From Competition to Collaboration

Ethical leadership in an era of health worker mobility

About THET

Health workers are at the centre of what we do. Without them there is no health.

Today, one billion people will never see a qualified health worker in their lives. For over 30 years, THET has been working to change this, training health workers to build a world where everyone everywhere has access to affordable quality healthcare.

We do this by leveraging the expertise and energy of the UK health community, supporting health partnerships between hospitals, Royal Colleges and universities in the UK and those overseas, improving patient care through targeted training programmes.

In the past ten years alone, THET has reached over 107,500 health workers across 31 countries in Africa and Asia in partnership with over 130 UK institutions, drawing on funds from DFID, DHSC and Johnson & Johnson amongst others.

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INTRODUCTION

In the UK we struggle to educate, train and retain health workers in sufficient numbers. Since the inception of the UK's National Health Service (NHS) in 1948, we have relied on a steady stream of professionals recruited from elsewhere.

Many of these individuals, whose training has often been paid for by their own governments, come from countries facing grave shortages of health workers themselves and it is especially those low- and middle-income countries LMICs that are of most concern to THET. A study carried out in June 2018 showed that, of the top 15 countries NHS staff are most commonly recruited from, seven are LMICs.[1] Indeed, we can say that the NHS owes a great deal to countries who can ill afford to lose such a precious resource.

There are a wide range of factors, both positive and negative that explain why these talented and ambitious individuals come to the UK. Unemployment and/or underemployment is one reason. Many LMIC governments are either choosing not to, or are unable to allocate enough resources to health. In the course of researching this report, for example, we visited Uganda – a country which is struggling to find jobs for 29,000 nurses, despite a desperate need. India requires an extra 1.5 million doctors and yet an ever-growing number of highly qualified doctors and nurses are deciding to leave, facilitated by bilateral agreements with countries including the UK.

Many health workers feel compelled to migrate in order to find employment, but others actively seek to progress their professional development and improve their economic prospects. The opportunity to work abroad offers huge rewards for the individuals involved, both professionally and personally, allowing them to access further training and employment opportunities, and the chance to send remittances back home.[ii] Indeed, the World Health Organization (WHO) is reporting a 60% rise in the number of migrant doctors and nurses working in OECD countries over the last decade.[iii]

In this report we explore how the UK is deeply involved in this global challenge. In particular, we look at how the UK can play a role in shaping the nature of this increasingly mobile 'global health workforce', what this

could look like, and how we can manage recruitment into the NHS in ways that do not damage the development of resilient health services in LMICs

There are perhaps two outstanding characteristics which make the UK of particular interest globally:

First, the scale at which we are operating. In the different nations of the UK, we are striving to sustain the oldest and largest national health services the world has ever seen, employing more than 1.2 million people.[2] The UK's NHS is both an exemplar to countries across the world, and a leading competitor for workforce as it has one of the highest levels of reliance on internationally trained health workers of any OECD country.

On the other hand, the UK is playing a leading role internationally in contributing to the advancement of health and wellbeing in LMICs. In 2017, the UK spent £14.1 billion through Official Development Assistance (ODA), with 14.7% being spent on supporting health.[iv] It is an impressive commitment which flows both from a recognition of the moral value of assisting LMICs, and from the vested interest the UK has in building a world that is equipped to tackle challenges, such as disease and antimicrobial resistance, which are global in nature.

The specific timing of this report is shaped by the UK's decision to leave the European Union (EU), and informed by THET's deep engagement in LMICs and the UK's global health activity. In the past year, for example, we have worked closely with three Whitehall departments and several arms-length NHS institutions, including Health Education England. We do not take a view on the merits or otherwise of our decision to leave the EU, but we do express our concern that it is vital that our efforts to help establish resilient health systems overseas are not undermined by our need to attract health workers to the UK.

We believe that the ways in which the UK shapes its overseas recruitment ambitions, in light of the decision to leave the EU, will critically impact on the ability of our partners in LMICs to deliver improved health outcomes for their own citizens. At the heart of this report, therefore, is the argument that as we embark on delivering the NHS Long Term Plan and accompanying Interim NHS People Plan[3], we need to be mindful of the fact that decisions made at a national level impact on, and potentially undermine, the role we seek to play at an international level at this critical juncture in our history. But we also go further.

We argue that the UK can no longer take for granted its status as a 'destination of choice' for health workers. This is borne out in one element of this report: a survey we undertook of NHS staff from diaspora communities. We cannot 'compete' our way out of a workforce crisis which is affecting all countries.

We write with conviction that the UK's response to the global shortage of health workers should be to forge closer, more collaborative links between our health service and those of LMICs in order to establish the UK as a trusted partner internationally.

Greater collaboration and less competition between nations is ultimately the answer to achieving a sustainable future which benefits health workforces in all countries, and this will involve closer collaboration between respective government departments.

Our aim for *From Competition to Collaboration* is therefore to help guide our partners in government in these challenging times by articulating an ethical route, consistent with the WHO Global Code of Practice, through the immense challenges of workforce shortages, drawing on our second preoccupying concern as a charity: the fate and wellbeing of our NHS. We seek, therefore, to articulate how we can work in ways that both strengthen the NHS and the health services of LMICs using the full authority of our ODA and national commitment to the NHS.

From Competition to Collaboration shares the learning we have gathered through THET's programmes and partnerships and builds on our previous policy reports, notably *In Our Mutual Interest* (2017), to help chart a way forward for policy makers at the national level both in the UK and in LMICs. In this report, you will find insights from policy makers in low-, middle- as well as high-income countries alongside personal testimonies from health workers whose lives and careers help shape the world we live in today.

We do hope you find these insights useful.

