workforce development.
- Integrate, protect and retain internationally-recruited staff by ensuring fair employment conditions, high quality induction and pastoral support, recognition of their skills, and strong safeguards against exploitation, enabling them to build stable, rewarding careers within the NHS.
- Underpin voluntary guidance by establishing binding, mutually beneficial government to government agreements that set out shared expectations, clearly defined responsibilities -including worker protections, and mechanisms for accountability.

What we mean by "proportionate co-investment"

Proportionate co-investment is a predictable, rules-based and fair contribution that all countries recruiting health workers internationally provide, in addition to the existing investments made by source countries in training and developing their workforce. This contribution helps to strengthen the most fragile and understaffed health systems of the countries from which these health workers originate. By reinforcing source countries' own investments, proportionate co-investment ensures that international recruitment is genuinely mutually beneficial and does not exacerbate workforce shortages in countries already under strain.

About the Inquiry

The Inquiry was established to address the tension at the heart of the UK's reliance on international health workers.

The NHS depends on global recruitment, but this creates real consequences for countries whose health systems can least afford to lose staff. Through evidence gathered across multiple oral sessions and written submissions, the Inquiry explored both the benefits the UK gains from international mobility and the pressures placed on already stretched source country health systems. It begins with an honest account of the benefits and costs of international health worker recruitment.

Across the Inquiry, NHS leaders, national governments, health workers and global institutions, including the WHO, shared powerful testimonies.

They described the opportunities migration offers, but also the personal, professional and financial pressures it creates. Many highlighted the strain on health systems when experienced staff leave without replacement. These insights directly shape the findings and recommendations that follow, supporting a fairer and more sustainable approach to global workforce mobility.

1) CONTEXT – A system under strain

A structural reliance on mobility

Global situation: The WHO projects a global shortage of 11 million health workers by 2030, with 6.1 million being in Africa and more than half of this is a shortage of nurses (WHO, 2026a).

This shortfall is concentrated in lower-income contexts: unmanaged recruitment in this environment risks deepening inequities and undermining global health security (WHO, 2026b). By contrast, as of 2025, 23% of the world's doctors, nurses and midwives are based in just 10 high-income countries, which together account for only 9% of the world's population (WHO, 2025a). In stark contrast, the 55 countries on the WHO Health Workforce Support and Safeguards List - those with a health workforce density below the median of 49 per 10 000 population and a UHC service coverage index below the threshold - have only 5% of these three cadres (WHO, 2025a; WHO, 2023).

Globally, one in eight of the estimated 29 million nurses worldwide are practising in a country other than that in which they trained or were born (RCN, 2024). Highlighting the significant maldistribution of health workers across countries.

The international migration of health workers from LMICs to high-income countries (HICs) is also accelerating, driven by global health workforce shortages, economic disparity and active recruitment policies.

The Executive Board, in its consideration of the Expert Advisory Group report on the WHO Global Code of Practice on the International Recruitment of Health Personnel, noted the "emphasis on the need for meaningful co-investment in health workforce development and health system strengthening in source countries, in order to support health workforce sustainability and the delivery of proportional benefits" (WHO, 2026b).

Sustained, long-range approaches that place the well-being of the health workforce at the centre of system investments are essential. Investing in health systems delivers substantial economic returns, with each dollar invested generating an estimated $2–4 USD. Greater numbers of health workers are linked to increased life expectancy, higher productivity and long-term economic development (World Health Professions Alliance, 2026a).

The Organisation for Economic Cooperation Development (OECD) note rising international inflows into HICs are happening at the same time as shrinking Official Development Assistance (ODA) budgets, with destination countries across the G20[1] showing increased dependence on international recruitment (OECD, 2025). This creates workforce scarcity and a paradoxical surplus which undermines service coverage, health system resilience and shared health security.

UK reliance: International recruitment is now a structural reliance of the UK's health workforce. In the UK, as of October 2025, 36% of doctors were trained abroad.

This is double the OECD average of 18% (OECD, 2021). For several decades, international nurses have comprised above 10% of new UK registrants every year since 1990, often reaching double or triple that rate (Buchan, 2025). As of March 2025, the Nursing and Midwifery Council (NMC) register comprised 853,707 nurses, midwives and nursing associates. Of these, 24.1% (204,890 registrants) were internationally educated (NMC, 2025).

More than one in five (22.7%) nurses on the Nursing and Midwifery Council (NMC) register received their initial training outside of the UK. In the 12 months to March 2024, 49.4% of new joiners to the register were internationally educated (RCN, 2024). The UK's adult social care workforce has also become heavily dependent on international recruitment, with 105,000 internationally-recruited care workers in 2023/24 before policy restrictions reduced numbers (Skills for Care, 2025).

[1] The G20 or Group of 20 is an intergovernmental forum comprising 19 sovereign countries, the European Union (EU), and the African Union (AU).

These trends are similar across other HICs, where structural reliance on internationally-trained doctors is evident (OECD, 2025; WHO Regional Office for Europe, 2025). For example, in Ireland, more than 40% of doctors are internationally trained; with nearly half of nurses from India and the Philippines (Hanlon & Humphries, 2025), while in New Zealand, it is nearly 47% who are internationally trained (Buchan et al 2025). The European region also reports sharp growth in cross-border inflows across countries (foreign-trained doctors +58% and nurses +67% since 2014), underscoring widening imbalances between destination and source countries (OECD, 2025; WHO Regional Office for Europe, 2025; Committee on Employment and Social Affairs Committee on Public Health, 2025).

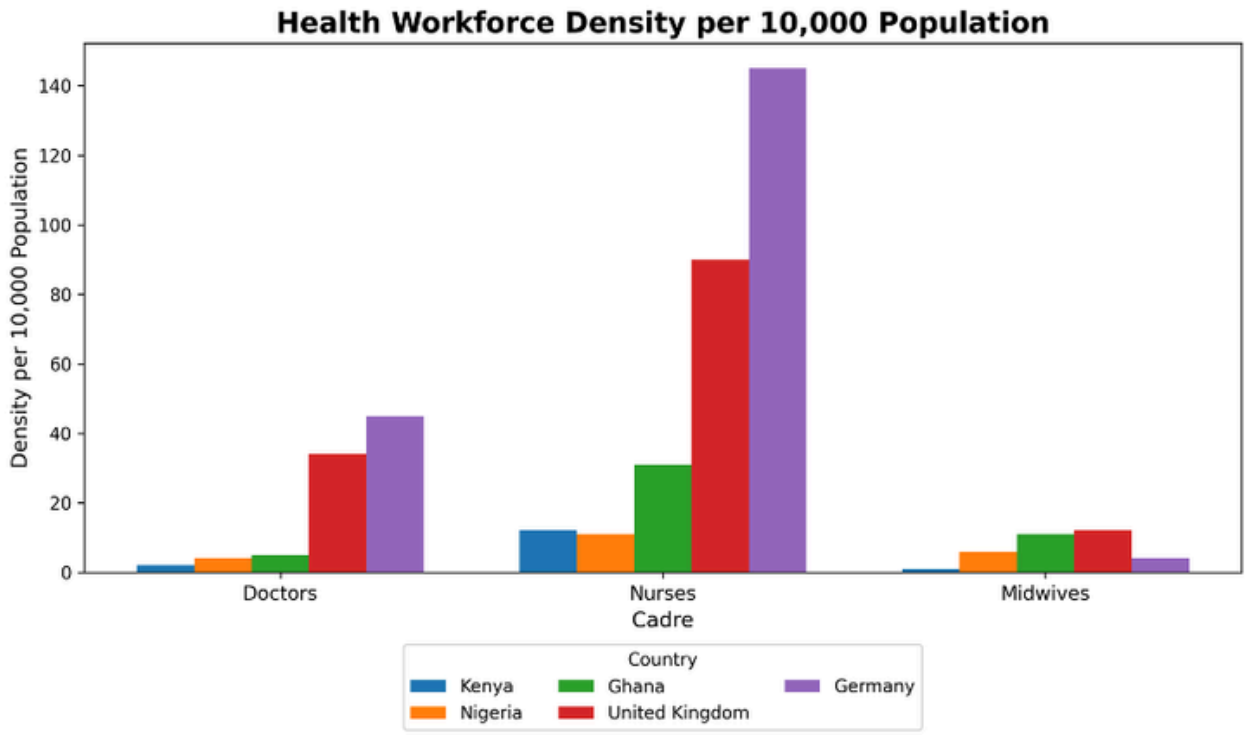
Source countries: While destination countries benefit significantly from the expertise and contributions of migrant doctors, nurses and other professionals – LMICs, in particular, are left with depleted systems and critical gaps in care, particularly those with fragile health systems.

This undermines efforts to achieve universal health coverage.

Figure 1 compares the density of doctors, nurses and midwives per 10,000 population across five countries. As shown, there is substantial variation in workforce availability not only across LMICs (the minimum WHO benchmark is 44.5 health workers per 10,000 population (Ahmat et al, 2022)) but between LMICs and HICs like the UK and Germany. Disparities in health workforce capacity have direct implications for service delivery, particularly where low densities coincide with high female representation in nursing and midwifery cadres.

Furthermore, source countries' training systems and workforce planning are often shaped by outmigration and the expectation that many health workers will migrate (IOM, 2025. For example, more than 8,000 nurses every year, on average, migrate out of the Philippines, with 2,700 nurses from India (Lanati & Thiele, 2021). In the Philippines, the government places an annual cap in order to regulate migration and manage health worker deployments – for example, in 2021 this cap was increased to 6,500 health workers (Reuters, 2021). Evidence from the Inquiry suggests that some source countries are offering language training to enhance international employment opportunities.

