Houston Area Model United Nations
Standard Committee

WHO



Chair | Aiza Dada

Topic B: Addressing the Shortage of Healthcare Workers

Houston Area Model United Nations 52

February 4 & 5, 2027

Atilgan Ozdil/Anadolu Ag

Chair Letter

Welcome delegates,

Welcome to HAMUN 52! My name is Aiza Dada, and I am incredibly excited to be your chair for WHO this year.

I am currently a sophomore biology major in the honors college here at UH, and I plan to study politics and ethics with a minor in Phronesis. I first joined Model UN as a junior in high school, when I saw how much of a blast my friends were having. Since then, I've joined the collegiate Model Debate circuit and had the amazing opportunity to travel to New York, Washington D.C., and Philadelphia for conferences. Last year, I had the pleasure of serving as vice chair for CSW at HAMUN. Model UN has given me the opportunity to meet some incredible people, challenge the way I think, and become much more comfortable defending ideas under pressure.

I am especially excited to chair WHO because public health is one of those subjects that affects literally everyone, whether or not we spend much time thinking about it (and as a bio major, I'm always thinking about it). Both topics this year will force us to question: what happens when medical solutions exist, but the resources needed to provide them are not equally available? There will be no shortage of things for you all to disagree about, which, conveniently, is the entire point of committee.

My biggest piece of advice is to research your country, not just the topic. Think about funding, feasibility, and implementation. Also, please do not feel like you need to walk into committee knowing the entire global healthcare system by heart. Come prepared, speak even when you are nervous, listen to other delegates, and be willing to change your approach when somebody raises a point you had not considered. Some of the best moments in Model UN happen when a debate goes somewhere you never expected. Have fun with it, take risks, and enjoy the occasional chaos!

Best of luck, and please reach out with any questions!

Aiza Dada
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WHO and the Workforce

The World Health Organization is the United Nations agency in charge of international public health. It was founded in 1948, is based in Geneva, Switzerland, and has 194 Member States. Its central goal is universal health coverage (UHC): every person getting the care they need without being pushed into poverty to pay for it. UHC cannot happen without people to deliver it. A clinic with no nurse and a hospital with no surgeon cannot help anyone, which is why WHO treats the health workforce as one of the basic building blocks of any health system.

Keep in mind that WHO's odes, guidelines, and recommendations are voluntary, and it cannot make a country train more nurses, pay doctors more, or stop a hospital from hiring abroad. Resolutions create expectations and pressure, but countries decide whether to act. In this committee, that means a good solution is one that Member States will actually want to carry out, through persuasion, funding, and cooperation.

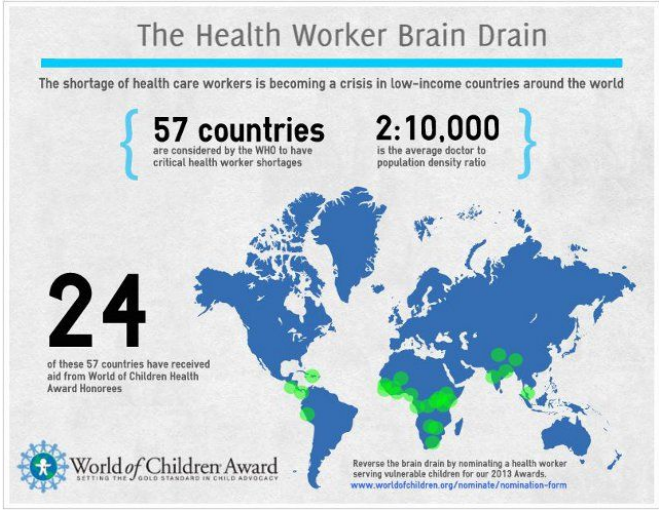
Workforce is also one of the areas where WHO has been most active over the past two decades. The World Health Assembly has adopted the Global Code of Practice on international recruitment (2010), the Workforce 2030 strategy (2016), and several resolutions on protecting and investing in health workers (2021, 2022, and 2025). WHO's Secretariat collects country data through the National Health Workforce Accounts, publishes reports such as *State of the World's Nursing* 2025, maintains the Health Workforce Support and Safeguards List, and helps governments plan how many workers to train and hire. A 34-member Executive Board prepares the Assembly's agenda and follows up on its decisions.