Ben Simms, CEO, THET

Graeme Chisholm,
Policy Manager, THET

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[1] Nationality is self-reported and might sometimes reflect cultural heritage of birth.
[2] 1,236, 537 as published in NHS Workforce Statistics, February 2019.

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[3] The NHS Long Term Plan sets out priorities for the NHS over the next ten years. The Interim NHS People Plan aims to tackle workforce challenges in the NHS over the coming year.

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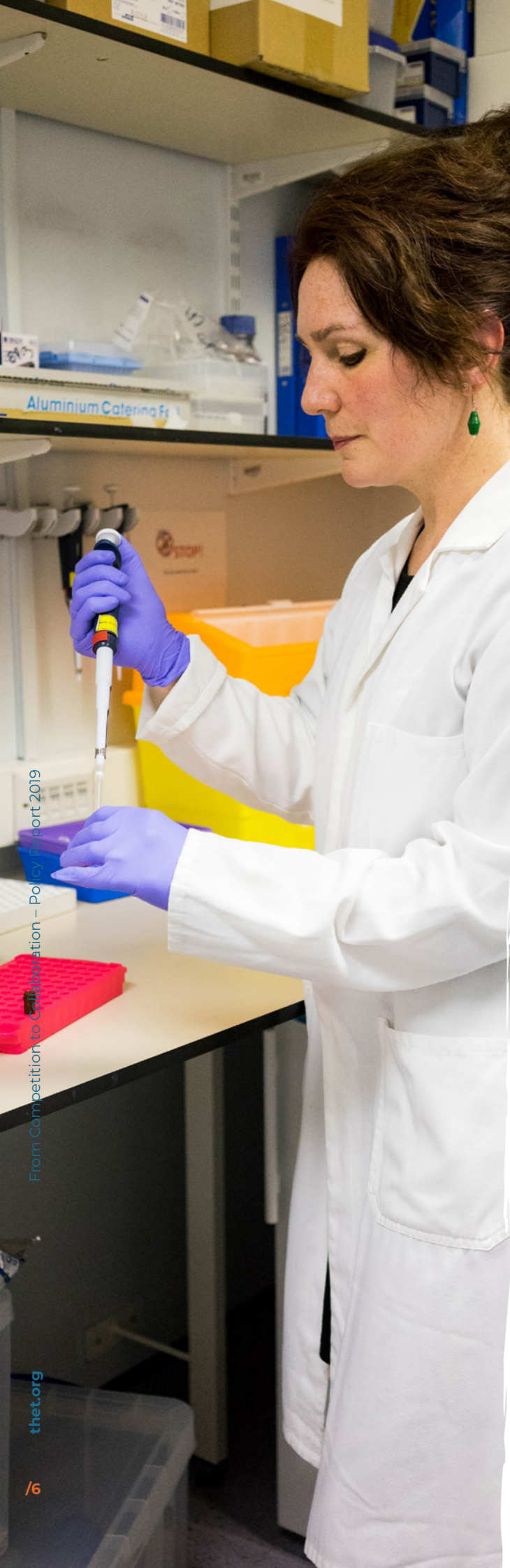
Forewords

This is an important and timely report which focuses on the staffing needs of low- and middle-income countries and the problems presented by the migration of health workers to the UK and other high-income countries.

I was involved in preparing the World Health Organization's Code of Practice on the International Recruitment of Health Personnel which was agreed in 2010 and has gone some way to solving these problems. However, as this report shows, countries are still facing great shortages of health workers made worse by international migration.

The NHS is once again turning to increased international recruitment in order to meet its own staff shortages and it is time to re-look at this vital issue and find sustainable solutions.

I believe this report is right not to call for stopping all such migration – a task that would be impossible to achieve and, if attempted, would infringe the rights of individuals seeking to improve their lives by travelling to work elsewhere – but rather to focus on exploring how the UK can use its influence to forge closer partnerships between the NHS and health services overseas in ways that strengthen both parties.

I have long called for the NHS as a global employer to support the education, development and training of health workers in countries whose workers have come to the UK – an arrangement through which everyone can gain. This valuable report offers ideas about how this can be done. It draws on THET's three decades of insights and experience, builds on its earlier reports and calls for, among other things, closer collaboration between UK departments, particularly the Departments of Health and Social Care and International Development.

This is a positive and constructive report which should be read by everyone who shares a passion for the achievements of the NHS, and for the UK's record in international development, and everyone who is looking to re-imagine our relationship with the rest of the world at a time of unprecedented strain on health services everywhere.

Lord Nigel Crisp, Co-Chair, All Party Parliamentary Group - Global Health, UK

THET has worked in Uganda for many years and is a trusted partner in making the expertise of the UK's National Health Service available to us.

In more recent years, THET has also played an important role in supporting the development of the Uganda UK Health Alliance, which is helping to ensure that these efforts are coordinated with each other and with the Ugandan Government.

However, it is also true to say that, for many more years, Ugandans have been travelling to work in the NHS. Uganda's loss is the UK's gain.

The adoption of the WHO Code of Practice was an important step forward in the past and it is now clearer than ever before that we need to be driven by the principles that underpin the Code, to help guide us as we develop mutually beneficial links between our respective health services.

This is why this report is important. It acknowledges the common challenges we face in terms of the chronic shortages of health workers, and how we address the complexity of this in our increasingly mobile world.

I call on fellow governments in the UK as well as in other countries to heed this report's recommendations. For I believe that showing ethical leadership and acting ethically through mutually beneficial partnerships will help reduce the need to fill gaps in the UK and elsewhere with health workers educated and trained in countries such as my own.

Dr Diana Atwine, Permanent Secretary, Ministry of Health, Uganda

The need for health workers is increasing worldwide. Simultaneously, the international mobility of health workers is accelerating.