Figure 1. Health Workforce/Population Densities in Selected Countries



Source: National Health Accounts Portal (WHO, 2026a). https://apps.who.int/nhwaportal/Home/Index Accessed 17.02.2026

Comparable data for annual health worker outflows from low-income African countries is limited in publicly available global datasets. However, multiple analyses confirm that African lower-income countries (LICs) experience among the highest rates of health worker outmigration globally, with substantial impacts on service coverage, mortality and economic stability (Saluja et al., 2024; OECD, 2025; WHO, 2025b).

The pressure for health workers is intensifying: HICs face rapidly ageing populations – projections show a 25% rise in older adults in England needing care by 2025 – and ageing workforces – one-third of OECD doctors were aged over 55 in 2015 (Buchan et al., 2019).

Long training periods (10 years to train a GP in the UK), stagnant applicant numbers and low completion rates for nursing in the UK mean that training capacity and supply does not match health workforce demand. Further to this, one-third of GPs is considering leaving direct patient care within five years (Odebiyi et al., 2021) and the outflow of nurses from the UK is becoming more prominent. For example, between April 2023 and February 2024, 12% of the UK's nursing workforce – around 9,000 nurses – registered to work in Australia, a sharp rise from previous levels (Buchan et al., 2025).

2) FINDINGS – Evidence on the ground

Scale of reliance - what the Inquiry heard

Depth of reliance: International recruitment of health workers has been essential in delivering universal health coverage in the UK since the NHS was founded in 1948, and this reliance is now deeply embedded in the health system.

Around one-fifth of all NHS England staff identify a non-UK country of origin, while in London, this proportion rises to around one-third of frontline NHS staff (nurses and doctors) identifying a non-UK nationality (Harker, 2025).

Workforce trends further underscore the depth of this reliance. Analysis of the General Medical Council (GMC) register, filtered by Primary Medical Qualification (PMQ) in October 2025, showed that over one-third of licensed doctors in the UK were internationally trained (General Medical Council, 2025; Eaton et al., 2023) similarly reported that since 2018, nearly half of all new GMC registrations have been for doctors trained abroad.

This pattern is mirrored among nurses and midwives, where a quarter of over 800,000 professionals on the register (nearly 200,000) in the UK (NMC, 2025), are internationally educated.

Moreover, the recent reduction in nursing vacancies, from approximately 40,000 to 25,000, was achieved primarily through large-scale international recruitment, rather than growth in the domestic training pipeline.

Witnesses described the NHS as being "completely reliant" on international recruitment, reflecting persistent domestic workforce planning shortcomings rather than typical migration patterns.

The Inquiry heard that the UK's reliance is double the OECD average for doctors (19%), and nearly three times the OECD average for nurses (9%) (OECD, 2021). The evidence presented in the Inquiry suggests that the UK is training fewer health workers than required to meet domestic demand and is increasingly relying on international recruitment.

> **"We would wish it to remain a welcoming place... but that's very different to being completely reliant, which is where we are currently in the UK on international migration. – Hearing 1**

Where shortages bite hardest: International staff fill roles that domestic staff either cannot or are not willing to take up.

They are concentrated in underserved geographies, hard-to-recruit specialities and across mental health and community services. Internationally-recruited staff also sustain some of the most pressured acute wards, as well as specialist nursing roles such as intensive care, paediatrics, public health and advanced practice.

The Inquiry also heard that middle-grade medical staffing, where gaps make it difficult to recruit consultants or sustain safe rotas, has become reliant on international recruitment. Persistent gaps make it difficult to recruit consultants or maintain safe rotas, with one example highlighting a service operating with only two or three consultants against a recommended 10.

Similar patterns were reported across services such as mental health, microbiology and infection prevention services, radiology, haematology and some acute specialties. These areas serve diverse populations with high levels of need and have remained consistently underfilled by the domestic workforce.

> **“It’s often thought that it’s newly-registered, newly-educated nurses, who are being recruited. It’s not. They’re often specialist nurses which are targeted…**
> **– Hearing 2**

Recruitment pauses do not end dependence: Evidence presented to the Inquiry points to systemic inadequacies in workforce planning, production and retention within the NHS.

The UK is not training sufficient doctors or nurses to meet demand, demographic pressures and to address an ageing workforce, and is unlikely to in the near-term. In nursing, for example, witnesses cited that the shift from commissioned training places to self-funded nursing degrees contributed to a decline in nursing applications in the UK by approximately 21% between 2021 to 2024.

Dependence is reinforced by retention challenges. Witnesses described attrition among UK-trained staff due to workload, burnout, pay erosion and limited career progression. Further, internationally-educated professionals do not provide guaranteed long-term stability.

Evidence presented indicated that only one in three internationally-educated nurses intend to stay in the UK permanently. Literature evidence further highlights that the UK is becoming a stepping stone country. In 2023 to 2024, nearly three in four Certificate of Current Professional Status (CCPS) applications (an indicator of intention to leave from international nurses) were from nurses registered in the UK in the last three years (Buchan et al., 2025). Many of these are nurses trained in India, Nigeria or in the Philippines. This dual attrition, domestic and international, creates a cycle in which continued recruitment is required to maintain existing service levels. Every nurse leaving may add to the replacement challenge (Buchan et al., 2025).

Witnesses observed that the recent slowing of formal international recruitment is not an indicator of reduced reliance. NHS Trusts retain autonomy as employers and may continue international recruitment independently, in addition to passive recruitment where international health professionals independently choose to apply for jobs in destination countries. Moreover, data from the NMC register shows that although international recruitment slowed in 2024-2025, internationally-educated professionals still make up over 24% of the entire register, which equates to more than one in four professionals.

Despite the slowdown, about 39% of all new joiners in this period were internationally educated.

Although domestic recruitment increased (by 1,800 joiners), this was far outweighed by the drop in international joiners (by 8,957), leaving no realistic prospect that UK-educated staff could replace the shortfall. These figures demonstrate that a drop in annual international joiners reflects a change in rate, not a reduction in reliance, as internationally-educated nurses remain deeply embedded in the UK's nursing workforce composition (NMC, 2025).

Therefore, pauses in international recruitment without parallel expansion of domestic training based on local priorities and strengthened retention strategies are unlikely to end NHS's dependence on internationally-educated workforce.

Comparison with other HICs: The UK is not unique; across the hearings, a clear picture emerged of deep and systemic reliance by HICs on internationally-recruited health workers.

WHO and OECD data presented during the sessions show that 10 HICs account for nearly two-thirds of global migration of doctors and nurses, revealing structural dependence rather than temporary supplementation.

Speakers emphasised that few countries, whether high or low income, train sufficient numbers of health workers to meet their domestic needs

Persistent shortages in the health workforce and widespread deficits across many regions are well documented in the literature, while OECD analysis shows that these shortages have driven HICs' increasing reliance on international labour markets to fill essential and specialist roles (OECD, 2025).

Ireland illustrates this dependency starkly: 53% of nurses and 42% of doctors working in Ireland are internationally trained, among the highest proportions in the world. Germany also demonstrated significant reliance: 85–95% of nurse recruitment is conducted by private agencies. The U.S. health sector's large-scale recruitment is driven by domestic workforce shortages, high retirement rates, and unmet training needs, creating a sustained pull for foreign-trained nurses and allied health professionals.

This dependency is deepening in the face of ageing populations, service pressures, and under-investment in domestic workforce pipelines, making international recruitment a critical and currently unavoidable pillar of health system functioning in many HICs.

The NHS 10-year plan and reducing reliance: The Inquiry highlighted that the NHS 10-year workforce plan seeks to reduce the UK's reliance on international recruitment to approximately 10% by 2035, a shift described by expert witnesses as both strategically necessary and historically ambitious.

While this ambition was recognised, witnesses also raised concerns about its feasibility. They noted, for example, that the UK has never fallen below 10% reliance on international nurses since at least 1990, with long-term averages of about 30% – this underlines the scale of transition required to achieve this target.

This ambition is further complicated by persistent domestic supply constraints, including declining applications to nursing programmes, limited training capacity and challenges with recruitment and retention of the health workforce. Witnesses noted the intensifying global workforce shortages alongside attrition of domestic and internationally recruited health workers already in the UK. These factors heighten the difficulty of reducing reliance on international recruitment while maintaining safe staffing and service continuity. Therefore, reducing international recruitment to 10% will require major, sustained investment in domestic training pipelines, improved retention and more coherent long-term-workforce planning. Overall, there is need for the UK to adopt more robust workforce planning, and a commitment to substantial financial investment.

Case study

Using England's nursing workforce as an example, Buchan's analysis emphasises that training supply must be closely aligned with local workforce demand to be effective. At present, universities set student nurse intakes largely according to their own capacity and applicant numbers, rather than regional staffing requirements. This creates persistent mismatches between the nurses being trained and the vacancies that local health systems need to fill, particularly in areas (e.g. mental health, community nursing) where enrolment and completion rates remain too low to address shortages. At the same time, financial pressures and vacancy freezes in some areas mean new graduates may struggle to secure jobs locally, even while other regions face significant gaps. These dynamics highlight the limits of simply expanding training numbers without coordinating education pathways with regional workforce planning. A more integrated approach linking training volumes, specialisms and deployment to local labour market needs is essential to ensure domestic nurse education meets the needs of England's diverse health systems (Buchan, 2025).

What destination countries gain

Fiscal gains (training costs avoided)

The UK has saved an estimated £14 billion from not paying to train health workers.

By drawing extensively on health workers trained abroad, the UK effectively avoids the full cost of training domestically.

The following section uses NHS Workforce Statistics (June, 2025) figures as a basis for estimating the approximate value of training costs that the UK has averted through international recruitment.

