Briefing

Reports of the International Development Committee: Strengthening Health Systems in Developing Countries and Recovery and Development in Sierra Leone and Liberia. House of Commons debate, 11 December 2014.

The reports by the International Development Committee into Strengthening Health Systems in Developing Countries and Recovery and Development in Sierra Leone and Liberia are very welcome and raise a number of pertinent issues. Whilst we welcome DFID's overall response to the report on health systems strengthening- in particular its commitment to develop a framework for its work on health systems strengthening - a number of elements would benefit from greater clarity. In particular: the full scope for the development framework, including whether it will address the broader structural determinants of health; what additional actions DFID will take to tackle unacceptable cultural barriers to access to health services; and whether it will provide financial compensation to the health systems of countries who continue to subsidise the UK through their health workers.

Key points

- Through its health workers, Sierra Leone may be providing a subsidy of up to £22.4 million to UK Health services.

- DFID's response to recommendation 10 by the International Development Committee regarding health worker compensation requires further clarity. DFID should clarify whether it intends to provide financial compensation – in addition to aid - to low income countries whose health systems are subsidising UK health services. It should also conduct research into the possibility of a global compensation mechanism for countries that have suffered as a result of international recruitment.

- DFID should reinstate its bilateral budget for Sierra Leone to equal that of 2013-2014, in line with the recommendation from the International Development Committee.

- We welcome DFID's acknowledgement that tackling inequalities in access to health for the poorest and most marginalised, including women and girls, disabled people and ethnic minorities is vital. We would welcome greater clarity on whether there is additional actions it will take at the international level to tackle unacceptable cultural barriers to access to health services. In particular it should set out whether it will champion the disaggregation of data by ethnicity throughout the post 2015 framework.

- DFID's commitment to develop a framework for its work on health systems strengthening - outlined in its response to the Committee's report on health system strengthening - is very welcome. We call on DFID to provide greater details on the scope of this framework and the timeframe for its development. The impact that that polices across HMG have on poverty and health requires a robust, cross government approach to development. This must address both the social determinants of poor health - such as water and sanitation, nutrition, gender based violence, discrimination and poverty in addition to the structural determinants – inequitable distribution of power, money, and resources. This includes addressing the actions of British companies overseas, dealing with the impacts of the UK's international policies such as those on illicit drugs, and reforming the global tax architecture.

Health workers

The shortage of health workers in Sierra Leone is an instrumental barrier to an effective health system. In 2010 Sierra Leone had 136 doctors for a population of just over 6 million, or one doctor for approximately every 50,000 people.i It is in the bottom 10 countries for overall health worker density.ii As of November 12 2014 over 100 health workers, including five doctors have died from Ebola.

As aknowldeged by the International Development Committee, Sierra Leone's health workforce is actually subsidising the NHS. Sierra Leone is one of five African countries with an expatriation rate of over 50%[iii] meaning that more than half the doctors born in Sierra Leone are now working in countries of the OECD. Despite having only 136 doctors and 1,017 nurses in 2010, a further 27 doctors trained in Sierra Leone are currently in the UK.[iv] The data does not record the level at which they are working. It costs the NHS £269,527 to train a junior Doctor (Foundation 1). If we assume were to assume all 27 are junior doctors this would represent a subsidy of 7.3 million to UK health services. However if those doctors are working as GPs that figure would be £13.5 million and consultants it would almost double to £15.2 million.[v]

As the Committe notes, the UK Nursery and Midwifery Council register lists 103 nurses that were trained in Sierra Leone.[vi] It costs £70,000 to train a nurse in the UK[iii] - a contribution of £7.2 million to UK health services. Altogether this suggests the subsidy Sierra Leone is providing to UK health services could be up to £22.4 million.

The right to migrate is not in question, but it is unacceptable that a country with one of the weakest health systems in the world is subsidising the country with the strongest.[vii] The International Development Committee report on Heath System Strengthening recognised this recommending[1] "*DFID work with the Department of Health to review its approach to the UK recruitment of health workers from overseas. This review should consider options for compensating source country systems."* However, whilst DFID's response to the report outlines opportunites for UK health workers to work overseas through the Health Partnership Scheme (HPS), and the Medical Training Initiative (MTI) to boost the skills of overses doctors when working in the UK its reference to finacial compensation is vague stating *Decisions about any new funding will depend on future budgets and operational plans*."

