



Aid in Reverse: The UK's responsibility to address the health workforce crisis

If the situation remains as it is today, one billion people world-wide will never see a health worker.¹

Health workers are essential for healthcare. Their absence threatens the health of individuals and populations, destabilises health systems, and deepens existing global health inequalities. Africa has 24% of the global disease burden yet only 3% of the world's health workers to fight it.²

In 57 countries the World Health Organization (WHO) has labelled the health worker shortage *critical*.³ The scarcity of health workers constitutes a major barrier to the provision of essential health services, such as safe delivery, childhood immunisation and the prevention and treatment of HIV/AIDS.⁴

The migration of health workers has had devastating effects on health across Africa. Health centres can't open, vaccines can't be administered and people are denied basic care. Let's be clear: people die due to this health worker crisis. Countries that rely on African health workers must acknowledge the impact of their actions.

DR TADESSE KASSAYE WOLDETSADIK
Horn of Africa Area Programme
Manager, Health Poverty Action





Photo: © Health Poverty Action

The causes

Causes of the health worker crisis include the insufficient supply and training of health workers; their inadequate distribution, with rural and remote locations often the worst affected; inefficient utilisation,ⁱ and migration. Migration increases the unequal distribution of health personnel globally, weakens health systems, restricts development and amplifies global health inequalities.

The potential loss of human capital from sub-Saharan Africa alone as a result of this 'brain drain' is estimated as high as several billion US\$.⁵

Health workers migrate for a number of reasons. There are the key 'push factors' in source countries: challenging working environments, lack of infrastructure and training opportunities, long hours and low wages, and 'pull factors' in destination countries, which include the prospect of better remuneration and living conditions.⁶ Faced with the ongoing strain of weak health systems, poor equipment, long working hours and low pay, it is hardly surprising that health workers often choose to migrate, exacerbating the struggle of their remaining colleagues. **Some wealthy countries have exploited this, by relying on internationally trained health workers to provide domestic health care and actively recruiting health workers from countries with weak health systems.**

Mozambique is facing a huge lack of health workers on all levels, which is one of the main barriers to accessing healthcare.

DR REZIQUE UAIDE

**Director, Tete Health Training School
speaking to Action for Global Healthⁱⁱ**

The UK's role in the crisis

Between the late 1990s and the mid 2000s, the Department of Health actively recruited international health workers to fill shortages in the NHS. This peaked in 2003ⁱⁱⁱ and then dropped again. Despite this decline in new registrations in recent years, the UK remains one of the largest destination countries for migrant health workers.⁷ More than 30% of all doctors and 10% of all nurses in the UK are internationally-trained⁸ and twice as many gained their Primary Medical Qualification (PMQ) from a country outside the European Economic Area (EEA).⁹

Furthermore, the UK's cyclic 'boom and bust' approach to recruitment – actively recruiting to fill shortages and tightening restrictions at other times – has led to its own set of problems, as it has for other countries that have encouraged temporary migration of health workers as part of their own national development plans.¹⁰

- i. One often cited example are the Philippines, where inadequate health workforce planning, combined with scarce domestic job opportunities and the promotion of temporary migration has contributed to a cyclic oversupply of nurses, despite a failure to address domestic health needs (Lorenzo et al., 2007; Cheng, 2009; The Guardian, 2011; University of the Philippines, 2012).
- ii. In Tete province, Mozambique there are 63 medical doctors serving a population of 2 million people.
- iii. Although data from the UK General Medical Council (GMC) suggest that new full-time registrations of internationally-trained doctors peaked in 2003, it has been suggested that – rather than representing an actual spike in new registrations – this is an artefact resulting from changes to registration procedures (Buchan et al., 2009).

Donor countries may be saving more money by employing migrant health workers than they contribute to the workers' home countries in the form of aid. It is in fact, aid in reverse.

How is the UK addressing this?

In 2001, the UK launched a Code of Practice for international recruitment for NHS employers,¹¹ the first Code of its kind on a country-level. By adhering to the Code, employers pledged to refrain from active recruitment of health professionals from the Global South, unless there is a bilateral agreement in place.

The Code also sets out guidelines for international recruitment, covering aspects of recruitment, selection, induction and equal opportunities in employment, pay and career prospects.¹² In 2004, the Code of Practice was strengthened to extend to recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector organisations that provide services directly to the NHS.¹³ The UK has also signed a number of bilateral cooperation agreements with source countries.¹⁴

As a member state of the World Health Organization (WHO), the UK has also adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel at the 63rd World Health Assembly in May 2010 (WHO, 2010). The Code covers not just migration, but the rights of migrant health workers and the responsibility of donor countries to provide financial and technical assistance to countries of the Global South aimed at strengthening health systems.

Is this working?

A major drawback in the UK Code is the fact that it excludes the private sector (with the exception of those supplying the NHS) and health workers initially recruited for the private sector may later end up working in the NHS via this route. Further, several publications have concluded that the UK's decline in newly registered health workers over the last decade is not predominately due to recruitment codes of practice, but to declining demand and more stringent registration conditions and changes to visa and employment requirements.¹⁵

Whilst the WHO Code is an important step, it is voluntary, and despite calls from some source country member states during its negotiation, it does not address the need for wealthy countries benefiting from internationally trained health workers to compensate source countries for their loss.

Aid in Reverse

It has been argued that the money saved by the UK government through the employment of migrant health workers might in some cases exceed the amount of development assistance for health paid by the UK to the source countries of these workers.¹⁶ This is key. Attempts to address the health worker crisis will fail if we do not address the paradox at the heart of this problem: Donor countries may be saving more money by employing migrant health workers than they contribute to the workers' home countries in the form of aid. It is in fact, aid in reverse.