Looking across hospital and community health services in NHS England only, there are currently 81,000 non-British doctors including consultants, associate specialists, specialty doctors and staff grades, representing 34% of the total medical workforce. Based on GMC data cited in describing NHS's reliance above, using professionals' nationality as a proxy is likely to understate the true share of internationally-trained doctors, whilst we also note that GMC figures include doctors working outside the NHS.

Although a conservative, indicative estimate of UK's training costs savings from recruiting internationally-trained health workers was shared at the hearings, further analytical work has since been undertaken to refine this figure (Crawfurd, 2026).

Cost data from *Unit Costs of Health and Social Care 2007 report* include government subsidy as well as costs borne by individual trainees through student loan repayments and living expenses was used to estimate training costs. Further, Full Fact analysis suggests that after accounting for expected student loan repayments, the taxpayer funds roughly 70% of the economic costs, which includes their salaries.

We conservatively assume that only half of government spending on trainee salaries represents a true training cost, with the remainder reflecting the value of the clinical service trainees provide. On this basis, around half of the total economic cost can be treated as the government's actual investment in training.

Applying this (35%) share to the number of internationally-trained consultants, GPs and nurses currently working in NHS England yields an estimated £14 billion (rounded from £13.8 billion) in saved training costs.

Table 1. UK Training Subsidy

Cadres	Non-UK Nationals	Average cost of training in UK, 2007 (£)	Total savings (£ billion)
Doctors (Hospitals)	81,127	122,012	£9.9
GPs	9,070	109,004	£1.0
Nurses & Midwives	128,530	22,589	£2.9
Total			£13.8

Source: NHS Digital (2025); Curtis (2007)

> **In no year back to 1990 has the UK been 10% or less reliant on international nurses... the average is closer to 30%. – Hearing 3**

This figure is intentionally conservative. It excludes other staff groups such as allied health professionals and does not account for additional cost savings related to attrition, delayed entry into the workforce, or expanded domestic infrastructure that larger training cohorts would require. Nonetheless, it provides a credible estimate of the scale of financial benefit the UK derives from international recruitment.

The UK saved £1.1 billion in the last year alone from not paying to train foreign health workers: Over the most recent year for which data is available (June 2024-2025 for doctors and nurses, September 2024-2025 for GPs), there has been an increase in the stock of foreign nationals working in the NHS of around 4,000 doctors, 4,000 nurses, and a slight decrease in the number of GPs (by 425).

If we assume they would all have otherwise been trained domestically at current costs, that adds up to an annual cost of £1.1 billion.

Recent WHO African Region estimates (2024) place the average cost of training a doctor for six years in the African region[2] at US$17,351, and the cost of training a nurse for three years at US$10,172. Applying these figures to the 4,000 doctors and 4,000 nurses who joined NHS England in 2024–2025 would suggest that a proportionate UK co-investment, covering only the basic cost of training on equivalent number of health workers in the region, would amount to approximately US$110.1 million (£81.1 million, exchange rate as of 18 February 2026) (WHO African Region, 2024, p.51)

This estimate reflects only the upfront cost of pre-service training. It does not account for the level of clinical expertise or seniority of the health professionals recruited to the NHS, nor does it capture the broader economic impact on countries that financed their training.

However, this is an example of just one element of investment. As this Inquiry has heard, training alone is insufficient without considering the full health worker lifecycle. Various analyses suggest that workforce shortages stem not only from limited training capacity but also from systemic challenges across education, deployment, employment, performance management and retention (Health Policy Watch, 2023; WHO, 2024; Deussom et al., 2022).

[2] Based on data from Kenya, Ghana, Mozambique, Zambia, Uganda and Zimbabwe

Cost implication for the NHS 10 year plan: The government's 10 year plan for the NHS, launched in July 2025, includes a target for only 10%of recruitment to be from overseas (DHSC, 2025).

In the most recent year, international recruitment was around 30%. For the government to have paid to train 20% of actual recruitment of doctors, GPs, nurses and midwives in the last year would have cost an additional £700 million.

Other HICs averted training costs: Canada's health system relies significantly on internationally-educated health workers. In 2022, there were about 79,000 internationally-educated health workers, representing 14.5% of its workforce, with even higher proportions of pharmacists (35%) and physicians (31%).

By employing health workers who trained abroad, Canada effectively avoided an estimated CN$22 billion in domestic training costs, equivalent to more than CN$1 billion per year over a 20-year career cycle (Royal Society of Canada and Canadian Academy of Health Sciences, 2025).

Applying this methodology across 10 HICs[3] shows that these health systems collectively gained approximately $170 billion in "education subsidy" by recruiting around 570,000 foreign-trained medical doctors. The largest fiscal gains accrued to the US ($64.7 billion), the UK ($42 billion) and Saudi Arabia ($20.4 billion) (Campbell, 2025).

Service delivery resilience

Internationally-trained health workers play a critical role in strengthening service delivery resilience across the NHS and wider UK health and care system.

Evidence from across the Inquiry shows that these health workers fill long-standing structural gaps, ensuring continuity and stability of essential services, especially in more rural areas of the UK and delivering high-quality services in underserved parts of the NHS.

> **Often [health workers] go where our local colleagues do not want to go**
> **– Hearing 1**

[3] The 10 HICs analysed included: USA, Saudi Arabia, United Kingdom, Germany, Australia, France, Canada, Argentina, United Arab Emirates and Switzerland.

They have also enabled the NHS to maintain uninterrupted provision in high-vacancy specialties. For example, in one UK microbiology service, where there are severe consultant gaps, recruitment of international specialists averted around £600,000 per year in locum costs and sustained coverage in underserved regions.

High turnover among domestic staff is linked to higher 30-day mortality rates for both all-cause and emergency admissions (Moscelli et al., 2024), meaning that internationally-recruited staff who fill these gaps materially improve service resilience and patient outcomes.

Benefits from skills and innovation

Given the challenges that the UK faces, international recruitment has become a strategic necessity to sustain health system performance and enable extended healthcare capacity, including support for ageing populations.

Internationally-trained health workers contribute specialised skills, innovation and expanded reach that significantly enhance the UK's ability to care for diverse and underserved populations.

Witnesses in the Inquiry emphasised that internationally-trained staff accelerate learning through exposure to different clinical learning environments and that diaspora health workers act as "agents of change," bringing approaches that strengthen UK services, providing practical improvements in skills mix and supervision.

In one coordinated memorandum-based partnership model between a UK health system and Kerala, international recruitment focuses only on middle and senior level posts to address longstanding gaps. This approach embeds training elements into the roles, ensures protected time for training of resident and locally-employed doctors, and provides structured support for health workers on arrival to the UK. This ensures that internationally-trained health workers are not only supported in their new roles but are also recognised for the scarce skills and expertise they bring to the NHS.

The Inquiry looked at evidence that underscores that the UK nursing workforce is experiencing persistent shortages in critical areas, such as mental health, learning disabilities and community health, (Buchan et al., 2019) and that increasing domestic student numbers alone is not enough unless the workforce produced is aligned to service needs.

> **When they come to the UK, they don't need a lot of orientation because of the great background they have... their skills are good. – Kenya Roundtable, October 2025.**

What's at stake for source countries

Impact on health systems

Health workforce densities in several source countries are already critically low. As shown in Figure 1 above, the differential of health workforce densities between high and low income countries is stark.

These gaps reflect structural shortages that are intensified when trained staff move abroad. Witnesses described one source country losing a sizeable share of its medical and nursing workforce to migration, with the UK and Ireland among the principal destinations, placing additional strain on its health system. Testimony was consistent with the published evidence of these patterns.

In systems already operating below recommended minimum staffing thresholds, such losses directly reduce service availability and increase pressure on remaining staff. The outmigration of specialist nurses and doctors was highlighted as especially destabilising, given their limited numbers, critical roles in maintaining essential services, and the capacity and duration to replace these professionals once they move abroad.

These outward flows are driven by the persistent global health workforce shortage and stark income differentials between the Global North and Global South, which create powerful pull factors for skilled workers. The impact is particularly visible in priority health outcomes.

Maternal mortality ratios (MMR) starkly illustrate the strain on some source countries' health systems: Nigeria's maternal mortality ratio was reported at 993 per 100,000 live births, compared with 8 per 100,000 in the UK, illustrating the level of inequity.

While workforce migration is not the sole determinant of such outcomes, sustained outflow from fragile health systems aggravates service gaps and undermines progress towards universal health coverage, particularly in rural and hard-to-reach areas.

Training faculty erosion

A central and often under-acknowledged impact of outmigration from source countries is the loss of training faculty, including tutors, lecturers and clinical instructors/preceptors – and the impact on the quality of education and practice for current and future generations of health workers.

Evidence presented during the Inquiry highlighted that the loss of these educators constrains the capacity of training institutions by reducing the number of qualified instructors available to teach, supervise and mentor trainees. This impacts enrolment, clinical supervision, quality assurance, and creates longer and less efficient training cycles. In addition, the loss of trainers undermines safe practice, increasing risks to patient safety and reducing the quality of learning environments for trainee placements.

In effect, the outmigration of educators is not simply a staffing problem, it erodes the pipeline required to replenish the workforce in countries already functioning with critical health workforce deficits, creating a cycle of scarcity and undermining long-term health workforce sustainability, threatening national health systems resilience and ultimately the global availability of health workers.

Rural workforce shortages and underserved communities: The Inquiry heard how, in an LMIC, fewer than one in four cities meet the health worker density recommended by the WHO.

Large urban cities continue to draw a majority of health workers, while rural and geographically-isolated communities remain chronically underserved.

> **We are losing our most experienced and specialised health workers… this is a big loss for services and mentorship. – Kenya roundtable, October 2025**

According to Inquiry witnesses, this imbalance deepens inequities in access to care and leaves specialist services such as mental health, diagnostics and maternal health vulnerable to workforce shortages.