The achievement of Universal Health Coverage in many countries is dependent in large part on the service provided by migrant health workers. At the same time, international health worker mobility has the potential to compromise progress in others.

This report advances important debate on this complex, and often sensitive, topic.

The UK is a central player in advancing a more enlightened approach to managing international health worker mobility, as this report acknowledges. Its National Health Service is the world's fifth largest employer, with substantial and potentially growing, reliance on migrant health workers. And it is, and has been, one of the most outstandingly generous contributors to the development of health services in Africa and Asia, spending 0.7% of its national wealth on citizens overseas and regularly deploying its NHS staff to share skills and expertise.

It is the call for greater coherence and cooperation that sits at the heart of this report, which bravely searches for an ethical way forward, where all benefit.

The WHO Code of Practice is a central pillar of such an ethical approach, and I am glad the report highlights this. But the report goes further, drawing on THET's long history of partnering with the NHS to improve health services overseas. As such, THET, an NGO in Official Relations with WHO, puts forward evidence and an ethical position which needs to be heard and debated. Collaboration, is indeed the way forward.

Jim Campbell, Director, Health Workforce, World Health Organization

Executive summary

Our report opens with a recapitulation of the facts. By 2030, the world will be short of 18 million health workers, but these shortages are already acutely felt.

This year, The King's Fund noted that current shortages of staff across NHS Trusts in England are at 100,000 and concludes: "If the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030."[v]

A similar story is reported across the UK. In Scotland, for example, a parliamentary report noted: "The principal job shortages across health and social care in Scotland reflect observable trends both UK wide and internationally. Nevertheless, these observable market trends are also exacerbated by issues of population demography and the remote and rural context, which is a defining feature of the environment in which we deliver health and social care services."[vi]

However, the workforce shortages faced by the UK are dwarfed by those in LMICs. Today in South-East Asia, there is a shortage of more than 7 million health workers. Africa, a continent of 1.3 billion people, needs in excess of 4 million additional health workers.[vii] As Mark Britnell noted in his recent book *Human: Solving the Global Workforce Crisis in Healthcare*, "*We are in trouble. Over the next decade we are heading towards a global workforce shortage in healthcare that will harm patients, citizens, and societies.*"

All governments have a responsibility to educate, train and employ health workers in sufficient numbers and to ensure that these staff are well supported.

This is true for the UK, and it is true for LMICs which face the greatest shortages. And yet, all governments, in different ways, are failing.

In lieu of sustained commitments to educate, train and retain people in sufficient numbers at a national level, we live in an increasingly competitive world where countries are accelerating their efforts to recruit health workers from overseas.

This forms the focus for Section 2 of this report, which documents how health workers are travelling the world in unprecedented numbers.

There are no exact figures to capture the proportion of the world's 43 million health workers that are on the move. However, the trends are clear: in the UK, for example, there are 3,711 doctors with an African nationality working in the NHS. What is perhaps less known is that over 7,500 British doctors have left the UK in recent years to live and work in Australia, and that nurses are moving to work in countries as diverse as Qatar, Canada and New Zealand.

It is the contention of this report that there are no winners in this escalation in international recruitment. For this reason, Section 3 of this report looks at why we should shift the compass, from competition to collaboration, and begin to work in partnership to create health workforce sustainability in an increasingly mobile world.

There exists a contradiction between providing ODA to LMICs and the recruiting of health workers from the very same LMICs. The report focuses in particular on the UK and its partners in LMICs, exploring the history of NHS recruitment of health workers from overseas, and the record of UK ODA in contributing to the development of health systems.

The final section, therefore, moves to articulate how we believe the UK is well placed to provide ethical leadership in shaping the migration and mobility of health workers, building on its track-record both in being the first country to deliver Universal Health Coverage (UHC) to its citizens, and a country that is making a generous and sustained contribution to the development of LMICs through ODA.

We offer the following recommendations to help map what the UK's role could look like in shaping our health workforce of the future.

Recommendations

The United Kingdom of Great Britain and Northern Ireland

Across the United Kingdom, health is a devolved matter. Devolved governments do not, however, have control over development cooperation or immigration.

Within the report, we explore themes common to all and try to highlight learning from different contexts. Our recommendations are, in the main, directed at UK government departments. However, as many of the themes explored are shared by all, we hope that aspects of each recommendation may also be instructive to devolved governments.

ETHICAL LEADERSHIP
Recommendation 1

There is currently little policy coherence at the UK government level between NHS international recruitment strategies that encourage health worker migration for training opportunities within the NHS, and ODA used to strengthen health systems in LMICs.

To the UK Government:

1.1 Establish a unified health workforce strategy at the national level which maximises the synergies between UK ODA funding and NHS investments in workforce, allowing for the meaningful circulation of health workers.

To the Department for International Development:

1.2 Use ODA to support the continued professional development of health workers on their return from training in the UK and align this with bilateral programmes to support LMIC health system strengthening.

To Health Education England, NHS Improvement and NHS England:

1.3 Work with civil society to develop a best practice toolkit for NHS employers that ensures supportive policies and processes for the induction and ongoing pastoral care of international health workers in the UK.

Recommendation 2

LMIC governments that are signatories to the Abuja Declaration are still not assigning 15% of their annual budgets for health.[viii] As a result, governments struggle to educate, train and employ sufficient numbers of health workers, increasing the migration of health workers to other countries.

To LMIC Governments:

2.1 Assign health budgets that deliver health workforce strategies at the national level which optimise existing workforces and promote health system sustainability.

ETHICAL RECRUITMENT
Recommendation 3

The UK has in past years played a leadership role in contributing to the development of resilient health systems in LMICs. However, unethical recruitment practices are increasingly undermining LMIC health systems, driven largely by the behaviour of private recruitment agencies.

