



Whose Charity? Africa's aid to the NHS

Health services in the UK are benefiting from the collapse of health services in some of the poorest countries of the world due to the widespread and increasing migration of health professionals. Children in these countries are unable to obtain the most basic health services and many die as a consequence.

Research summarised in this briefing¹ reveals that current UK policy in this area is ineffective in tackling this inequality. Using Ghana as a case study, it sets out a range of practical suggestions for how the UK Government should respond.

In particular it calls on the UK Government to address this basic inequality through financial restitution and by actively promoting partnerships between a wide range of health institutions to sustain effective healthcare in Africa. African health professionals should be equal partners – with equal human rights – in this endeavour.

DIAGNOSING THE PROBLEM

The scale of migration of health professionals from poor to rich countries has been increasing dramatically in recent years. The UK Government has tried to tackle this issue by introducing a recruitment policy (Code of Practice).

However, the trends in migration show the policy has been ineffective in limiting the impact on poor countries. In 2003, one in three work permits issued to nurses were applicants who came from countries where active recruitment is prohibited, mainly in Sub-Saharan Africa.²

Doctors: Between 1999 and 2004, the total number of doctors registered in the UK and trained in Ghana, doubled from 143 to 293.³

Nurses: There were 40 new registrations of Ghanaian nurses in 1998/9; by 2003/4 an estimated cumulative total of 1021 had registered.⁴

It is estimated that over half of the doctors trained in Ghana have migrated. An understaffed system is supplying a large proportion of its workforce to the rest of the world.

This briefing was written in conjunction with health charity Medact. www.medact.org

Poverty: a root cause of migration

Health professionals migrate for a combination of reasons. In poor countries they often work in dangerous and demanding conditions with chronic shortages of essential supplies (including drugs). They have limited opportunities for training or professional fulfilment in delivering quality health services. In addition to these overwhelming pressures, in many poor countries salaries are extremely low and sometimes not paid at all.

One of the reasons for this is the failure of the international community to back the building of health systems and support of personnel, as well as poor recruitment and retention policies on the part of some developing country governments.

The demand for health professionals in the complex international labour market has soared in recent years, partly as a result of rising expenditure on healthcare in some high income countries. The demand from rich countries has been compounded by a decline in numbers entering and retained in nursing. Low pay and low status has been a deciding factor for many. Exacerbating the situation is the imminent retirement of a large proportion of UK health professionals. Overall, by 2008, it is estimated that the UK will need 25,000 more doctors and 250,000 more nurses than it did in 1997.⁵

A number of other factors have made migration easier from some countries. For example:

- Globalisation has meant that knowledge of job opportunities, and the ease with which information and relevant documentation is available, has increased substantially.
- The ability of would-be migrants to raise the funds required: loans for migration are increasingly available to professional migrants.
- The migrant is now less reliant on personal connections and instead can proceed through a commercial agency, which helps with the process of obtaining visas, work permits and searching for jobs as a service available for market payment.

Who's paying the price?

The movement of health professionals from poor to richer countries means that while health systems in rich countries benefit, there is a decline in the services available in poor countries, with serious implications for health in these countries. Poor, rural people end up with the weakest health services. **Need is already immense in Ghana: one child in every ten dies before the age of five, compared to one in every 150 in the UK.**⁶

This inequity has to be viewed in the context of gross shortfalls in spending on health services in poor countries. The average per capita spend on health in the UK is £927 per year; in Ghana it is only £6.⁷ In 2001, the World Health Organisation recommended that at least £15-20 was needed to deliver a basic package of health services.⁸

In addition, the individuals who choose to move are often highly skilled with strong leadership qualities, adding to the depletion of infrastructure and capacity.

AN UNJUST SUBSIDY

“For small countries the loss of even one health worker can provoke an absolute shortage and inability to maintain basic services.”⁹

Health systems in rich countries, which attract health professionals from overseas, are therefore being subsidised by some of the poorest countries in the world. There are a number of ways of looking at the scale of this unjust subsidy.

First, poor countries spend money training health professionals. When health professionals migrate these countries lose the benefits of this investment. It has been estimated that Ghana has foregone around £35 million of its training investment in health professionals.¹⁰ In comparison, the UK has saved £65 million in training costs by recruiting Ghanaian doctors since 1998.