The same country continues to train large numbers of health professionals each year, producing around 27,000 new doctors, nurses and midwives annually. Yet an estimated 50,000 health workers migrate every year. When outmigration occurs at this scale, it weakens service continuity, slows progress towards universal healthcare reforms and deepens inequalities between urban centres and underserved rural regions.

The loss of newly-trained and midcareer professionals also intensifies existing shortages in specialist fields, making it even harder for rural populations to access essential care.

Benefits to source countries

Remittances: Remittances are among the most tangible benefits of health worker migration for source countries: they support household welfare, finance education and health expenses, and provide a major source of external finance and foreign exchange.

By increasing household purchasing power and enabling investments in local enterprises, these financial inflows stimulate broader economic activity, generating indirect job creation that extends beyond the health sector. Evidence shows that remittances are used not only for essential household needs but also to support small business development and entrepreneurship, contributing to economic diversification and employment in communities of origin.

According to the "Experts in Our Midst" report, remittances form part of broader economic exchanges, including direct investment, philanthropy, technology transfer and the flow of skills and knowledge, all of which shape development outcomes in countries of heritage (THET/GHP, 2021).

However, remittances are primarily private transfers, not systematic investment in health systems. Their benefits are unevenly distributed across households and can be vulnerable to economic and policy shocks in destination countries (Ratha et al., 2024; Packer et al., 2010).

> **"A frequently used example of benefits to source country has been remittance. But then this cannot be used as proxy for mutual benefit because...it goes to individual families and not to the health system of source countries**
> **– Hearing 2**

Reduced unemployment: International health worker migration also brings important employment benefits to source countries, operating through several labour market and economic pathways.

The prospect of working abroad can generate a "brain gain" effect, stimulating greater enrolment in health professional training and ultimately expanding the pool of qualified workers at home. (Batista et al., 2025).

Evidence from the Philippines shows that international nursing opportunities triggered a surge in training, with more newly licensed nurses remaining domestically than those who migrated, thereby increasing the overall supply of health professionals available to the national health system (Batista et al., 2025).

Witnesses drew attention to the situation in some countries where fiscal constraints limit the number of health workers that can be absorbed into the public sector, and where outward migration can act as a labour market safety valve, reducing graduate unemployment and easing pressure on saturated labour markets, an effect recognised by several source countries, where managed emigration was viewed as a pragmatic response to converting "paradoxical surpluses" into jobs and earnings (Awases et al., 2004, Hutchinson et al., 2025).

> **[Low- and middle-income countries] are training more health workers than they can employ, and they are very keen to send that surplus abroad to receive remittances and other forms of training and business linkages.**
> **– Hearing 3**

Expanded capacity and skills:
International recruitment can generate skills and capability gains for source countries when mobility is deliberately managed and linked to investment and structured pathways.

Witnesses in the Inquiry repeatedly emphasised that mutual benefit is currently under-specified in most bilateral arrangements, but also pointed to practical models, such as health partnerships, skills partnerships, traineeships and recognition/alignment pathways, where outmigration can result in expanded training capacity and improved competencies at home (e.g. investments in faculty, simulation labs, specialist tracks and workforce data systems and registries, alongside pre-departure preparation and post-arrival professional development). Written submissions and roundtable discussions revealed that internationally-recruited healthcare workers show significant professional growth including greater confidence and leadership development when supportive integration practices are in place (Pressley et al., 2024).

This aligns with WHO's position that, while unmanaged migration can exacerbate shortages, well-governed mobility can strengthen health systems in both source and destination countries, particularly where agreements embed skills transfer, training support and protections that improve health worker welfare and professional development.

In this sense, the "skills benefit" is not simply the acquisition of individual clinical skills abroad, but the creation of institutionalised skills formation: expanded domestic training pipelines (including "home" tracks[4]), better specialty preparation that reduces deskilling/underemployment, and leadership development that can be reinvested in service improvement, education and supervision on return or through structured diaspora engagement.

Diaspora contribution and circular migration

Witnesses also presented evidence that demonstrated the skills benefits related to diaspora, circular migration and "brain circulation", formal or informal, through which internationally-recruited health workers contribute back to their countries of origin via continuing professional development, mentorship, short-term clinical teaching, service delivery and knowledge exchange.

Witnesses highlighted that diaspora contributions (skills transfer, training support and wider professional networks) are often substantial yet under-measured and argued they should be deliberately built into co-investment packages (including gender-sensitive leadership pathways and measurable key performance indicators (KPIs)). This is consistent with published evidence on diaspora engagement, which finds diaspora health workers contribute to capacity strengthening of local health workers through knowledge and skills transfer, alongside policy and systems learning across settings; circular migration is increasingly identified as a goal because returning health workers bring back new practices, standards and professional networks (THET/GHP, 2021; GHP, 2023; Nganda et al., 2025, International Organization for Migration, 2022).

Taken together, the Inquiry evidence and published literature suggest that the most robust "skills dividend" for source countries comes when international recruitment is treated as a skills partnership, with explicit provisions for training capacity, specialty skills, leadership development, diaspora knowledge exchange and return/circular options, rather than as a one-way labour market response to vacancies in destination systems.

[4] "Home Track" is when students decide to remain in their home country following their involvement in the Global Skills Partnerships programme. The additional professional expertise and skills they acquire can be used to support their career development in the Philippines (Global Skills Partnerships, 2026).

Lived experience of health workers

Evidence presented during the Inquiry and supported by written submissions and published literature suggests that internationally-recruited workers face significant systemic barriers from recruitment through to settlement.

Many experience unethical and exploitative recruitment practices, including illegal fees and misleading information about working conditions. Early integration is marked by inadequate induction, limited cultural or language support, and challenges navigating the UK health system (Lanada & Culligan, 2024; Florence Nightingale Foundation, 2024). Immigration constraints, especially the No Recourse to Public Funds (NRPF) condition, exacerbate financial hardship, leaving many unable to meet basic needs, struggling with childcare costs, and facing long-term family separation due to restrictive visa rules. High housing costs, rental discrimination and unsuitable accommodation further compound these difficulties (RCN, 2024).

Within the workplace, internationally-educated staff frequently report racism, discrimination and insufficient recognition of their skills. Nearly two-thirds of international nurses experience discrimination, and almost half experience racism (RCN, 2025).

They are often underemployed, not fully utilised and placed at lower bands despite senior experience due to poor recognition of previous training and expertise, with few reporting a higher level of life satisfaction (Bowers, et al., 2024: de Vries, et al., 2016). They experience unclear career pathways and limited mentorship (Lanada & Culligan, 2024; Mpando et al., 2025). Many feel emotionally strained, excluded from leadership pipelines and disproportionately targeted in disciplinary processes.

These combined pressures, coupled with high workload, low pay and slow routes to settlement, drive many to consider leaving the UK for countries with better pay, pathways to residency and more supportive work environments. In 2024, of the 3,000 internationally-educated members surveyed by the RCN about their experiences of the cost-of-living crisis, 62% said they had considered leaving the UK and returning to their country of training. More than half (51%) of internationally-educated nurses reported they were likely to leave their career in nursing altogether (RCN, 2024).

3) MODELS – Current ethical frameworks

Evidence across the Inquiry indicates that the architecture for managing health worker mobility more ethically already exists but remains unevenly applied and rarely measured.

Witnesses repeatedly contrasted the current "default" model, largely demand-led recruitment governed by voluntary norms, with a set of more structured mechanisms that can operationalise mutual benefit. **Health partnerships** were consistently presented as a practical route to turn mobility into mutual knowledge and skills exchange, bidirectional learning and reciprocal system strengthening through curricula development, supervision models, quality improvement and service redesign, including diaspora-led knowledge exchange. Within these partnerships, diaspora professionals act as "agents of change" bridging clinical learning environments.

Contributors emphasised that partnerships – government to government, institution to institution, and peer-to-peer – can accelerate learning and innovation ("learn globally, deliver locally"). For example, the NHS, as a centre of excellence for education and health workforce development, could expand delivery of time-limited (3-4 years) Global Training Pathways, enabling international health workers to gain defined competencies in the NHS before reintegrating into their home health systems. This could build on the evidence of initiatives such as the Medical Training Initiative (MTI) – which has demonstrated global health workforce development impact while delivering benefit to the NHS – and similar fellowship routes. Elements such as clear curricula, supervision and accreditation, indicators for measuring performance and impact, including explicit return and reintegration plans should be integral to these approaches. Such models should be delivered only through partnerships that are mutually beneficial – ensuring proportionate co-investment in health workforce and health systems capacity in partner countries.'.

Stronger bilateral and structured pathway models, including approaches such as the Germany–Philippines skills partnerships, Ireland's time-bound Kenya agreement and structured training routes, and South Africa's long-standing training collaboration with Cuba, demonstrate how mobility can be linked explicitly to co-investment in training capacity, skills alignment and reintegration, with clearer governance and greater predictability than ad-hoc recruitment.

Across hearings, expert witnesses stressed that these mechanisms deliver most effectively when backed by political will, clear roles for ministries of health and transparent indicators of delivery and reporting.

Unless these conditions are in place, "mutual benefit" remains aspirational; and if programmes focus only on enabling outward flows (e.g. surplus export) without parallel investment in absorption and retention, they risk entrenching the structural drivers of "paradoxical surplus" rather than resolving them. These conditions are often absent in current agreements and should therefore be treated as minimum design requirements for future policy.

Various models which have been trialled to manage health worker migration more ethically, including their advantages and limitations, can be found in Annex 1.

4) DISCUSSION – What does good look like?

A global workforce crisis – experienced everywhere, but not equally: Health workforce capacity is a global public good; health workers are foundational to functioning health systems and to realising the right to health.

International recruitment is a "lifeline" for wealthy systems but can erode service capacity in fragile health systems. As the evidence in the sections above outlines, international recruitment is a shared strategy among HICs.