Whilst, in the case of Sierra Leone, it was the civil war that prompted the migration of many of the country's health workers, between the late 1990s and the mid-2000s, the UK actively[2] recruited international health workers from other low and middle income countries to fill shortages in the National Health Service (NHS). Whilst this has reduced significantly since 2003, 25.6% of doctors currently working in the UK were trained outside of Europe, [viii] meaning that we continue to benefit at the expense of the health systems of some of the world's poorest countries.

The UK must provide financial compensation to Sierra Leone - in addition to aid - to refund their subsidy to our health system. DFID should also conduct research into the possibility of compensation mechanism for countries that have suffered as a result of international recruitment. This should clarify the actors to be compensated; the nature of the loss; the logic and methods of calculating how much is due; and the channels for administrating compensation funds.

Aid to Sierra Leone

The UK has been the lead donor in the Ebola response in Sierra Leone pledging £230 million of additional DFID support, as well as support from the MoD. However the International Development Committee in its report on Sierra Leone and Liberia notes that before the crisis the DFID reduced its 2014-15 bilateral budgets for Sierra Leone by £14.5 million, a cut of 18.6% relative to 2013-14.ix The UK bears a responsibly to Sierra Leone, in particular in relation to its status as a former British colony. In **addition to its humanitarian support, we support the recommendation of the IDC that DFID should reinstate its bilateral budget for Sierra Leone to equal that of 2013-2014.**

1 The full recommendation stated: The staffing of the UK health sector should not be at the expense of health systems in developing countries. We recommend DFID work with the Department of Health to review its approach to the UK recruitment of health workers from overseas. This review should consider options for compensating source country systems, promoting training schemes that involve a temporary stay in the UK, and strengthening local programmes to enable more medical training to take place in country.

2 "Active" recruitment refers to a situation in which an employer takes the lead to stimulate interest and recruit health staff from another country.

Tackling inequalities in access to health

Indigenous peoples and other cultural and ethnic monitories experience some of the worst health outcomes. Indigenous women and those from other cultural and ethnic minorities are more likely to die or face complications related to pregnancy,[x] and maternal and child mortality rates can be twice as high in indigenous communities as the national averages.[xi] For example in Guatemala, the rate of chronic malnutrition among indigenous children under five is approaching twice that of non-Maya children.[1]The estimated maternal mortality rate in 2000 was 153 per 100,000 live births, but the figure for the indigenous population was three times higher than for the non-indigenous population.[2] In Namibia the Human Development Index of the indigenous San people is just one third of the rest of the population.[3] **We are pleased that this has been recognised both by DFID and the IDC. We would welcome further clarify on how DFID will work to remove cultural barriers to health services. In particular it should clarify whether it intends champion the disaggregation of data by ethnicity throughout the post 2015 framework.**

Framework for health systems and a cross government approach to poverty

A range of UK policies and practices have an impact on health and health systems. Those identified by The WHO Commission on the Social Determinants of Health include inequitable trade policies, reversal of capital flows, debt burden, and impact of EU export subsidies.[xii] The framework for its work on health systems strengthening announced by DFID in its response to the IDC report on health systems strengthening is very welcome and provides an important opportunity to ensure action on wider government policies that impact on global health.

The International Development Committee report on Sierra Leone and Liberia notes how the people of Sierra Leone are not benefitting from the country's rich resource wealth. These are resources that have the potential to make a significant contribution to funding the health system. The UK bears some responsibility for this. The largest extractives company operating in Sierra Leone is the British company African minerals, a company linked to numerous human rights violations in Sierra Leone.[xiii]

Sierra Leone is losing significant sums in untapped tax revenue. In 2014, research by the Budget Advocacy Network (BAN) and the National Advocacy Coalition on Extractives (NACE) estimated that in the coming years Sierra Leone will lose $240 million a year as a result of tax incentives from 3 main taxes. Almost all these losses are as a result of tax incentives offered to British companies.[xiv]

Sierra Leone is also loosing further amounts of revenue to illicit financial flows (IFFs) – unrecorded financial outflows which consist of both 'illegal' capital due to corruption, theft and criminality; as well as 'legal' capital driven by tax avoidance and commercial transactions that exploit international trade and fiscal loopholes. In 2011 the figure lost was USD $213 million.[xv] IFFs are facilitated through the global network of tax havens. Whilst this is a global problem, with 10 tax havens under UK jurisdiction[3], we bear a large share of responsibility. The Tax Justice Network's (TJN) authoritative Financial Secrecy Index[xvi] ranks jurisdictions according to their secrecy and the scale of their activities.Whilst the UK is ranked 21 in their 2013 index, TJN notes that if it were to be assessed along with its Crown Dependencies and Overseas Territories it would rank first by a significant margin.[4]