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Topic at a Glance

Every health system runs on people. Hospitals and clinics can be built and medicines can be shipped, but without a nurse to give the injection, a midwife to attend the birth, or a doctor to read the scan, none of it helps the patient. Right now there are not enough of these people, and they are not where they are needed most.

WHO estimates that the world will be short by about 11 million health workers by 2030. That is a little worse than the 10 million figure it gave in 2022, which means progress has slowed. Most of the missing workers are in low- and lower-middle-income countries, especially in Africa, South-East Asia, and the Eastern Mediterranean. Wealthy countries have shortages too, but they can often fill them by hiring from abroad, which pulls trained people away from places that can least afford to lose them.



There is no single cause. Countries do not train enough people. Trained people are paid poorly, work in unsafe or overworked conditions, and leave. Workers cluster in cities and avoid rural areas. Governments cannot always afford to hire the graduates they do produce. And recent cuts to international health aid have made the money problem worse.

This committee has to find workable responses to a problem where nearly every solution has a cost for someone. Training more workers takes years and money. Limiting recruitment protects poorer countries but may limit the freedom of individual workers, who have every right to look for a better life. Paying more means higher health budgets. Delegates will need to think about what their own country has to gain or lose, and then look for common ground anyway.

The world has already tried some responses, but most of them are voluntary. WHO's Global Code of Practice on international recruitment (2010) and its Support and Safeguards List of 55 countries ask wealthy countries not to actively recruit from the places with the biggest gaps. Neither is legally binding, and many countries do not report on how they use them. Delegates will have to decide whether to strengthen these tools, replace them, or focus on other approaches, such as better pay, community health workers, and new sources of funding.

Key terms:

These are some terms you will probably hear a lot, so get familiar with them!

Brain drain: when skilled people leave a country, often for better pay or conditions somewhere else

Task-sharing: letting less specialized workers (with the proper supervision) take on duties that usually require a more highly trained person

Community health worker (CHW): a trained local resident who provides standard care, education, and referrals in their own community

Circular migration: a pattern where workers move abroad for a period and then return home with new skills rather than leaving for good

Absorptive capacity: a country's ability to actually hire and pay the workers it trains

Shortage/shortfall: the gap between the number of healthcare workers in a country and the number it needs to give people sufficient coverage (WHO's 11 million figure is an estimate for 2030 and not a measure of today's gap)

Why this matters right now

WHO's estimation of the number of health professionals has gone up from 10 million to 11 million between its 2022 and 2025 estimations. The trend of reduction in shortage estimates in previous years was alarming to many Member States.

There is increased competition for workers among developed countries. Population aging in Europe, North America, East Asia, and the Gulf region means growing demand for caregivers and nurses. Also, several developed nations opened up visa pathways for health workers in recent years.

The African continent began to respond to the issue of health worker shortage. African leaders adopted the Africa Health Workforce Investment Charter in 2024 and the second investment forum on health workers was held in Accra, Ghana in May 2026.

Technology poses a new set of problems. Telemedicine, electronic records, and AI solutions are being examined as ways to make less go farther. These can certainly be helpful, but they also require power, internet access, and training, which are precisely what areas with shortages lack.

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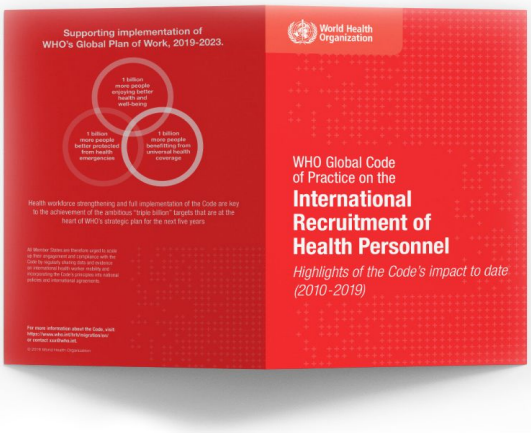