Countries with the most fragile health systems, those facing the highest maternal mortality and the lowest health worker densities, are the least able to replace experienced staff. In these settings, even recruitment that meets ethical standards can still damage the health system if it is not accompanied by proportionate investment.

The "honest account":

The benefits to the UK are real and substantial: international recruitment remains a structurally significant component of the UK's health workforce strategy, delivering fiscal, operational and system-level advantages that would be challenging to replicate through domestic training alone.

Evidence submitted to the Inquiry demonstrates that the UK derives sizeable efficiency gains by drawing on internationally-trained health professionals, reducing the immediate requirement for large-scale domestic training expansion and enabling the rapid deployment of fully qualified health workers into priority service areas.

In addition to these workforce benefits, international recruitment strengthens the UK health system through the transfer of global expertise. The integration of internationally-trained professionals has accelerated the diffusion of clinical innovations, supported more culturally competent service models and facilitated learning from health systems that have achieved efficiencies in community-based, preventive and integrated care, contributing directly to the evolution of NHS practice and leadership capabilities.

The strategic value of international recruitment extends to wider system resilience. The UK's ability to access a global workforce mitigates domestic pipeline constraints, supports service continuity during periods of demand volatility and reinforces the NHS's position within an increasingly interdependent global health labour market.

Taken together, the evidence indicates that international recruitment does not only fill workforce gaps; it confers structural and strategic benefits that enhance the performance, adaptability and global connectedness and resilience of the UK health system.

The costs are real: International health worker migration can generate important employment and economic benefits for source countries, but these gains are often indirect, uneven and insufficient to compensate for the loss of health system capacity, especially where systems are already fragile.

The consequences of depleted workforce capacity and health systems through international recruitment and migration are not abstract; they are visible in health workforce densities – a direct determinant of access, quality and health outcomes, such as maternal mortality, where ratios remain dramatically higher in LMICs than in HICs, reflecting gaps in access to skilled personnel and functioning services.

In short, health workforce mobility can improve employment prospects and household welfare, but without system-level co-investment and predictable replenishment, it can simultaneously undermine service coverage and training capacity, meaning the aggregate effect on the health system may still be negative even when household-level benefits are real.

Mutual benefit is real, but it must be intentionally designed: The evidence suggests that health worker migration has mutual benefit, with source governments identifying employment, remittances, skills benefits and how migration has generated learning and innovation in the NHS.

However, the mutual benefit potential is only achieved when mobility is governed well and ethically.Mutual benefit is achievable when destination countries co-invest holistically in training, employment and retention and when agreements include worker protections and monitoring.

Current models shifts risk: Current "ethical recruitment" mechanisms are not delivering. Voluntary codes and uneven bilateral agreements are insufficient, rarely measured and rarely deliver co-investment.

Stakeholder positions are increasingly explicit that ethical recruitment should include proportional co-investment and stronger accountability, not just "do not recruit" lists. Mutual benefit must be intentionally designed; bilateral mechanisms need tailoring and alignment with country priorities and governance structures.

Such investments should follow the health worker lifecycle – training alone is insufficient without decent jobs, safe and conducive working conditions, and effective retention strategies, otherwise, the result will be more qualified but unemployed health workers.

Unreliable and unpredictable global labour market demand creates "boom-and-bust" cycles undermining source country investments in production and creating structural instability in source countries, contributing to un- or underemployment.

Without measurable, proportionate co-investment, full lifecycle support and meaningful enforcement, bilateral agreements risk becoming symbolic gestures that protect reputations rather than honouring the ethical and moral responsibility destination countries have to ensure these partnerships genuinely strengthen health systems in the countries they recruit from.

Domestic pipeline reform alone is not enough. Self-sufficiency plans are necessary, but targets can be politically attractive and operationally unrealistic: the ambition to reduce reliance is laudable, yet questionable in terms of feasibility and cost.

International recruitment is therefore unavoidable in the short term because the UK cannot train enough health workers quickly enough; closing the gap would require tens of billions of pounds in training costs and a scale-up that the Inquiry witnesses judged unrealistic.

Over the long term, however, dependence at current levels is unsustainable: it risks weakening fragile health systems abroad, undermining global health security, and leaving the UK exposed to an unpredictable global labour market.

Workforce planning should remain committed to reducing reliance over time but must be honest about assumptions and timeframes.

Internationally-recruited staff are already sustaining services, filling critical vacancies and bringing expertise the NHS urgently needs.

Yet the current approach is under significant strain, reflected in poor retention, onward migration and a "boom-and-bust" pattern that leaves both staff and source country health systems exposed. Retention is one of the fastest routes to sustainability: fewer leavers mean less dependence. The priority now is to support and retain the internationally-recruited workforce in the NHS, through better integration, progression and stable career pathways, while ensuring that any ongoing international recruitment is managed responsibly, with predictable arrangements and proportionate co-investment that strengthens (rather than undermines) source country health systems.

Together, these actions can promote a more sustainable, stable and self-sufficient health workforce. Done well, this can deliver mutual benefit for the NHS, the individuals who migrate and the countries that train them.

A more stable future requires serious domestic investment alongside ethical, predictable international recruitment, underpinned by proportionate co-investment.

To ensure transparency and accountability, the NHS should publish indicators of self-sufficiency and retention, not only recruitment volumes, so progress can be tracked against real sustainability outcomes.

Why "proportionate co-investment" emerges logically from the evidence

Proportionate co-investment refers to a predictable, rules-based and fair contribution made by countries that recruit health workers internationally to strengthen the most fragile and understaffed health systems where these health workers come from.

The aim is to ensure mutual benefit, support sustainable health workforce development and avoid worsening shortages in countries that are already under strain.

Unmanaged migration and unethical international recruitment are generating profound structural harm: experienced workers, faculty, clinical instructors and specialist cadres are being lost faster than countries can replace them. This accelerates workforce shortages, depletes training and supervisory capacity, increases pressure on those who remain, undermines equitable distribution, particularly in underserved rural areas and drives severe service disruption and volatile boom and bust cycles.

These losses erode not only the workforce today but also the systems required to train, deploy and retain future workers, leaving source countries unable to stabilise their labour markets through domestic action alone.

The evidence is unequivocal: when destination countries benefit from the labour and expertise of workers trained elsewhere, and when their recruitment practices impose external costs, the case for shared responsibility is not discretionary; it is both a practical necessity and an ethical obligation.

As mentioned above, there is need for meaningful co-investment in health workforce development and health systems strengthening in source countries in order to deliver proportional benefits (WHO, Executive Board, 2026).

While stakeholders commended the EAG's report and supported its recommendations to strengthen the Code and prioritise resources, some were concerned that this would not be enough to stem the growing tide of active recruitment and the harm being done to essential health services in under resourced regions. They urged member states to require, rather than encourage, HICs to make targeted co-investments in the health workforce and health systems in source countries (World Health Professions Alliance, 2026b).

This urgency is intensified by a rapidly deteriorating global health financing landscape: aid cuts, shrinking fiscal space, and widening funding gaps are already destabilising services and weakening system resilience. In such conditions, discretionary or ad hoc support is inadequate, too unpredictable, too slow and too fragile to counteract system-wide destabilisation.

Co-investment therefore emerges as the only logical and effective response: predictable, jointly-financed resourcing capable of stemming system collapse and rebuilding, growing and stabilising the global health workforce at scale.

Of course, the scope of this co-investment – and how to deliver it – will need to be discussed in depth. It could be argued that the benefit the UK derives from averted training costs is offset by the global health aid that the UK provides, both bilaterally and through multilateral pooled funds.

The opaqueness of the latter, in particular, makes it difficult to parse out how much has been invested. Yet we can use proxies: only 7% of global health funding currently goes to the health workforce, primarily through health systems strengthening channels (Micah et al., 2022; Demeshko and Dempster, 2026). It is therefore likely that the UK's global health investments are not currently proportionate to the benefits they receive. Yet more needs to be done to understand the scope of this discrepancy, and then to explore the various different channels through which increased funding for health systems strengthening could be disbursed.

Political will is crucial

Political will means choosing honesty over headlines and delivery over declarations.

The UK will continue to rely on international recruitment in the short term, so the real test is whether it will recruit responsibly – with clear assumptions, transparent metrics and a plan to reduce dependence over time, while supporting internationally-recruited staff to stay and progress in the NHS.

If the UK benefits, it should contribute; agreements should be fair to the countries it recruits from, with mutual benefit designed in, not assumed.

That requires moving beyond voluntary codes to enforceable partnerships, rooted in collaboration with partner governments and Ministries of Health and underpinned by predictable, proportionate co-investment, consistent with WHO's safeguards approach that discourages harmful recruitment practices, and the NHS's own commitment to retention and sustainable workforce planning.

Political will, government commitment and leadership are required on both sides because safe, ethical mobility cannot be delivered by destination country rules alone: destination countries must commit to predictable, government-to-government arrangements that specify mutual health systems benefits and safeguards, while source countries must be willing and able to negotiate, govern and implement those agreements through government ministries, departments and agencies, aligning recruitment with national workforce plans and protections.

Without shared political will, the system defaults to instability and exploitation, "boom-and-bust" cycles on the destination side and weak enforcement capacity on the source side. Joint commitment enables mutual benefit: predictable recruitment, worker protections, and proportionate co-investment can be designed into agreements only when both governments sustain leadership, transparency and accountability over multiple years.

Upcoming global moments, including the 79th World Health Assembly and the UK leadership of the G20, will be pivotal to champion UK and global action on health workforce mobility and co-investment.