A strictly prohibitionist and militarised approach to global illicit drug policy, driven by the UK and other Northern countries, has also entrenched IFFs related to the drug trade by ensuring that the trade remains risky and profitable. In addition, such policies have pushed the drug trade into countries less equipped to enforce drug policies or deal with the impacts of the drug trade and of the militarised "War on Drugs". These countries include Sierra Leone, which the UN Office on Drugs and Crime calls "one of the major gateways in West Africa for cocaine trafficking". Some governments are under pressure to devote resources to strengthening its law enforcement capabilities as a result of global drug policies, even though health and basic services are significantly underfunded.

[3] Some also consider the City of London Corporation to constitute a tax haven.

[4] TJN describe this as follows: If the Global Scale Weights of just the OTs [Overeas Territories] and CDs [Xrown Dependencies] were added together (24% of global total), and then combined either with their average secrecy score of 70 or their lowest common denominator score of 80 (Bermuda), the United Kingdom with its satellite secrecy jurisdictions would be ranked first in the FSI by a large margin with a FSI score of 2162 or 3170, respectively (compared to 1765 for Switzerland). Note that this list excludes many British Commonwealth Realms where the Queen remains their head of state. http://www.financialsecrecyindex.com/introduction/fsi-2013-results (Accessed 26/05/2014)

Around the world, strictly prohibitionist illicit drug policies have profound impacts on health, including blocking Southern countries' access to legal pain relief medication over fears that it may be diverted to the illicit market.

DFID's commitment to develop a framework for its work on health systems strengthening is very welcome. It should provide greater clarity on the scope of this framework and the timeframe for its development.

DFID must make the case for the ways in which the UK policies across HMG - including but not limited to tax, climate change, trade, and illicit drugs - impact on poverty and development.

In particular it must ensure that the framework for its work on health systems strengthening includes both the social and structural determinants of health and sets out how it will work with as range of government departments to address this.

About us

Health Poverty Action is an international development organisation committed to addressing the full range of factors that impact on health and poverty. We work to strengthen health systems in 13 countries worldwide. We have worked in Sierra Leone since 2005 We are also the UK partner in the EU funded cross European *Health Workers for All and All for Health Workers* advocacy project that builds evidence and strengthens advocacy for a sustainable health workforce worldwide.

Health Poverty Action would be pleased to provide further briefing or speaking notes. Contact: Natalie Sharples n.sharples@healthpovertyaction.org + 44 (0)20 7840 3772

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iii OECD, 2010. Policy Brief: International Migration of Health Workers [online] OECD. Available at http://www.oecd.org/migration/mig/44783473.pdf
iv GMC, personal correspondence
v British Medical Association, Press briefing, How much does it cost to train a doctor in the United Kingdom?, January 2013

vi International Development Committee, 02 October 2014, 6th Report -Recovery and Development in Sierra Leone http://www.publications.parliament.uk/pa/cm201415/cmselect/cmintdev/247/24706.htm
[iii] Health Education England, 28 May 2013 New education and training measures to improve patient care, accessed 08/12/14 http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/
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viii GMC, 'List of Registered Medical Practitioners – statistics [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [Accessed 6 October 2014]
ix International Development Committee, 02 October 2014, 6th Report -Recovery and Development in sierra Leone http://www.publications.parliament.uk/pa/cm201415/cmselect/cmintdev/247/24706.htm
x See Lancet Series on Indigenous Health, Vol. 366 and 367, 2005-6.
xi Health of the Indigenous Population in the Americas, PAHO, 2006.
[1] See 'Guatemala's Malnutrition Crisis', S. Loewenberg, The Lancet, Volume 374, Issue 9685, 18 July 2009, p187-9
[2] Source: 'Línea basal de mortalidad materna para el año 2000', Ministry of Public Health and Social Welfare Baseline Maternal Mortality Study, 2000
[3] According to Minority Rights Group International, using UNDP indices.
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xiii Human Rights watch, 2014, Whose Development?
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xiv Budget Advocacy Network (BAN)and National Advocacy Coalition on Extractives (NACE), 2014, Losing Out, http://www.christianaid.org.uk/images/Sierra-Leone-Report-tax-incentives-080414.pdf
xv Global Financial Integrity, losses by country http://www.gfintegrity.org/issues/data-by-country/, accessed 08 December 2014
xvi Tax Justice Network, Financial Secrecy Index, http://www.financialsecrecyindex.com/