To the Department of Health and Social Care:

3.1 Strengthen implementation of the UK Code of Practice for International Recruitment and ban international recruitment agencies from the NHS Employers approved list who use sub-contractors to recruit from LMICs.

3.2 Strengthen implementation of the WHO Code of Practice on the International Recruitment of Health Personnel.

3.3 Encourage other WHO member states to strengthen implementation of the principles and recommendations of the WHO Global Code of Practice on the International Recruitment of Health Personnel including incorporation into national laws, polices, and international cooperation.

ETHICAL PARTNERSHIPS
Recommendation 4

The UK has the experience and potential to position the NHS as a global leader in workforce development. However, progress in shaping the NHS's engagement with LMICs is currently haphazard, expressed through a tantalising patchwork of initiatives.

To the Department of Health and Social Care and the Department for International Development:

4.1 Invest in the UK health system to become a global centre of excellence for workforce development by promoting both outward and inward mobility through partnerships with LMIC countries that are defined by mutual benefit.

Recommendation 5

There is a lack of clarity on how the design and implementation of current 'train and return'[4] schemes benefit LMICs and there is a lack of coordination in tracking professional progress of LMIC health workers who train in the UK on their return to their country of heritage. This is undermining the synergy between UK ODA funding and NHS investments in workforce.

To the Department of Health and Social Care:

5.1 Conduct an evaluation of 'train and return' schemes to understand their impact on domestic and international health workforces.

5.2 Engage trade unions, regulators, professional associations and international partners such as WHO inclusively in the design, monitoring and governance of 'train and return' schemes.

5.3 Scale-up ethical programmes that actively encourage de facto circular mobility of health workers, which include the ethical improvements outlined in this report and which also ensure benefits to LMICs.

5.4 Provide further guidance to ensure 'train and return' schemes clearly benefit international health workforces.

Recommendation 6

Public safety is being undermined by inefficiencies in processes to facilitate the transferability of registration of health workers between regions and countries.

To professional regulators:

6.1 Global regulators should work together to harmonise registration requirements and streamline processes to support the registration of migrating health workers.

Recommendation 7

Progress has been made on ensuring programmes that encourage mobility of UK health workers to and from LMICs are co-developed and deliver clear benefits to LMIC health systems. However, further work is required.

To the Department for International Development and the Department of Health and Social Care:

7.1 Scale-up publicly financed Skills Mobility Partnerships which include the ethical mobility of UK health workers to and from LMICs as described in this report.

7.2 Promote more long-term, sustainable education programmes of cadres of health workers and fewer short-term interventions.

7.3 Focus these longer-term education programmes in locations in LMICs where they are most needed, such as rural and regional centres.

Methodology

The research process and evidence gathering for the development of this report comprised four main approaches.

A rapid literature review of published and grey literature was conducted to gather a wide range of evidence to inform the key topics of this report. This comprised exploring themes in relation to four aspects of workforce development: policy, financing, representation and regulation. This included governmental, intergovernmental, non-governmental reports, evaluations, policy papers, books, websites, letters, guides and academic literature in the form of journal articles and reports.

To ensure this report reflects the experiences of practitioners, semi-structured interviews were also conducted with 28 key informants; 13 from Germany, the Republic of Ireland, Norway, Switzerland and the UK, and 15 from Uganda and Zambia.

A qualitative survey was conducted to gather information on the experiences of health workers practicing in the UK who identify as members of an LMIC diaspora community. The survey was distributed to NHS health institutions including health partnerships and diaspora organisations and 139 responses were received. The report also draws on research findings conducted for Amref on health worker migration in Zambia.

In order to guide the development of this report, a steering group of leading figures in global health was convened. Steering Group members included representatives from academia, the World Health Organization, Health Education England, NHS Employers, NHS England, the Academy of Medical Royal Colleges, INGOs; Intrahealth and ACHEST, nurse leaders and former representatives of the International Confederation of Midwives and the Government of Tanzania, as well as THET country directors in Tanzania, Uganda, and Zambia.

Limitations

We use the term health worker as a shorthand for referring to the very many different cadres of health professions. Throughout this report data on doctors, nurses and midwives predominate due to the paucity of data on other cadres.

We also appreciate the vital role care workers and health care assistants play in the delivery of services and the gendered nature of much of the health worker mobility of these cadres which we do not explore in this report.

[4] 'Train-and-return schemes' allow international health workers to learn as they work temporarily in the UK usually for two to three years.

1. Health workforce

1.1 INTRODUCTION

Healthcare is one of the largest sectors and employers in the world, worth over $9 trillion globally and consuming an average 10% of a country's GDP.[ix]

Health is an investment that both underpins economic growth and is a major part of our national economies – an investment which also contributes to the economic empowerment of women and young people. One quarter of economic growth in LMICs between 2000 and 2011, for example, is estimated to have resulted from improvements in health.[x]

In 2013, 43 million people were employed in health. Millions more are employed in social care. In the UK, The King's Fund reports that the NHS, already the world's fifth largest employer, employs a staggering 1.2 million people. A further 1.6 million people are employed in social care.[xi]

It is also recognised that health is increasingly global. We are living in a world where health challenges are spreading beyond national borders and require global efforts to both respond to health emergencies and prevent future health crises. The West African Ebola outbreak, the spread of the Zika virus, and the rise in anti-microbial resistance, are all examples of recent and current challenges that have precipitated a global response.