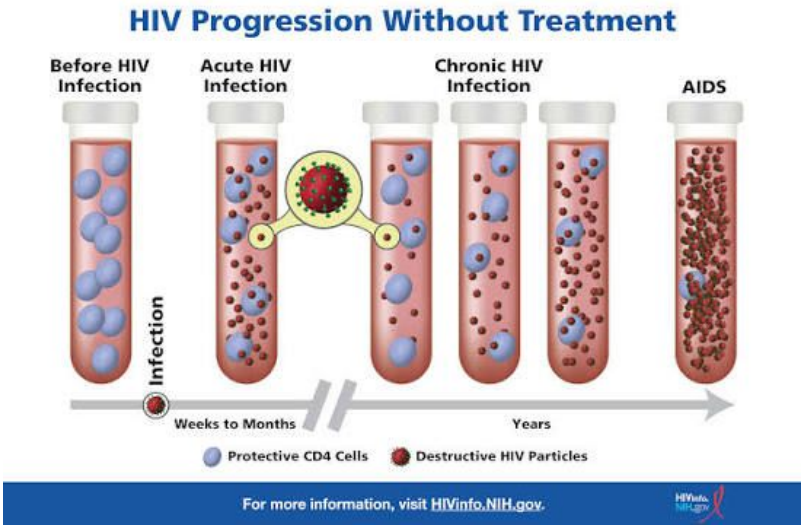
History of the Issue

Early warnings (1970s to 2005): The idea that health systems depend on enough trained people is old. In 1978, countries at the Alma-Ata conference declared that primary health care, meaning basic care close to where people live, should be the foundation of every health system. That vision relied heavily on community-level workers. Over the next decades, however, many poorer countries were forced to cut public spending during economic crises and debt negotiations, which shrank health budgets and discouraged hiring. By the 1990s and early 2000s, the HIV epidemic was overwhelming health workers in sub-Saharan Africa, and many countries had too few staff to deliver the new treatments that finally became available.

The 2006 World Health Report: WHO's 2006 World Health Report, titled *Working Together for Health*, was the moment the world began paying serious attention. It identified 57 countries with a critical shortage of health workers, using a rough benchmark of 2.3 doctors, nurses, and midwives per 1,000 people. It also launched a decade of action on the issue, and the Global Health Workforce Alliance, a partnership hosted by WHO, was created to keep up momentum.

The Global Code of Practice (2010): By the late 2000s, health worker migration was a major source of tension. In May 2010, the World Health Assembly adopted the WHO *Global Code of Practice on the International Recruitment of Health Personnel* (resolution WHA63.16). It is explained in detail later in this guide because it remains the main international agreement on this topic.

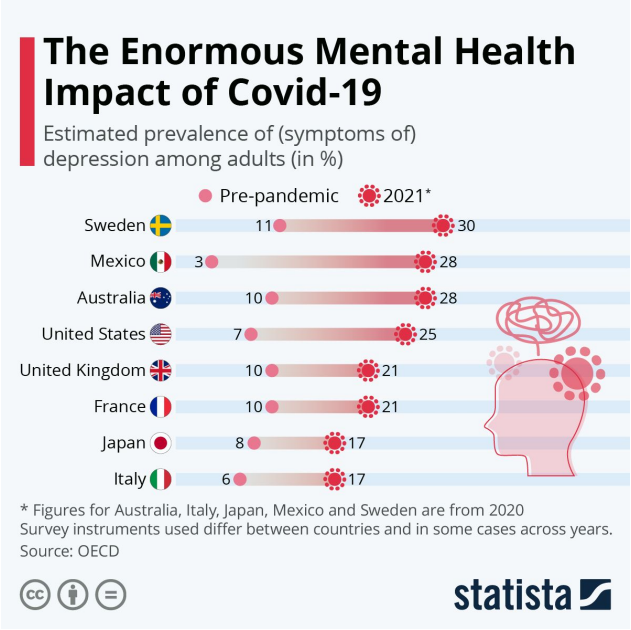




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History of the Issue Continued

Workforce 2030 and the jobs argument (2016): In 2016 the Assembly adopted the *Global Strategy on Human Resources for Health: Workforce 2030* (WHA69.19). It set targets for countries and warned of a possible 18 million worker shortage by 2030 if nothing changed. In the same year, a UN High-Level Commission on Health Employment and Economic Growth argued that health jobs were not just a cost but an investment, one that could create millions of new jobs, especially for women and young people. This framing helped shift some conversations from "we cannot afford more health workers" to "we cannot afford not to hire them."