5) RECOMMENDATIONS – A practical route forward

Recommendation 1: A strategic and realistic approach to international recruitment

The UK Government should:

1.1 Formally recognise international recruitment as a structural and enduring component of the NHS health workforce in the medium term, rather than a short-term or transitional measure, and reflect this explicitly in workforce planning assumptions.

1.2 Review the ambition in the NHS England 10-Year Health Plan (Department of Health and Social Care, 2025) to reduce international recruitment to below 10% by 2035, assessing deliverability, affordability and historical precedent, and develop alternative scenarios and contingency actions should the target not be met.

1.3 Develop a cross-government implementation plan framing health workforce capacity as a global public good, setting out objectives for UK sustainability and global health security, and committing to annual public reporting on UK reliance and related impact.

Recommendation 2: Workforce planning and predictability

The UK Government should:

2.1 Ensure the forthcoming NHS 10-Year Workforce Plan should include transparent, measurable and regularly updated estimates of international recruitment requirements, and retention assumptions, alongside a public dashboard of indicators (self-sufficiency, inflows/outflows and retention), not recruitment volumes alone.

2.2 End the current "boom-and-bust" approach to international recruitment by establishing a predictable, long-term international recruitment framework aligned with NHS workforce projections and agreed parameters with source countries.

2.3 Ensure the voices and experiences of internationally-recruited and diaspora health workers meaningfully inform workforce policy and planning as well as their implementation and evaluation through continuous consultations.

Recommendation 3: Investment in supply and retention

The UK Government should:

3.1 Continue to invest in domestic workforce supply, while ensuring that demand and population health priorities are met, and address declining enrolment linked to self-funded education models, while clearly stating the time horizons over which domestic supply can realistically reduce reliance.

3.2 Operationalise its retention commitments by scaling evidence-based interventions that improve all staff experience (flexible working, leadership, professional development, career progression, wellbeing) with specific retention objectives tracked nationally – so that all staff can build stable, rewarding careers in the NHS, and retention is recognised as a strategic, cost-effective source of health workforce capacity.

3.3 Require NHS employers to provide a consistent support package based on evidence-based good practice for internationally-recruited staff, including recognition of prior experience, structured induction and integration, access to training, career progression and pastoral support and to report compliance and outcomes.

Recommendation 4: Ethical recruitment and global workforce responsibility

The UK Government should:

4.1 Strengthen the UK's approach to ethical international recruitment by underpinning voluntary guidance with enforceable, mutually beneficial, government-to-government agreements, including routine monitoring, clear responsibilities, transparency and accountability.

4.2 Explicitly recognise the impact of UK recruitment on fragile health systems, particularly where the NHS recruits experienced health workers, specialists and educators whose loss may undermine service delivery and training capacity in source countries and address this in the development of mutually beneficial agreements.

4.3 Explicitly require worker protections within recruitment policy and bilateral arrangements, including a review on recruitment fees, safeguards against exploitation, parity of employment conditions and accessible reporting and remedy mechanisms.

Recommendation 5: Proportionate co-investment in source countries

The UK Government should:

5.1 Demonstrate commitment and political will by establishing transparent and predictable funding mechanisms for proportionate co-investment in the most understaffed and fragile health systems, based on recruitment gains and saved training costs.

5.2 Strengthen bilateral agreements into enforceable compacts tailored to country context, including: joint workforce planning; co-investment commitments across the full health worker lifecycle; explicit and robust worker protections; shared governance; KPIs; and independent evaluation.

Recommendation 6: Transparent and mutually beneficial government to government partnerships

The UK Government should:

6.1 Establish co-investment mechanisms tied to recruitment gains and saved training costs, supported by ethical and transparent government-to-government partnerships that ensure international mobility translates into enhanced and sustainable health workforce capacity in source countries. These partnerships could include time-limited and predictable models that address locally-identified priorities (e.g. UK Medical Training Initiative, Global Training Pathways, Global Skills Partnerships) that enable international health workers to gain defined competencies in the NHS and reintegrate into source country health systems.

Recommendation 7: International leadership and global health security

The UK Government should:

7.1 Use major international forums including the UK-Global Health Summit, the World Health Assembly, the UK G20 Presidency and its strategic leadership role within the Commonwealth to champion global action on health workforce mobility.

7.2 Position proportionate co-investment in the global health workforce as a matter of moral and economic imperative to bolster national and global health security and stability, backed by sustained financial commitments that demonstrates political will and leadership.

6) CONCLUSION

From reliance to responsibility

The evidence before this Inquiry presents policymakers with a stark choice.

If nothing changes, the UK will remain locked into an increasingly fragile cycle: continued reliance on international recruitment, vulnerability to global labour market shocks and growing pressure on countries whose health systems are already stretched. This trajectory is not sustainable – for the NHS, nor for global partners.

Yet the Inquiry also shows that fairness and self-interest align.

Internationally-trained health workers bring enormous value to the UK: they fill critical shortages, sustain essential services and contribute global expertise that enriches NHS practice and innovation. These benefits are real and substantial. Being honest about this is the essential first step toward a durable and responsible policy.

At the same time, the costs borne by source countries cannot be ignored. When the UK recruits experienced health workers, faculty and specialists from already-fragile health systems, the impact reverberates across training capacity, service delivery and outcomes such as maternal health and rural access.

With a global shortage of 11 million health workers projected by 2030, and the most fragile systems least able to replace the staff they lose, the current model risks deepening global inequities.

A central conclusion of this Inquiry is that health workforce capacity is a global public good. Strong, sufficiently staffed health systems do not benefit only the countries that train or employ those workers – they enhance global health security, pandemic preparedness and the stability of interconnected health economies.

When health workers are scarce in one region, the shockwaves are felt everywhere. When they are fairly and equitably distributed, supported and retained, the benefits accrue globally. This understanding strengthens the case for the UK to act.

The UK therefore faces both an obligation and a strategic opportunity.

The NHS cannot deliver its 10-Year Plan without a skilled, motivated and sufficiently supported health workforce that is available in the right place at the right time, and whose services are accessible, acceptable and of consistently high quality. International recruitment will continue to play a vital role.

But without a more predictable model and stronger retention, the UK will face rising vacancies, cyclical recruitment surges and increasing exposure to global labour market volatility.

A more sustainable path requires the UK to strengthen its domestic workforce and grow the global health workforce.

This means ensuring international recruitment is predictable, ethical and underpinned by proportionate co-investment that expands training capacity, supports job creation and equitable deployment and enhances retention in source countries. Such an investment is not simply morally right; it is strategically smart.

A well-financed, adequately staffed, skilled and motivated global health workforce enhances health security and resilience for the UK as much as for source countries.

The UK now has an opportunity to lead.

Upcoming moments – including the UK Global Health Summit, the 2026 79th World Health Assembly and the UK's G20 Presidency in 2027 – offer a platform to champion a modern, responsible and globally-minded approach to health worker mobility. Additionally, the UK has an opportunity to leverage its strategic leadership in the Commonwealth to catalyse and sustain co-investment.

To speak credibly on global health security, the UK must match the benefits it gains from international recruitment with the responsibilities it holds. That means moving beyond voluntary codes to enforceable, transparent partnerships supported by predictable, multi-year co-investment.

The choice is ultimately one of leadership: to recognise that the UK's reliance on international recruitment is structural, not temporary; to design mobility so that it strengthens, not weakens, health systems everywhere; and to act with the political will necessary to deliver a sustainable NHS workforce while championing a fairer, more stable global model.

The evidence is clear. The opportunity is real. The moment is now.

7) ABOUT

About the Inquiry

In June 2025, the All-Party Parliamentary Group (APPG) on Global Health and Security established the first national Inquiry in the UK Parliament to examine the benefits and costs of international health workforce recruitment and to develop practical recommendations for a fairer, more sustainable and transparent approach to workforce mobility.

The Inquiry took evidence across three hearings: two online evidence sessions held on 4 November and 18 November, and a hybrid evidence session on 9 December 2025. These hearings brought together political leaders, health workers, international partners, global institutions, policy experts and implementers. We took evidence through roundtable discussions held in Kenya and Uganda (2025), with contributions from service provider and health institutions, international partners, national governments, frontline health workers and global institutions.

The Inquiry was also informed by written submissions received following a public call for evidence, ensuring a broad range of perspectives from across the health and global health community.

About the Author

The report was prepared and written by the Secretariat to the APPG.

The lead author is Margaret Caffrey. Co-authors are Lorina Kagosha, Jessica Fraser, Ben Simms, Jonathon Foster and Grace Money from Global Health Partnerships (formerly THET).

Revisions, editorial contributions and data analytical support was provided by Helen Dempster, Anastassia Demeshko and the Center for Global Development. In addition, Lee Crawfurd from the CGD contributed data analytical support, providing essential data analysis that informed key findings of the report.

The report benefited from expert review by Navina Evans, Elaine Green and Louise McGrath who served as advisors to the Inquiry.

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About the APPG

The All-Party Parliamentary Group (APPG) on Global Health & Security is a cross-party forum of Members of the UK Parliament with a shared interest in strengthening the United Kingdom's engagement, understanding and policy leadership on global health as an essential pillar of international security and sustainable development.

The APPG operates as an informal yet influential parliamentary forum where MPs and Peers can explore multidisciplinary health issues, hear from experts and stakeholders, and stimulate parliamentary awareness and action. This includes sharing knowledge across health-focused APPGs, convening briefings and events, and contributing to policy discussions on topics where health intersects with national and international security.

We are committed to advancing understanding of the links between health investment, global health system resilience and security priorities, ensuring that the UK Parliament remains engaged with emerging global health challenges and opportunities.

About the Secretariat

Global Health Partnerships (formerly THET) is a leading charity that works with health professionals around the world to improve healthcare. Through long-term partnerships and shared learning, we help strengthen health systems and support better care for patients and communities globally.