This has led to more and more ODA funding being delivered through UK government departments other than the Department for International Development (DFID). And while it can also be argued that the sharing of the ODA budget with other government departments is one way of defending aid from the significant cuts seen elsewhere, this does also lead to concerns about the transparency and accountability of funds spent.[xii]
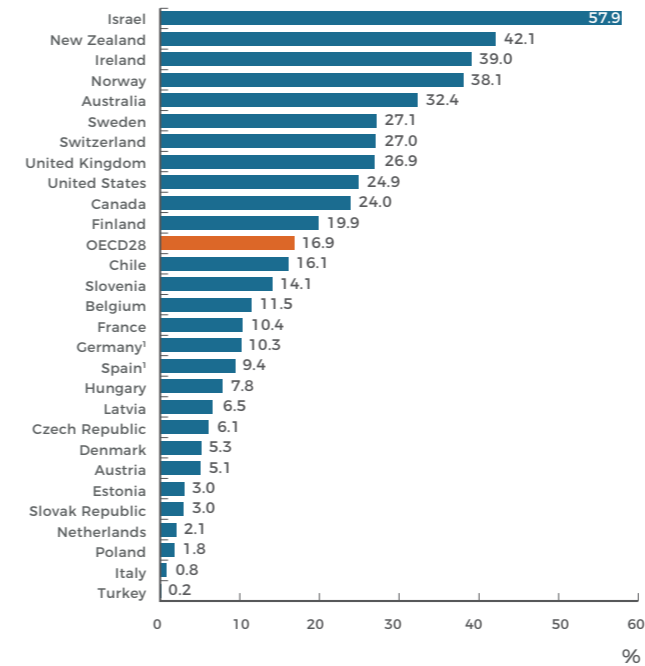
1.2 RIGHT JOBS, RIGHT SKILLS, RIGHT PLACES

'Right jobs, right skills, right places' is the clarion call of the WHO's 2016 Health Workforce paper, and they are the goals of policy makers the world over.[xiii] It is an ambition that is proving extraordinarily difficult to achieve. Our current workforce models are simply not working, not least because there is a chronic lack of investment in producing and retaining adequate numbers of health workers, as the figures overleaf demonstrate.[xiv]

In LMICs where THET is active, the effects of underinvestment in the health workforce is stark. In Tanzania, there is a shortage of more than 107,000 health workers.[xv] There are, for example, just four nurses and midwives for every 10,000 people, compared to a continent average of 11, or compared to 84 in 1,000 in the UK. THET has recently been supporting efforts to train community health workers (CHWs) in the Mwanza, Shinyanga, Geita, Simiyu and Kagera regions of the country. Out of the 12,000 CHWs trained, the government has only managed to employ 90. This issue of absorption is common to many of the countries that THET operates in. For example, Uganda has a staggering 29,000 nurses unemployed out of a total of 64,000 registered nurses. And the effects of these chronic shortages are felt most acutely in rural areas where ratios of health workers to patients are particularly poor.
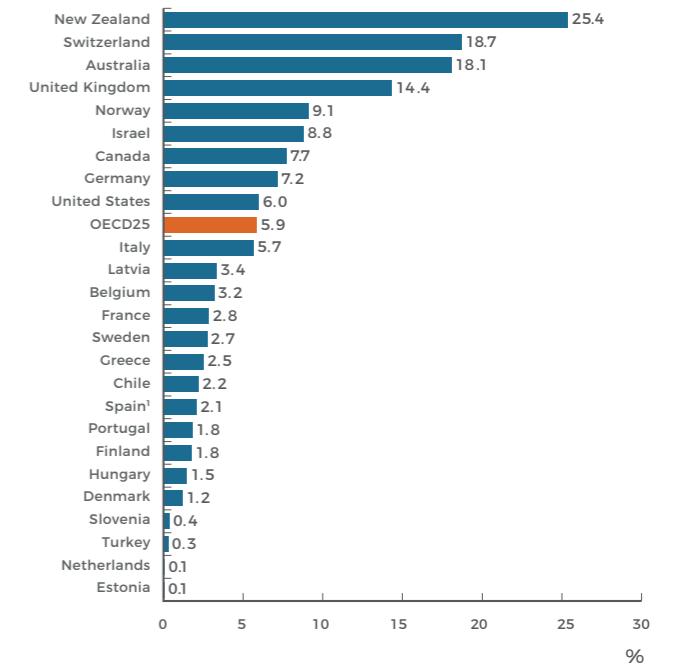
The UK has also struggled since the NHS came into being in 1948. For the UK however, an option that has long existed has been to recruit people from overseas to fill gaps. The NHS has relied on overseas-trained health workers since its inception.[xvi] Recruitment campaigns for nurses in Malaysia, Mauritius and the Caribbean were common in post-war Britain and by 1971, 12% of British nurses were Irish nationals. Today, roughly a third of the Tier 2 visas for skilled migrants go to NHS employees.[xvii] In fact, the UK has one of the highest levels of reliance on internationally trained health workers of any OECD country. One in three doctors and one in eight nurses in the UK were trained in another country.[xviii]

Share of foreign-trained doctors, 2015 (or nearest year)

Country	%
Israel	57.9
New Zealand	42.1
Ireland	39.0
Norway	38.1
Australia	32.4
Sweden	27.1
Switzerland	27.0
United Kingdom	26.9
United States	24.9
Canada	24.0
Finland	19.9
OECD28	16.9
Chile	16.1
Slovenia	14.1
Belgium	11.5
France	10.4
Germany[1]	10.3
Spain[1]	9.4
Hungary	7.8
Latvia	6.5
Czech Republic	6.1
Denmark	5.3
Austria	5.1
Estonia	3.0
Slovak Republic	3.0
Netherlands	2.1
Poland	1.8
Italy	0.8
Turkey	0.2

1. In Germany and some regions in Spain, the data are based on nationality (or place of birth in the case of Spain), not on the place of training.
Source: OECD Health Statistics 2017.