COVID-19 and its aftermath (2020 to 2022): The pandemic exposed how thin many health systems were. It also showed that health workers themselves needed protection, from adequate protective equipment to mental health support. In 2021 the Assembly passed resolution WHA74.14 on protecting and investing in the health and care workforce. The following year, resolution WHA75.17 endorsed the *Working for Health Action Plan 2022 to 2030* and the *Global Health and Care Worker Compact*, a set of voluntary commitments to protect workers' rights, safety, and fair pay.

Recent steps (2023 to 2026): In 2023, WHO updated its Health Workforce Support and Safeguards List. In May 2025, the 78th World Health Assembly adopted resolution WHA78.16, *Accelerating action on the global health and care workforce by* 2030, and also adopted the Pandemic Agreement, which includes an article on the health and care workforce. WHO released its *State of the World's Nursing* 2025 report the same month. A group of independent experts has also been reviewing whether the Global Code still works well, and the Assembly returned to the Code in 2026 (resolution WHA79.12). Delegates should read the exact text of that resolution and any related decisions before building their positions.

Topic Background

How big is the gap?

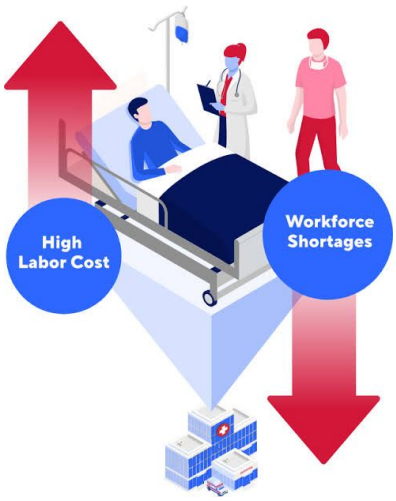
WHO's latest numbers show that there are now more than 70 million health workers in the world. That is a lot, but the total hides huge differences between regions. Nursing is a good example. WHO's *State of the World's Nursing 2025* report found about 30 million nurses worldwide and a shortage of roughly 5.8 million in 2023, which it expects to shrink to around 4.1 million by 2030. That sounds like good news, and in some ways it is. But nearly 80 percent of the world's nurses work in countries that hold only about half of the world's population. The shortage is mostly a problem of where people are, and who can afford them.

The countries with the thinnest workforces are often the ones with the heaviest disease burdens, such as high rates of maternal deaths, malaria, HIV, and tuberculosis. It is a severe disparity because the places with the most health problems have the fewest people to treat them. To put numbers on it, WHO's priority list for support (described below) uses a cutoff of 49 doctors, nurses, and midwives per 10,000 people. Many countries on that list sit far below it.

Why are there not enough workers?

1. Too little training. There are simply not enough medical and nursing schools, teachers, and clinics where students get practical experience in many countries. To train a physician, it takes about ten years. A country which decides to address the problem today is still going to feel its effects for several years to come.

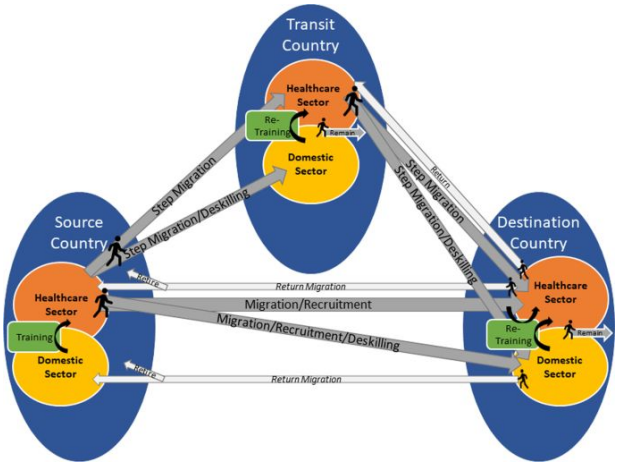
2. Not enough jobs, or jobs that are not good enough. This comes as a surprise to many. In some countries, nurses are trained, but the country cannot afford to employ them, leaving them jobless or forcing them to migrate. They are paid so poorly that they leave because of the lack of equipment and other safety measures. The long working hours, violence against health professionals, and burnout lead to migration from the field. The pandemic has worsened the situation tremendously. According to WHO, around 115,000 health professionals died in service during January 2020-May 2021.