The Center for Global Development (CGD) is an independent, nonpartisan and nonprofit think tank that works to reduce global poverty and improve lives through innovative economic research that, in turn, drives better policy and practice by the world's top decision makers.

ANNEXES

Health partnerships

Definition: Longstanding institutional collaborations delivering shared training, clinical mentoring, service improvement and reciprocal innovation. These partnerships often rely on diaspora health workers who contribute training and capacity strengthening in their countries of heritage.

Advantages	Limitations
Delivers bidirectional skills and service gains	Often under-funded and unmeasured; often dependent on volunteer time
Strengthens training, supervision and quality of care in source countries.	Scale rarely matches recruitment volumes.
Policy implication: Integrate funded, measurable partnership and diaspora programmes into recruitment/mobility pathways so skills exchange becomes systematic and scalable	

Quotes from Inquiry:

-"I might take some time from my frontline work in London and go back and do some training in Zimbabwe… This is out of my annual leave… It's not quantified."

-"Professional development-based migration should always be done through mutually beneficial partnerships… learning globally to deliver locally."

-"We are very keen on promoting professional development-based migration… it should always be done through mutual benefit pre-agreed partnerships either government-to-government, institution-to-institution or peer-to-peer."

-"Internally, we have this expression of learning globally and delivering locally as being the key to healthcare transformation… migration either virtual or real reinforces and creates pathways for that innovation and healthcare transformation."

Bilateral models

Definition: Bilateral labour agreements and skills partnerships embed co-investment in education and training systems, and include commitments on employment (decent work), fair remuneration and retention in origin and destination systems.

Advantages	Limitations
Enables investment in origin country training capacity (skills labs, curricula, faculty).	Weak governance: many agreements lack KPIs, co-investment clauses and transparent reporting.
Reduces deskilling and underemployment by aligning education standards, language and recognition requirements.	Risk of facilitating outward flows without employment or retention measures adequately financed
Improves decent work and retention through agreed minimum employment standards, with incentives for rural staffing and career progression, supporting stability in both origin and destination systems.	Implementation of employment standards, retention measures and equitable deployment incentives can be uneven, particularly where origin or destination systems lack funding, governance capacity or enforcement mechanisms needed to make these commitments meaningful and consistently applied.
Policy implication: Adopt a context appropriate bilateral framework with mandatory co-investment clauses, clear KPIs and annual reporting, shifting agreements from a focus on the mechanics of recruitment to measurable health system benefit.	

Quote from Inquiry: "[In] the Global Skills Partnerships model[5]… we invest from [the] beginning, hand-in-hand with the country of origin, in education." (Germany–Philippines)

[5] The Global Skill Partnership model is bilateral labour migration agreement whereby the country of destination trains potential migrants with targeted skills in the country of origin. Some trainees migrate to the country of destination (those on the "away track") and others contribute to businesses in their country of origin (those on the "home track"). It is a way of ensuring that migration does not contribute to "brain drain", but instead increases the global stock of skilled workers. Please see https://cgdev.org/bettermigration.

Structured pathways with explicit learning goals and evaluation

Definition: Time-bound training pathways, supervised placements and return-linked programmes that define competencies, development outcomes and include independent evaluation.

Advantages	Limitations
Ensure acquisition of specific, validated competencies, delivered through supervised, accredited placements.	Without sustained political will, governance and financing capacity, risk becoming short-term mobility schemes rather than contributing to long-term health systems strengthening.
Strengthen retention and workforce planning by linking participation to return-to-service requirements and structured deployment.	Needs adequate management capacity and design that includes co-investment and implementation support.

Policy implication: Launch a small number of proof-of-concept mobility partnerships with independent evaluation and publishable outcomes, embedding successful models into the NHS Long-Term Workforce Plan and future bilateral agreements.

Quote from Inquiry:

"We have sent thousands of young South Africans to Cuba… they get trained as doctors there… [and] complete their integration training in South Africa."
(South Africa–Cuba)

REFERENCES

1. Ahmat A., Asamani J.A., Abdou Illou M.M., et al (2022). Estimating the threshold of health workforce densities towards universal health coverage in Africa. BMJ Global Health. 7(Suppl 1):e008310.
2. Awases, M., Gbary, A., Nyoni, J., and Chatora, R. (2004). Migration of Health Professionals in Six Countries: A Synthesis Report. Brazzaville: World Health Organization Regional Office for Africa. Available at: https://www.afro.who.int/publications/migration-health-professionals-six-countries-synthesis-report (Accessed: 20 October 2025)
3. Bowers, B., Ul Haq, N., Young, A. and Oldman, C. (2024) Valuing internationally educated nurses and diversity in the community nursing workforce. Evidence-Based Nursing (Online First, 22 August). Available at: https://ebn.bmj.com/content/early/2024/08/22/ebnurs-2024-104158 (Accessed: 15 February 2026).
4. Batista, C., Han, D., Haushofer, J., Khanna, G., McKenzie, D., Mobarak, A.M., Theoharides, C., Yang, D. (2025). Brain drain or brain gain? Effects of high-skilled international emigration on origin countries. Science, 388(6749). Available at: https://www.science.org/doi/10.1126/science.adr8861 (Accessed: 9 September 2025)
5. Buchan, J. (2025). Nurse 'graduate guarantee': supply solution or short-term fix? The Health Foundation, 1 October. Available at: https://www.health.org.uk/features-and-opinion/blogs/nurse-graduate-guarantee-supply-solution-or-short-term-fix (Accessed: 20 October 2025).
6. Buchan, J., Shembavnekar, N. and Bazeer, N. (2019) Labour market change and the international mobility of health workers. Working Paper. London: Health Foundation. Available at: Labour market change and the international mobility of health workers Working Paper_0.pdf (Accessed: 10 October 2025).
7. Campbell, J. (2025) Accelerating action on the health and care workforce by 2030. Presentation at WONCA 2025, 18 September. World Health Organization.
8. Curtis, Lesley A., ed. (2007) Unit Costs of Health and Social Care 2007. Personal Social Services Research Unit, University of Kent, Canterbury, United Kingdom, 208 pp. ISBN 978-1-902671-53-6. Available online at: https://kar.kent.ac.uk/2785/
9. Committee on Employment and Social Affairs Committee on Public Health (2025). DRAFT REPORT on an EU health workforce crisis plan: sustainability of healthcare systems and employment and working conditions in the healthcare sector (2025/2062(INI))
10. Crawfurd, L. (2026) How Foreign-Trained Health Workers Saved the NHS £14 Billion [Manuscript in preparation]. Blog. Center for Global Development.

11. Demeshko, A., and Dempster, H. (2026) The UK's International Health Workforce Bargain: Financial Benefits Dwarf Aid Spent Abroad [Manuscript in preparation]. Blog. Center for Global Development.
12. Department of Health and Social Care (2025). Fit for the future: 10 Year Health Plan for England - executive summary (accessible version). Updated 30 July 2025. (Accessed 6 March 2026)
13. Deussom, R., Lal, A., Frymus, D., Cole, K., et al. (2022). Putting health workers at the centre of health system investments in COVID-19 and beyond. Family Medicine and Community Health, 10(2), e001449. Available at: https://fmch.bmj.com/ (Accessed: 3 March 2026).
14. de Vries, D.H., Steinmetz, S. and Tijdens, K.G. (2016). Does migration "pay off" for foreign-born migrant health workers? An exploratory analysis using the global Wage Indicator dataset. Human Resources for Health, 14(40). Available at: https://link.springer.com/article/10.1186/s12960-016-0136-5 (Accessed: 15 February 2026).
15. Florence Nightingale Foundation (2024). The potential impacts of additional advanced practice regulation on internationally educated nurses and midwives in the UK: final report. London: NMC-commissioned study. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/advanced-practice-review/florence-nightingale-foundation-kloe-09--23102024-1.pdf (Accessed: 15 February 2026).
16. Eaton, J., Baingana, F., Abdulaziz, M., Obindo, T., Skuse, D. and Jenkins, R. (2023) The negative impact of global health worker migration, and how it can be addressed. Public Health, 225, 254–257 pp. Available at: https://doi.org/10.1016/j.puhe.2023.09.014 (Accessed: 13 September 2025)
17. Full Fact (n.d.) Search page. Available at: https://fullfact.org/search/#gsc.tab=0 (Accessed: 3 March 2026)
18. General Medical Council (2025). Register data summary. GDE. Available at: https://gde.gmc-uk.org/the-register/register-summary/register-data-summary (Accessed 3 October 2025).
19. Global Health Partnerships (GHP) (2023). Voices of the Experts in Our Midst. London: GHP. Available at: https://www.globalhealthpartnerships.org/wp-content/uploads/2023/12/Voices-of-the-Experts-In-Our-Midst.pdf (Accessed: 15 February 2026).
20. Global Skills Partnerships (n.d.) Programme – Global Skills Partnerships. Available at: https://global-skills-partnerships.de/en/program/ (Accessed: 6 March 2026)
21. Harker, R. (2025). NHS staff from overseas: statistics (CBP-7783). London: House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-7783/ (Accessed 19 February 2026).