Share of foreign-trained nurses, 2015 (or nearest year)

Country	%
New Zealand	25.4
Switzerland	18.7
Australia	18.1
United Kingdom	14.4
Norway	9.1
Israel	8.8
Canada	7.7
Germany	7.2
United States	6.0
OECD25	5.9
Italy	5.7
Latvia	3.4
Belgium	3.2
France	2.8
Sweden	2.7
Greece	2.5
Chile	2.2
Spain[1]	2.1
Portugal	1.8
Finland	1.8
Hungary	1.5
Denmark	1.2
Slovenia	0.4
Turkey	0.3
Netherlands	0.1
Estonia	0.1

1. The data for some regions in Spain are based on nationality or place of birth, not on the place of training.
Source: OECD Health Statistics 2017.

The Interim NHS People Plan published in June 2019, calls for an increase in international recruitment.[xix] This assumes that the UK can continue, as it has in the past, attracting more and more health workers from elsewhere to solve its workforce crisis. But the UK is both a source and destination country for health workers – a beneficiary and victim of increased mobility.

The decision to leave the EU has already had a profound impact on the desirability of the UK as a destination for health workers, and especially those from the EU. The effects of this decision are being felt. In 2018, there was an 87% fall in the number of European nurses coming to the UK, according to the Nursing and Midwifery Council (NMC).[xx] In December 2018, the Royal College of Nursing reported a 40% drop in EU nurses coming to work in London's NHS since the year of the referendum result.[xxi]

And a recent report by the National Institute of Economic and Social Research estimated that, by 2021, England could face a shortage of 51,000 nurses.

The decline in numbers of EU health workers coming to the UK takes place in the context of increased competition from other countries. It is no longer clear that we can out-compete these countries. In short, the UK is no longer (if it ever was) the most desirable destination for health workers, as we will see from numerous examples in this report.

The UK therefore has every reason to be one of the first countries to recognise that there are no winners in this escalation of international recruitment.

Greater collaboration and less competition are ultimately the answer to achieving a sustainable future which benefits all health workforces.

The UK is also increasingly open to criticism for the impact its recruitment is having on LMICs, as we know from our interactions with Ministries of Health in Africa. Not only do we risk exacerbating inequality and poor health outcomes in LMICs, we risk damaging our reputation as a country that is quite rightly praised for the generosity of the support it provides through ODA. As we look to strengthen relationships internationally, exert our influence through soft power, and increase opportunities for commercial partnerships, it is vital that we position ourselves as a trusted partner to these national governments.

Key Figures

The density of skilled health workers varies greatly, from **106.4 per 10,000 population** in the European Region to **14.1 per 10,000 population** in the African Region

43 million
the number of health workers in 2013

40 million
number of new health worker jobs to be created by 2030

18 million
the potential shortfall in health workers by 2030

Over one third
of health investments required for the SDGs will be needed for the health workforce

The largest deficit of health workers is in **South-East Asia (6.9 million)** followed by **Africa (4.2 million)**

Major shortages of health workers are experienced in the WHO African, South-East Asia and Eastern Mediterranean Regions

2. An increasingly mobile health workforce

2.1 INTRODUCTION

Of the 43 million employed in health globally, how many are on the move? The World Health Organization (WHO) is reporting a 60% rise in the number of migrant doctors and nurses working in OECD countries over the last decade.[xxiii]

In this section, we explore the broad characteristics of a more mobile workforce, some of the patterns of mobility that are taking place, and the reasons why.

2.2 HEALTH WORKFORCE MOBILITY

"Migration is not exclusively a human rights issue...there are economic aspects and, for some, security issues. It sits in the middle of clashes of some very potent political forces."[xxiv]

Louise Arbour, UN Special Representative for International Migration.

Health workforces

The governments of LMICs clearly have a responsibility to make their health systems attractive to health workers with the resources they possess. Many countries also face significant rural to urban migration and shifts from public to private sector, all of which put pressure on governments to deliver healthcare to their populations.

Countries such as the Philippines, for example, actively train health workers and nurses particularly 'for export'. This is demonstrated by the fact that the pre-registration nursing curriculum in the Philippines is designed and delivered to largely meet the EU directive on nurse education, thus making it far easier for Filipino nurses to register in the UK. The Philippines is described as "the world's leading donor of nurse labour", despite serious difficulties in providing health coverage in remoter regions of the country, with resulting health disparities.[xxv] And yet, it is not hard to see why this historical trend will likely continue, with almost 10 million Filipinos overseas and remittances making up more than 10% of the economy.

As progress from the third round of the WHO's international recruitment code reporting reveals, many countries can now reasonably be considered to be both source and destination points for many health workers, albeit to varying degrees.[xxvi]

Health workers

There are many 'push' and 'pull' factors that influence health workers as they contemplate making the hard decision to uproot themselves from family, friends and community. And some health workers are not necessarily the 'primary migrant', but often travel to accompany partners before pursuing their careers.

We use the term 'push' to describe factors that might lead to a person leaving their country of birth, and 'pull' factors to describe factors that might incentivise a person to move to live in another.

Main push and pull factors in migration and international recruitment of health workers

PUSH FACTORS	PULL FACTORS
Low pay (absolute and/or relative)	Higher pay
Poor working conditions	Opportunities for remittances
Lack of resources to work effectively	Better working conditions
Limited career opportunities	Better resourced health systems
Limited educational opportunities	Career opportunities
Burden of disease	Provision of post-basic education
Unstable or dangerous work environment	Political stability
Economic instability	Travel opportunities
	Aid work

Source: adapted from Buchan et al. (2003).