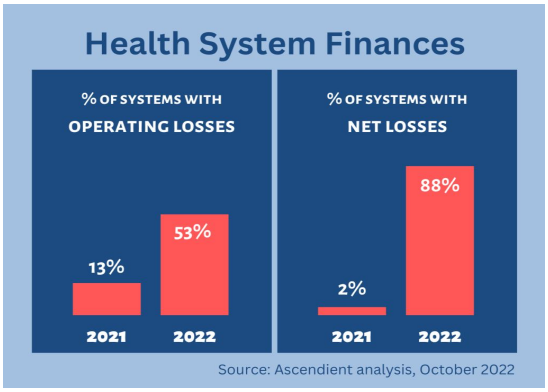


Topic Background

3. Uneven distribution within countries. Within a nation that seems to have enough laborers, most of them could actually be concentrated within the capital city itself. Rural areas, regions prone to conflict, and even slums are neglected. Laborers prefer urban settings due to the superior education system in place for their children, better living conditions, and extra income.

4. Migration. Individuals have the freedom to migrate for employment, and some of these people include health professionals. The issue arises when the movement becomes massive in scale. The wealthy nations that include the USA, UK, Canada, Germany, Australia, along with other Gulf nations depend on foreign-trained doctors and nurses. When these countries recruit from nations where there are already shortages of health professionals, then the losses cannot easily be made up. It is possible for one nation to train a nurse using years and public money only for her/him to practice abroad.





5. Money. Health budgets in many low-income countries are small and often depend on foreign aid. When aid goes down, hiring and salaries are among the first things to be hit.

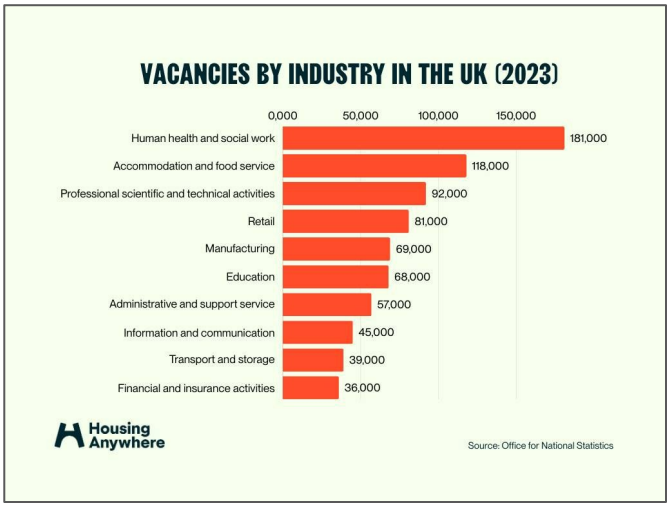
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Examples of Case Studies

Case 1: The Philippines, a country that trains for the world

The Philippines is among the biggest producers of nurses in the international labor market. Nursing studies and employment abroad have been promoted by the government for decades, and remittances of migrant workers make up a substantial share of the gross domestic product of the country. Filipino nurses can be seen in hospitals throughout the United States, the UK, the Gulf, and other countries. However, the country is the worst-end of the stick. It becomes problematic for any Philippine hospitals, particularly the rural and poorer parts, to retain nurses with experience, and even a limitation on the number of nurses allowed to leave has been discussed by the government. The Philippines proves that migration may be the tool of national strategy and still cause the problem of lack of workers domestically.



