

Healthcare AI governance gap

Only 8 percent of 50 surveyed countries reported a dedicated health AI strategy

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Independent evidence briefing and policy recommendations

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Media summary

Governments should demonstrate how their AI policies protect patients inside hospitals, says Professor Ameer Khalid Abdul-Hamid in this evidence briefing. The central concern is whether accountability, local testing and continuing supervision are keeping pace with clinical adoption.

WHO findings provide a striking illustration. In a survey of 50 countries in the WHO European Region, 64% reported using AI-assisted diagnostics, while just 8% reported a dedicated national health AI strategy. Separately, only 8% reported AI liability standards or guidance on applying existing liability standards. These findings describe the survey period, June 2024 to March 2025; they are not a worldwide census. [1,2]

The urgency remained visible in July 2026, when WHO's Regional Director for Europe highlighted limited workforce preparation: only one in five countries provided AI education before health professionals qualified, and one in four offered training during employment. [3]

This briefing calls for public reporting of hospital readiness, including named decision-makers, validation in the intended population, incident reporting and authority to suspend unsafe systems. These are the author's policy recommendations, rather than a new country ranking.

Quotation for media use

"Publishing an AI policy is only the beginning. Patients need to know that the AI used in their care has been properly tested, is being monitored and, crucially, that someone has the authority to act when something goes wrong."

The question for governments

Can a hospital demonstrate that every high-risk clinical AI system has an accountable owner and a working safety process throughout its use? A policy document alone cannot answer that question.

Verified statistics for editors

All figures below refer to the 50 responding countries in the WHO European Region and the 2024–2025 survey. Percentages describe countries reporting an indicator, not hospitals, patients or population coverage. [1,2]

Reported indicator	Countries	Share	Source
Cross-sector national AI strategy	33 / 50	66%	[1]
AI-assisted diagnostics in use	32 / 50	64%	[2]
AI chatbots for patient engagement	25 / 50	50%	[2]
Dedicated national health AI strategy	4 / 50	8%	[1]
Dedicated health AI strategy being developed	7 / 50	14%	[1]
AI liability standards or guidance on existing standards	4 / 50	8%	[1]
Government agency monitoring AI use in healthcare	12 / 50	24%	[1]
Policies addressing AI-related complaints	5 / 50	10%	[1]
Legal uncertainty identified as an adoption barrier	43 / 50	86%	[2]

What the numbers establish

The reported prevalence of AI diagnostics exceeded that of dedicated health AI strategies by 56 percentage points, calculated as 64 minus 8. This is a comparison between two indicators across the surveyed countries. It does not establish that any particular diagnostic tool was unsafe, or that the countries reporting the two 8% indicators were identical.

A dedicated strategy is one component of governance. Its absence does not establish the absence of medical-device regulation, privacy law, professional duties or hospital safeguards. Equally, its presence does not prove that these safeguards work in practice.

A wider view without a global percentage

WHO's April 2026 EU briefing, using the same collection period, reported AI diagnostics in 74% of the 27 EU countries and patient chatbots in 63%. These are a subset of the regional evidence, not an independent survey to combine with it. [4]

How governance should reach the patient

I propose that health ministries and hospital boards assess clinical AI through eight operational requirements. This framework is intended to guide implementation and public reporting. It is not a validated international scoring system.

- 1 Assign responsibility.** Identify the national oversight body, hospital committee and named clinical owner. Define responsibilities for clinicians, management and suppliers, including escalation when they disagree.
- 2 Classify the intended use and risk.** Assess the consequences of an incorrect output, the degree of autonomy and the clinical setting. Record what the system is permitted to do and what requires clinician review.
- 3 Validate in the intended setting.** Assess performance using relevant local patients, languages, equipment and workflows before routine deployment. Examine clinically meaningful errors and subgroup performance. Sample size should follow the intended use and statistical justification, rather than a universal patient number.
- 4 Protect clinical judgement.** Train staff to interpret limitations, question recommendations and override outputs when clinically justified. Include the risk of missing a diagnosis because the system produced no warning. Maintain a usable alternative when AI is unavailable.
- 5 Monitor after deployment.** Set performance thresholds, review intervals and responsibilities for investigating deterioration. Record software versions, significant updates and the evidence supporting continued use.
- 6 Make harm reportable.** Provide routes for staff and patients to report suspected AI-related harm. Define investigation, disclosure and redress processes, with appropriate legal advice about liability and existing professional obligations.
- 7 Give someone authority to stop use.** Establish who can suspend a system, what triggers suspension, how clinical services continue and what evidence is needed before restarting. These decisions should be documented and auditable.
- 8 Secure data and procurement.** Review privacy, access controls, cybersecurity and supplier obligations. Require contracts to support audit, incident notification, change management and appropriate access to performance evidence.

A practical first 90 days

During the first 30 days, a hospital should inventory its clinical AI tools and assign owners. Over the next 30 days, it should review the highest-risk tools for validation evidence, staff competence and incident pathways. By day 90, it should test suspension and service-continuity procedures and report unresolved gaps to its board. This timetable is a proposed implementation approach, not a WHO requirement.

For Saudi Arabia and other Arab health systems, I recommend particular attention to Arabic language performance, population diversity and equipment differences. Leadership can be demonstrated through transparent evidence that safeguards operate at the bedside, alongside national policy commitments.

Scope and interpretation

This is an independent synthesis of published evidence with author recommendations. It presents no original survey, institutional endorsement or audited global country ranking. Evidence was checked on 3 October 2026. The principal dataset was collected between June 2024 and March 2025; later publications and statements should not be described as new 2026 measurements of those indicators.

The WHO European Region includes 53 Member States and extends beyond the European Union and geographic Europe. Fifty countries responded. National reports can reflect differences in interpretation and knowledge of existing arrangements. The survey measures reported structures and practices; it does not audit every hospital or establish clinical safety outcomes. [1]

These regional percentages must not be presented as percentages of the world. The evidence assembled here does not establish how many countries worldwide have comprehensive, operational healthcare AI governance. A defensible worldwide count would require a published definition, a complete country assessment and transparent treatment of missing data.

International cooperation

HealthAI's Global Regulatory Network records Portugal as its tenth member in July 2026, following countries including the United Kingdom, Singapore and India. Membership describes participation in a regulatory collaboration; it is not proof of complete national governance and cannot be used to count all adequately governed countries worldwide. [5]

Primary sources

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[3] WHO Europe. Statement by Dr Hans Henri P Kluge. Govern AI in health before the gaps become irreversible. 15 July 2026.

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[5] HealthAI. Global Regulatory Network member directory. Accessed 3 October 2026.

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