Buchan, J et al (2003). International nurse mobility: Trends and policy implications. Available at: https://apps.who.int/iris/bitstream/handle/10665/68061/WHO_EIP_OSD_2003.3.pdf;jsessionid=7DC2C25A47D1C05910FBBEBCAC2BF5FC?sequence=1

Health workers are also increasingly the agents of their own destinies as their means of mobility is facilitated through private agencies, as well as through family links and social networks made ever more accessible through online channels.

In fact, many health workers now circulate globally, moving from one health system to another, increasing their experience, employability and value at each stop.[xxvii]

Circulation of health workers and the importance of the skills associated with these health workers is therefore a good way to frame our discussion of an increasingly mobile health workforce.

"They left the UK to work in the Middle East and they used their UK training stamp to increase their value in the Middle East. If they went straight from India to the Middle East they would get half of what they would get paid in the UK. If you go from India to the UK and then to the Middle East you get double the salary you get paid in the UK. So, you get four times as much by travelling through the UK for three years."

UK recruitment consultant.

Ugandan health workers – a low-income country perspective

In Uganda, where THET has been working since 1995, we have experienced firsthand several factors that lead to health worker mobility.

The following case study gives a sense of the journeys taken by medical professionals over the last year, echoing earlier studies of mobility, but also illustrating interesting inter-regional and wider continental mobility.[xxviii]

The government health system in Uganda is decentralised and is managed in urban as well as rural areas by government. Almost half of the health system, however, is provided by the private not for profit sector. In spite of incentives for health workers to work in these facilities, government institutions tend to be better staffed, as the government facilities are perceived as being more stable and dependable, better known, and more likely to provide training opportunities and secure career paths. Absorption of health workers in Uganda, as in many LMICs, is problematic with, for example, 29,000 nurses unemployed out of a total registered workforce of 64,000.[xxix]

Districts in particular lack financial resources. This leads to shortages of health workers and absenteeism in those who remain, as well as a lack of necessary equipment or indeed essential utilities, such as electricity, water and housing for health workers.[xxx]

Concrete data on health worker movement is not compiled centrally in Uganda, but organisations such as the Uganda Medical and Dental Practitioners Council have compiled their own data which gives us a sense of the scale.[xxxi] The following analysis is based on the Council's latest annual report from 2017/18. The data reveal that movement is not only one way. Health workers do also decide to enter Uganda, as Figure 1 detailing the pattern of mobility of doctors entering Uganda demonstrates, between July 2017 and June 2018, a total of 664 foreign practitioners were registered to work in the country.

However, most of these doctors worked for non-governmental organisations for short-term assignments.

In addition, a small number of doctors were sourced directly by government agencies, especially in highly specialised fields like cardiology and neurosurgery.

Most foreign practitioners come from North America, the USA in particular, and almost one quarter from Europe. Notably, 8% come from other African countries.
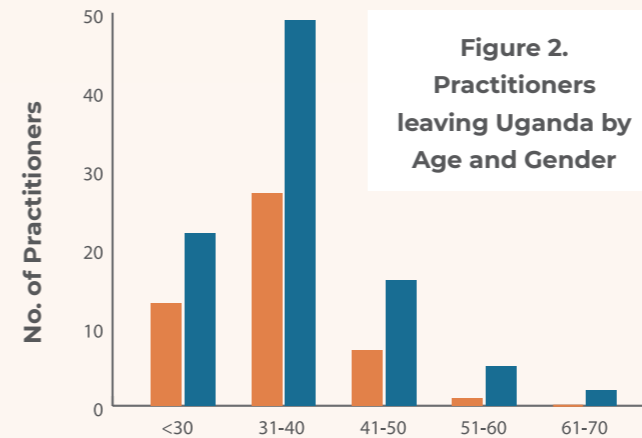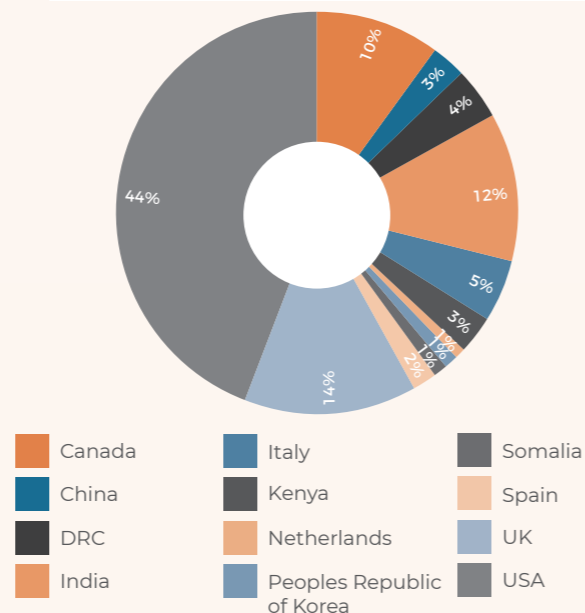
During the years 2016-2018 of the UK Aid funded Health Partnership Scheme (HPS), there were 169 instances of doctors volunteering for over 3000 days through health partnerships between UK health institutions and Uganda counterparts.

Between July 2017 and June 2018, 209 practitioners were granted certificates of good standing to support a move from Uganda. Although a useful measure, the certificate is a proxy indicator and does not capture those doctors who may leave the country temporarily or permanently to work outside medicine.

Notably, it is doctors early- to mid-career who are migrating as shown in Figure 2.

A significant number of doctors also move to countries such as Somalia and South Sudan, but these numbers are not captured in the official data as these countries require no documentation.[xxxii] This trend could be an illustration of Uganda's ambition to be a regional development partner.