Case 2: The United Kingdom and the "red list"

Recruitment of foreign-trained medical personnel has been one of the main features of the National Health Service of the UK for quite some time now. After the WHO came up with the Support and Safeguards List, the UK developed a national code of practice based on it. Countries listed on it have a “red” status that implies that approved recruiting agencies within the UK should avoid active recruitment from such countries even though individuals from these countries are free to apply independently. This is an excellent example of how an optional WHO list could become the basis for national policy. However, many questions come up. Does it benefit the source countries, or does it simply shift recruitment elsewhere?

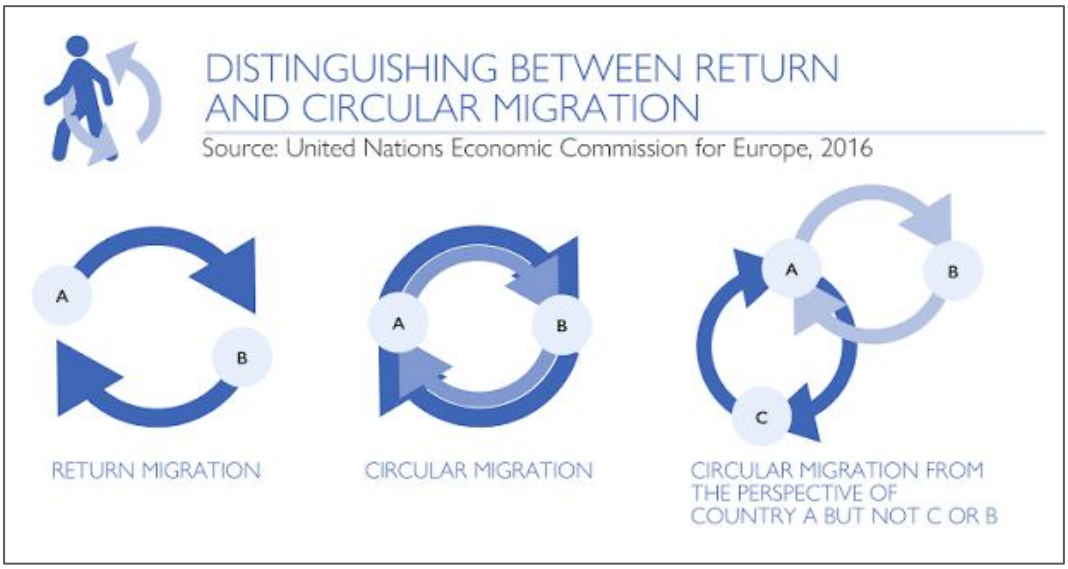


Past International Actions

The WHO Global Code of Practice on International Recruitment (2010): This is the key document for the migration part of the topic. The Code is voluntary. It does not ban health worker migration, and it says health workers have the right to move and that migration can benefit both individuals and countries. Further, it sets out principles for doing recruitment fairly. Among other things, it:

- discourages countries from actively recruiting health workers from places with serious shortages;
- calls for migrant health workers to be treated fairly and equally with local workers, including in pay and working conditions;
- encourages countries to train and keep enough of their own workers;
- supports ideas like circular migration, where workers return home with new skills;
- asks countries to share data and report to WHO regularly on how they use the Code.

The Code has had mixed results. Many countries say it has made them more aware of the problem. But it has weak enforcement, and reporting is uneven. A WHO report to its Executive Board found that only 16 of the 55 countries on its priority list for support (about 29 percent) sent in a report in one recent round, even though a record 105 countries reported overall in the most recent round. Critics say a voluntary code is too soft when national hospitals are desperate for staff. Supporters say it still gives poorer countries a document they can point to in negotiations.



Past International Actions Continued

The Support and Safeguards List (2020, updated 2023): To make the Code more targeted, WHO created a list of countries facing the most urgent workforce challenges. The 2023 version has 55 countries. To be on it, a country must have fewer than 49 doctors, nurses, and midwives per 10,000 people and a UHC service coverage index below 55. WHO asks other countries to avoid actively recruiting from those on the list, and to give them support instead. The list is not legally binding, and it does not stop an individual worker from applying for a job abroad on their own. Some destination countries, including the United Kingdom, have used the list to build their own "red lists" that stop official recruitment agencies from targeting those countries.