Second, poor countries lose health benefits as a consequence of losing staff. This has a knock-on effect on the health of the population, in particular the poorest people who carry the greatest burden of ill-health. The impact is particularly profound when HIV infection is widespread. A research project in Ghana is currently calculating the value of these ‘lost health benefits’.



Photo credit: Kalpesh Lathigra



Photo credit: The Wellby Trust

A local health centre in a developing country with scarce resources and the NHS today, a stark contrast with the previous picture.

Third, the work undertaken by migrant workers in the UK can be valued by the cost of their salaries – this is a direct measure of how we value the work these professionals do for us.

Ghanaian-trained doctors and nurses deliver services which the UK NHS values at around £39 million a year.

The value of health professionals lost to Ghana and other poor countries needs to be viewed in the light of annual NHS spending – currently £67 billion.¹¹

Large sums of money are sent home by migrants benefiting from better working conditions. According to the World Bank, remittances wired by all migrant workers through the banking system alone totalled US\$ 90 billion in 2003. The International Organization for Migration estimates that at least as much again is remitted outside the banking system.¹² While we acknowledge remittances partially mitigate the impact of migration on local communities, remittances are personal exchanges and do not get channelled back into the health system. Therefore, they do not compensate for the loss of health professionals.

This unjust subsidy is a barrier to the achievement of the Millennium Development Goals which envisage a global partnership for development and dramatic reductions in infant and maternal mortality. Furthermore, international human rights law places obligations on rich countries to respect the right to health in poor countries.

CURRENT POLICIES

The Code of Practice¹³

The UK Government has attempted to respond to the impact of emigration of health professionals on developing countries.

First introduced in 1999, the current Code of Practice for the International Recruitment of Healthcare Professionals (2004) states that all recruitment agencies contracted by the NHS for permanent, temporary or locum staff are prohibited from actively recruiting health professionals from all non-OECD countries, unless the country has a special agreement with the UK allowing such recruitment. This does not prevent individual health professionals from these countries, who volunteer themselves, from being considered for employment.

In spite of periodic tightening of the Code (2001 and 2004)¹⁴, there has been a large increase in registrations by health workers from listed developing countries in the last 5 years. In addition the Code does not address the inequalities that drive people away – poor working conditions, low salaries, insufficient medical supplies and collapsing systems. Instead, the policy assumes the main driver of migration is active hiring and advertising by recruitment agencies. This has not been the main channel or cause of migration from Ghana.

The UK Government's policy should be welcomed for recognising the detrimental impact of international recruitment on health systems. The Code also contains important provisions that aim to protect migrant health professionals. However, if we are to address some of the key issues underlying the migration of health professionals, then the UK Government needs to move towards a broader range of policies (as shown on page 4).

Ineffective retention policies

Governments in developing countries have made several attempts to manage the exodus of health professionals using coercive measures, such as compulsory public service schemes. These schemes vary in their degree of effectiveness according to the country context but they often act as a deterrent to migrants returning to their home country for service.

Policy measures are only likely to be successful if they are designed in consultation with would-be migrants and are deemed legitimate by them. Country policies should strongly aim to encourage not discourage return from overseas.

RECOMMENDATIONS

In May 2004, the 192 countries represented at the World Health Assembly¹⁵ adopted a resolution, which urged Member States to:

- 1. “establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems in particular human resources development in the countries of origin.”**
- 2. “frame and implement policies and strategies that could enhance effective retention of health personnel including but not limited to strengthening of human resources of health planning and management and review of salaries and implementation of incentive schemes.”**

We take these two recommendations and apply them to the UK Government, and outline actions required to make them a reality.



RECOMMENDATIONS

1. The UK Government should financially compensate poor countries with a shortage of health professionals.

The UK Government should acknowledge that poor countries are subsidising UK health services. Restitution is a financial contribution towards redressing the inequalities between poor countries of origin and destination countries. The amount should be determined through inter-governmental agreement on a case-by-case basis but should be informed by the figures presented above (page 2).

Policy-makers in Ghana recommend that restitution payments should be used to support training and health services. This should include increases in salaries and improvements in working conditions – including better management.