22. Health Policy Watch (2023). WHO raises alarm over increased healthcare worker migration to rich countries post-pandemic. Available at: https://healthpolicy-watch.news/ (Accessed: 3 March 2026).
23. Hutchinson E., Ugwu C., Kitutu F., Mulubale S. (2025). Not enough and too many: professional personhood among Africa's paradoxically surplus health workers. Wellcome Trust Discovery Award; 2025. Available at https://www.ismartrecruit.com/blog-passive-recruiting-definition-strategy-benefits (Accessed: 3 March 2026)
24. Hutchinson E., Kiwanuka S., Muhindo R., Nimwesiga C., Balabanova D., McKee M., Kitutu F.E. (2024). The paradoxical surplus of health workers in Africa: the need for research and policy engagement. Int J Health Plann Mgmt. 2024;39(3):956–962 pp. doi:10.1002/hpm.3745. Available at https://cdn.who.int/media/docs/default-source/health-workforce/hwp/2024_independentstakeholders.pdf?sfvrsn=5777dd08_3&download=true (Accessed: 3 March 2026)
25. International Organization for Migration (IOM) (2025). Health and Mobility. The Philippines. Framing document. 1 July 2025. Available at: https://philippines.iom.int/sites/g/files/tmzbdl1651/files/documents/2025-07/health-and-mobility.pdf (Accessed: 10 March 2026).
26. International Organization for Migration (IOM) (2022). Health innovation through diaspora engagement: Talent, partners and allies. Geneva: IOM. Available at: https://www.idiaspora.org/system/files/resources/document/health-innovation-through-diaspora-engagement-talent-partners-and-allies_0.pdf (Accessed: 15 February 2026).
27. Lanada, J.A., and Culligan, K. (2024). The experiences of internationally educated nurses who joined the nursing workforce in England. British Journal of Nursing, 33(2), 78–84 pp. doi: 10.12968/bjon.2024.33.2.78.
28. Lanati, M., and Thiele, R. (2021). Aid for health, economic growth, and the emigration of medical workers. Journal of International Development, 33(7), 1112-1140 pp. Available at: https://doi.org/10.1002/jid.3568 (Accessed: 22 September 2025)
29. Micah, A.E., Solorio, J., Stutzman, H. et al (2022). Development assistance for human resources for health. 1990–2020. Hum Resour Health 20, 51. Available at: https://doi.org/10.1186/s12960-022-00744-x (Accessed 3 March 2026).
30. Moscelli, G., Mello, M., Sayli, M. and Boyle, A. (2024). Nurse and doctor turnover and patient outcomes in NHS acute trusts in England: retrospective longitudinal study. BMJ, 387, p.e079987. Available at: https://www.bmj.com/content/387/bmj-2024-079987 (Accessed 7 October 2025).
31. Mpando, D., Zhao, Y., English, M. and Leckcivilize, A. (2025). Experiences of EU and non-EU internationally educated nurses and midwives in the UK: a scoping review. BMC Nursing, 24(1459). Available at: https://link.springer.com/article/10.1186/s12912-025-04080-y (Accessed: 15 February 2026).

32. Nganda, M., Mulongo, M., Otiso, L. and Tancred, T. (2025) Improving diaspora engagement for health workforce and health systems strengthening in Kenya, Ghana and the UK: preliminary findings (Evidence Brief). Liverpool School of Tropical Medicine/Global Health Partnerships. Available at: https://www.globalhealthpartnerships.org/wp-content/uploads/2025/03/Diaspora-Study-2-page-report-v4.pdf (Accessed: 15 February 2026).
33. NHS Digital (2025) General Practice Workforce, 30 September 2025. Published 23 October. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-september-2025 (Accessed: 1 November 2025)
34. NHS Digital (2025) NHS Workforce Statistics – June 2025 (Including selected preliminary statistics for July 2025). Published 25 September. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2025 (Accessed: 1 November 2025)
35. Nursing and Midwifery Council (2025). Annual data report: 1 April 2024 – 31 March 2025. London: NMC. Available at: https://www.nmc.org.uk (Accessed: 27 September 2025)
36. Odebiyi, B., Walker, B., Gibson, J., et al. (2021). Eleventh National GP Worklife Survey. Available at: eleventh-gpwls-2021.pdf (Accessed: 6 October 2025).
37. OECD (2021). International migration of doctors and nurses. In Health at a Glance 2021: OECD Indicators. Paris: OECD Publishing. Available at: https://www.oecd-ilibrary.org/sites/ae3016b9-en/1/3/8/11/index.html (Accessed: 25 July 2025).
38. OECD (2025). Cuts in official development assistance: OECD projections for 2025 and the near term (Policy Brief). 26 June 2025. Available at: https://www.oecd.org/en/publications/2025/06/cuts-in-official-development-assistance_e161f0c5/full-report.html (Accessed: 1 February 2026)
39. Packer, C., Runnels, V., Labonté, R. (2010). Does the Migration of Health Workers Bring Benefits to the Countries They Leave Behind? In: Shah, R.S. (eds) The International Migration of Health Workers. Palgrave Macmillan, London. Available at: https://doi.org/10.1057/9780230307292_4 (Accessed: 28 October 2025)
40. Ratha, D., Chandra, V., Kim, E.J., Plaza, S. and Mahmood, A. (2024). Remittances slowed in 2023, expected to grow faster in 2024. Migration and Development Brief 40. Washington, D.C.: World Bank/KNOMAD. Available at: https://documents1.worldbank.org/curated/en/099714008132436612/pdf/IDU1a9cf73b51fcad1425a1a0dd1cc8f2f3331ce.pdf (Accessed: 16 September 2025).
41. Philippines raises cap on health professionals going abroad (2021). Reuters. 18 June 2021. Available at: https://www.reuters.com/world/asia-pacific/philippines-raises-cap-health-professionals-going-abroad-2021-06-18/ (Accessed: 10 March 2026)

42. Pressley, C., Garside, J., Newton, D., Holbrough, F., Bagshaw, V., Cox, E. and McDonald, K. (2024). Supporting internationally educated nurses to stay and thrive in the NHS. Nursing Times, 120(6). Available at: https://cdn.ps.emap.com/wp-content/uploads/sites/3/2024/05/240513-Supporting-internationally-educated-nurses-to-stay-and-thrive-in-the-NHS.pdf (Accessed: 15 February 2026).
43. Pressley, C., Garside, J., Wu, L. and Stephenson, J. (2024). The long-term experiences and career progression of international nurses working in the health sector in England. University of Huddersfield Research Portal. Available at: https://pure.hud.ac.uk/en/publications/the-long-term-experiences-and-career-progression-of-international/ (Accessed: 15 February 2026).
44. Royal College of Nursing (RCN) (2025). Unreciprocated Care: why internationally educated nursing staff are leaving the UK. London: Royal College of Nursing. Available at: https://www.rcn.org.uk/Professional-Development/publications/RCN-Unreciprocated-Care-why-internationally-educated-nursing-staff-are-leaving-UK-pub-012-109 (Accessed: 15 February 2026).
45. Royal College of Nursing (RCN) (2024). Without a safety net: The impact of no recourse to public funds on internationally educated nursing staff. London: RCN. Available at: https://www.rcn.org.uk/-/media/Royal-College-Of Nursing/Documents/Publications/2024/August/011-752.pdf (Accessed: 15 February 2026).
46. Royal Society of Canada and Canadian Academy of Health Sciences (2025). Protecting our Collective Future: Renewing Canada's Role in Global Health. Ottawa: RSC-CAHS. Available at: https://rsc-src.ca/en/protecting-our-collective-future-renewing-canadas-role-in-global-health (Accessed: 9 September 2025).
47. Saluja, S., Rudolfson, N., Massenburg, B.B., Meara, J.G. and Shrime, M.G., 2020. The impact of physician migration on mortality in low and middle-income countries: an economic modelling study. BMJ Global Health, 5(1), e001535. Available at: https://gh.bmj.com/content/5/1/e001535 (Accessed: 28 October 2025).
48. Tropical Health and Education Trust (THET) / Global Health Partnerships (GHP) (2021). Experts in Our Midst: Recognising the contribution NHS diaspora staff make to global health. London: THET. Available at: https://www.globalhealthpartnerships.org/our-work/policy-work/experts-in-our-midst/ (Accessed: 15 February 2026).
49. WHO African Region (2024). A decade review of the health workforce in the WHO African Region, 2013-2022: implications for aligning investments to accelerate progress towards Universal Health Coverage. ISBN: 9789290314981 (Accessed: 18 February 2026).

50. World Health Organization (2026a). National Health Workforce Accounts (NHWA) Portal. Available at: https://apps.who.int/nhwaportal/ (Accessed: 17 February 2026)
51. World Health Organization (2026b). WHO Global Code of Practice on the International Recruitment of Health Personnel. Draft decision proposed by Germany, the Philippines, Romania and Thailand. Executive Board 158th Session. Agenda Item 13. 2 February 2026. EB158/CONF./3
52. World Health Organization (2025a) Health and care workforce: WHO Global Code of Practice on the International Recruitment of Health Personnel. Report by the Director-General. Executive Board 156th Session, Document EB156/14, 28 January. Available at: https://apps.who.int/gb/ebwha/pdf_files/EB156/B156_14-en.pdf (Accessed: 11 March 2026).
53. World Health Organization (2025b). Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel. Document EB158/17, 22 December 2025. Geneva: World Health Organization.
54. World Health Organization (2024). Health workforce. Available at: https://www.who.int/health-topics/health-workforce (Accessed: 3 March 2026).
55. World Health Organization (2023). WHO health workforce support and safeguards list 2023 https://iris.who.int/server/api/core/bitstreams/7a4c60c5-0610-44da-ad9d-6e20fd938d92/content (Accessed: 17 February 2026).
56. WHO Regional Office for Europe (2025). Health workforce migration in the WHO European Region: country case studies from Albania, Armenia, Georgia, Ireland, Malta, Norway, Republic of Moldova, Romania and Tajikistan. Copenhagen: WHO Regional Office for Europe; 2025. Licence: CC BY-NC-SA 3.0 IGO.
57. World Health Professions Alliance (2026a). Constituency statement to the WHO Executive Board 158 (Feb 2026). Agenda Item 26: Economics of health for all
58. World Health Professions Alliance (2026b). Individual statement to the WHO. Executive Board 158 (Feb 2026) Led by FIP, on behalf of WHPA. Item 13: Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel.


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