Global strategies and action plans: Workforce 2030 (2016) and the Working for Health Action Plan (2022 to 2030) are the main roadmaps. They ask countries to plan their workforce based on data, to invest in education, to improve working conditions, and to create jobs where they are most needed. WHO also runs the *National Health Workforce Accounts*, a system that helps countries collect and report workforce data, and the *Working for Health Multi-Partner Trust Fund*, which pools donor money for workforce projects.

Regional efforts: Several regions have taken their own steps. African leaders signed the Africa Health Workforce Investment Charter in 2024. The European Union and others have supported training partnerships with African and Asian countries. A growing number of bilateral agreements, such as those some European countries have signed with source countries like the Philippines and Kenya, try to mix recruitment with investment in the source country's training system. As delegates, attempt to look up whether these deals are working as promised.



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Key Stakeholders

Source Countries

Countries that train many workers who then leave, such as the Philippines, India, Nigeria, Ghana, Zimbabwe, and Pakistan. Their positions are mixed. They worry about losing talent, but many also earn significant income from workers' remittances and see migration as an opportunity, not only a loss.

Donors and Development Partners

Governments and organizations that fund health programs, including the European Union, the Nordic countries, the Gates Foundation, Gavi, the Global Fund, and the World Bank. Their funding decisions have a large effect on whether workers can be hired and paid.



Destination Countries

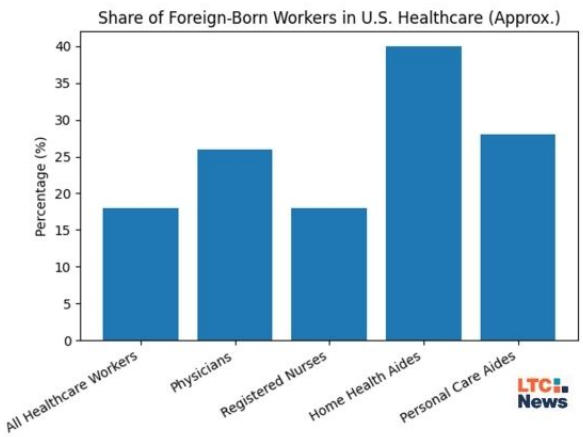
Wealthier countries that recruit workers, including the United States, the United Kingdom, Canada, Australia, Germany, and Gulf states like Saudi Arabia and the United Arab Emirates. They rely on foreign workers to keep hospitals and care homes running, and they worry about their own aging populations.

Countries with Limited Resources

Many are in sub-Saharan Africa and parts of South Asia. They have the greatest needs and the fewest options, and they mostly want money, training support, and respect for the Code.

Private Companies and Recruitment Agencies

Agencies that arrange overseas jobs for health workers can help workers find opportunities, but some have been criticized for charging high fees or misleading recruits. WHO has noted that private recruiters are an important and hard-to-track part of the pictu



QUESTIONS TO CONSIDER

- Is your country mostly a sender, a receiver, or both? How does that change your priorities as a delegate?
- Should the WHO Global Code remain voluntary, or should it become more stringent? If more stringent, how would this be enforced, and who would be in charge of it?
- How should the Support and Safeguards List be used? Should it be expanded or made more frequent and binding?
- How can countries respect individual workers' right to move while also protecting health systems that are already struggling?
- If wealthy countries recruit trained workers from poorer ones, do they owe something in return? What could reimbursement look like? Money, training support, or something else?
- How can WHO help countries pay for more health workers when budgets are tight and aid is declining?
- Which approach is more feasible for your country in the short term: training more workers, keeping the ones you have, or utilizing community health workers better?
- What role should private recruitment agencies, hospitals, and professional associations play, and how should they be held accountable?
- How can technology help, and what are its limits in places without reliable electricity or internet?
- How should the committee address health workers in conflict zones and other emergencies?
- Since WHO recommendations are not binding, what would make countries actually follow whatever this committee agrees on?

You do not need to answer all of these in your position paper. Use them as starting points for research and for building your country's approach.

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