What needs to happen?

The UK, like all countries that have benefited from the international recruitment of health workers, needs to remember its debt. It needs to tighten up its own Code to cover the whole of the private sector and fully implement the WHO Code. It must do more to protect the rights of migrant health workers, extend bilateral agreements and memoranda of understanding, support programmes that encourage circular migration and compensate source countries through robust financial compensation and technical assistance to strengthen health systems.

Example from Ghana

Over half of Ghana's health workers have migrated. Using salary estimates, in 2004 the annual value of Ghanaian health workers to UK health service users was estimated at £39 million. That same year UK aid to Ghana was £65 million. Whilst the proportion spent on health is not available, it is likely that savings to the UK health services was greater than UK aid given to Ghana for health.

Mensah K, Mackintosh M, Henry L, 2005. *The 'Skills Drain' of Health Professionals from the Developing World: a Framework for Policy Formulation*, Medact.

“I am lucky the TBA referred me to Abdaal! We received treatment at no cost. Many women have not been lucky at childbirth.”

AMINA SAED, SOMALILAND

In Somaliland, maternal mortality is among the highest in the world. Of every 1,000 children born, 72 die within the first month of life.¹⁷ Prior to Health Poverty Action's DFID funded programme the Abdaal referral health centre to which Amina was taken when her baby was in distress during labour had minimal facilities, no paid staff and was only open 2 to 3 hours a day. Berbera hospital, where she received an emergency caesarean, previously only provided these irregularly due to poor availability of staff and supplies. Thankfully, due to a scheme to provide transport and train and incentivise health workers, Amina's story is a happy one. She received the operation that most likely saved her and her baby's life. Two years ago, her story – like that of many women – would have been very different.

Who we are

Health Poverty Action (www.healthpovertyaction.org) works to strengthen poor and marginalised people in their struggle for health. We are the UK partner of the project *Health workers for all and all for health workers*, a European civil society initiative that contributes to a sustainable health workforce worldwide. In collaboration with organisations in Belgium, the UK, Italy, Germany, Poland, Romania, Spain and the Netherlands, and with the support of health workers, we call upon politicians and policymakers to take urgent action to address the health workforce crisis.

www.healthworkers4all.eu

The project is funded by the European Union.

Contact n.sharples@healthpovertyaction.org

This briefing was written by Health Poverty Action based on research by Nele Jensen. Health Poverty Action is grateful for contributions from Action for Global Health, RESULTS and VSO.

References

1. WHO, (2010) Increasing access to health workers in remote and rural areas through improved retention. Global Policy Recommendations
2. WHO, 2006, *World Health Report 2006 – Working Together for Health*, WHO, xix
3. Ibid., P220
4. Ibid.,: xv
5. Mensah K., Mackintosh M., Henry L, 2005. *The 'Skills Drain' of Health Professionals from the Developing World: a Framework for Policy Formulation*, Medact; Mills E.J et al, 2011. The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis. *BMJ*. 2011 Nov 23;343:d7031
6. WHO, 2006, *World Health Report 2006 – Working Together for Health* [online] WHO, P99

7. Wismar M., et al. 2011. *Health Professional Mobility and Health Systems. Evidence from 17 European countries*. WHO Europe.
8. GMC, 2013. *List of Registered Medical Practitioners – statistics* [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [accessed March 15 2013]; NMC, 2013, personal communication
9. GMC, 2013. *List of Registered Medical Practitioners – statistics* [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [accessed March 15 2013]
10. The Guardian, 2011. *Nursing dream fades for Filipinos as UK jobs dry up* [online] The Guardian. Available at <http://www.guardian.co.uk/world/2011/feb/23/nursing-dream-filipinos-uk-jobs> [accessed March 19 2013]; Cheng M.H., 2009. *The Philippines' health worker exodus*. *The Lancet* 2009 Jan 10;373(9658):111-2.
11. Department of Health, 2001. *Code of Practice for NHS Employers Involved in International Recruitment of Healthcare Professionals*, DoH.
12. Department of Health, 2001. *Code of Practice for NHS Employers Involved in International Recruitment of Healthcare Professionals*, DoH; Buchan J et al, 2009. *Does a code make a difference? Assessing the English code of practice on international recruitment*. *Human Resources for Health* 7:33.
13. Ibid
14. Dussault G, et al. 2012, *Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel in the European Region* [online] WHO Regional Office for Europe, P14
15. Buchan et al. 2009. *Does a code make a difference? Assessing the English code of practice on international recruitment*. *Human Resources for Health* 7:33; Blacklock et al., 2012, *Effect of UK policy on medical migration: a time series analysis of physician registration data*. *Human Resources for Health*. 2012 Sep 25;10(1):35; GMC, 2012. *The state of medical education and practice in the UK*, UK GMC.
16. Mackintosh et al., 2006, *Aid, restitution and international fiscal redistribution in health care: implications of health professionals' migration*. *Journal of International Development* 18(6), pp. 757–770.
17. UNICEF, 2011, Somaliland, preliminary results Multi-Indicator Study (MICS), P2.

Cover photo: © Eric Miller Design: www.revangeldesigns.co.uk



This leaflet has been produced in the framework of the project 'Health Workers for all and all for Health Workers' DCI-NSAED/2011/106, with the financial assistance of the European Union. The contents of this leaflet are the sole responsibility of the project partners and can under no circumstances be regarded as reflecting the position of the European Union.