A number of mechanisms for spending and accounting already exist in poor countries which can ensure that funds are channelled transparently into health services – in Ghana the existing pooled funds for health would be a logical route for restitution.

Restitution should not be implemented as a tax on individual migrants – this would inevitably circumscribe their right to freedom of movement. Governments should promote the restitution payment as a financial contribution towards redressing the inequalities between very poor countries of origin and destination countries.

The UK Government should initiate a debate on ways in which other wealthy countries that rely on migrant health professionals can support poor countries with enormous health problems, and use its chair of the G8 and EU in 2005 to lobby other countries to do the same.

2. The UK Government should not rely on the Code of Practice to deal with the impact of migration on poor countries. Positive policies are needed which reduce inequalities.

The Code of Practice is ineffective in preventing migration or dealing with its consequences. It must be supplemented with positive policies which reduce inequalities in health services between poor source countries and the UK. The provisions in the Code of Practice to protect overseas trained health professionals should be actively implemented (currently there is no mechanism for enforcement). The Government should not attempt to tighten the Code to ban health workers from proscribed countries from working in the UK as this would infringe on their rights to freedom of movement.

3. As part of the restitution effort, partnerships should be established with poor countries, by a range of health institutions including the NHS to provide incentives for migrants to stay at home and return as well as scope for career enhancing migration.

A wide range of institutions – including the NHS, professional associations, trade unions, and medical academia – should ensure that financial restitution is accompanied by policies that give incentives to migrants to return from abroad as well as incentives to stay at home. In addition, a broad range of UK health actors could be involved in helping to redress the inequalities between the Ghanaian and UK health services. For example, medical academics could form research links to compensate for the 'beheading' of health services that often occurs during 'brain drain'. The aim would be to ensure health professionals in both countries are colleagues in a joint enterprise of health service development.

CONCLUSION

The inequalities in healthcare between rich and poor countries are already stark. Migration of health professionals is making the situation worse. The UK Government should ensure that its policy framework is consistent across all departments. Urgent action to compensate poor countries should be complemented by plans to prevent staffing shortfalls by producing more health professionals in the UK.

ENDNOTES

- 1 K Mensah, M Mackintosh and L Henry, 2005, *Migration of health professionals from the developing world: a framework for policy formulation*. Medact, London
- 2 J Buchan and D Dolvo, 2004, *International recruitment of health workers to the UK: a report for DFID, 2004*. London: Department for International Development Resource Centre. http://www.dfidhealthrc.org/shared/publications/reports/int_rec/int-rec-main.pdf
- 3 K Mensah, M Mackintosh and L Henry, 2005, *Migration of health professionals from the developing world: a framework for policy formulation*. Medact, London
- 4 K Mensah, M Mackintosh and L Henry, 2005, *Migration of health professionals from the developing world: a framework for policy formulation*. Medact, London
- 5 C. Nullis-Kapp, 2005, 'Health worker shortage could derail development goals', *Bulletin of the World Health Organization* Vol 83 (1) p6
- 6 World Health Organization www.who.int/whosis
- 7 WHO, 2002, *World Health Report*, WHO, Geneva
- 8 WHO, 2001, *Macroeconomics and health: investing in health for economic development*. The report on the Commission on Macroeconomics and Health, WHO, Geneva
- 9 WHO, 2004, *Recruitment of health workers from the developing world* EB11/4/5 4.3
- 10 T Martineau, K Decker and P Bundred, 2002, *Health Professionals: Levelling the Playing Field for Developing Country Health Systems*. Liverpool School of Tropical Medicine. <http://www.liv.ac.uk/lstm/research/documents/InternationalMigrationBriefNote.pdf>
- 11 <http://www.dh.gov.uk/assetRoot/04/09/79/99/04097999.pdf>
- 12 WHO, *Migration and Health Workers Special Issue of Bulletin of the World Health Organization* Vol 82, Number 8, 559-636, August 2004
- 13 Department of Health, 2004, *Code of Practice for the international recruitment of healthcare professionals*. London. The Code only applies in England and Wales.
- 14 Measures put in place in 2004 do not become active until December 2005
- 15 World Health Assembly, 2004, Resolution 57.18, Fifty-seventh World Health Assembly, May 2004. WHO Geneva