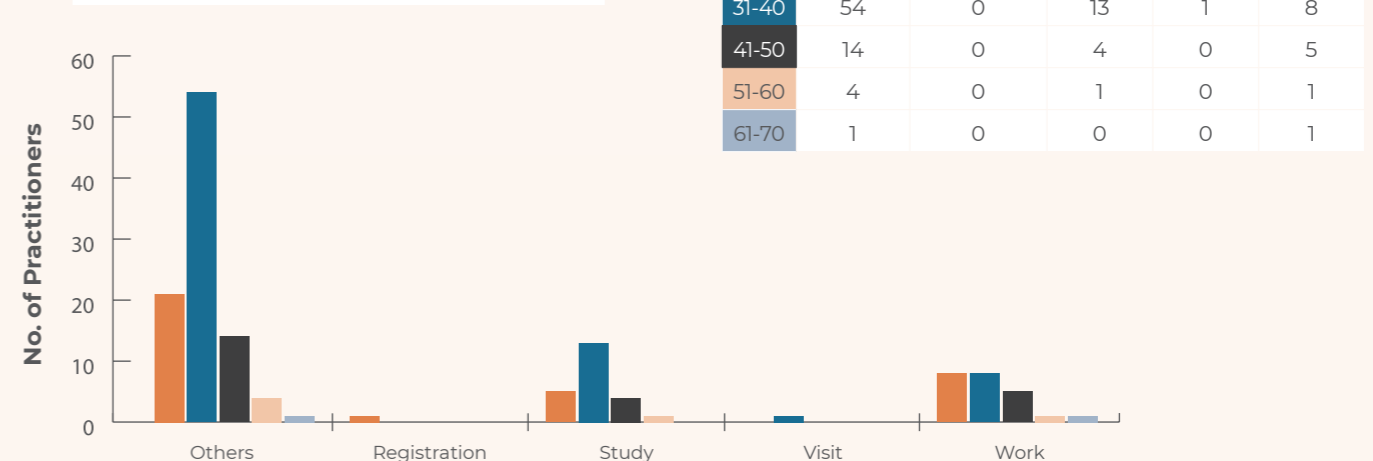## Figure 1. Practitioners Entering Uganda

Legend:
- Canada
- China
- DRC
- India
- Italy
- Kenya
- Netherlands
- Peoples Republic of Korea
- Somalia
- Spain
- UK
- USA

Figure 2. Practitioners leaving Uganda by Age and Gender

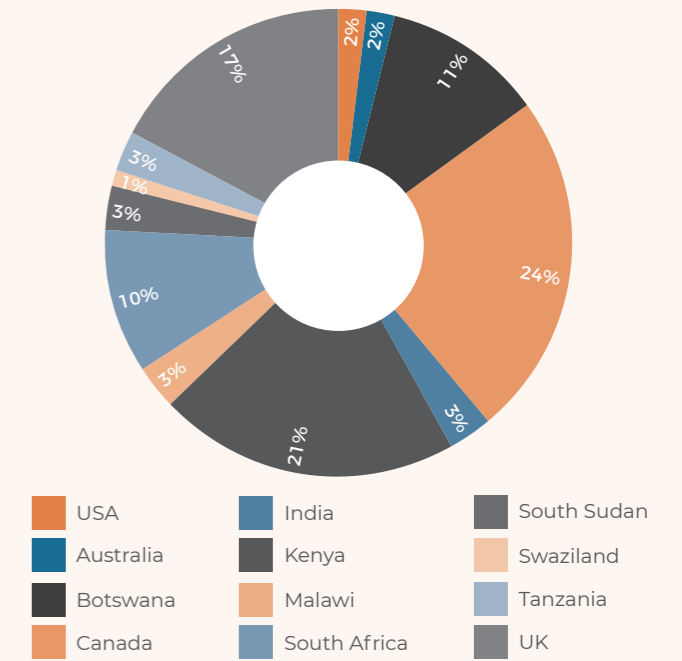|	<30	31-40	41-50	51-60	61-70
F	13	27	7	1	0
M	22	49	16	5	2

In terms of reasons for leaving Uganda, data is limited with most giving no clear reason for departure. However, improved terms and conditions is clearly a significant underlying issue - see Figure 4.

The most popular African destination was Kenya, with other East African countries making up 27% of migration destinations, and African countries as a whole making up more than half of migration destinations. Canada was the most popular destination of all, with the UK in second place for destinations outside Africa. Interestingly then, most Ugandan doctors in this sample period decided to migrate regionally or to other countries in Africa.

Figure 3. Destination Of Practitioners Leaving Uganda

Legend:
- USA
- Australia
- Botswana
- Canada
- India
- Kenya
- Malawi
- South Africa
- South Sudan
- Swaziland
- Tanzania
- UK

Notably, Uganda does not record data for those who return although this phenomenon of return was stated as being 'very, very low' by a representative of the regulator.

It is perhaps worth acknowledging that there is a great need to explore the pattern of mobility for other health workers and not only doctors. We would value insights the reader of this report can share with us.

Figure 4. Reasons for leaving Uganda by Age Range

	Others	Registration	Study	Visit	Work
<30	21	1	5	0	8
31-40	54	0	13	1	8
41-50	14	0	4	0	5
51-60	4	0	1	0	1
61-70	1	0	0	0	1

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2.3 ONE NHS, MANY NATIONALITIES

The UK has always struggled to train and retain sufficient numbers of health workers to serve the needs of our population. Since the NHS came into being in 1948, the UK has relied on its ability to recruit overseas-trained staff.[xxxiii]

The UK is both a source and destination country for health workers. Overall it is a significant net 'importer' of doctors, nurses, midwives, allied health professionals and care workers.

Most NHS staff in England are British but a substantial minority are not.

A recent House of Commons Library Briefing Paper states we have 'One NHS' and 'Many Nationalities', with NHS Digital providing highly accurate data on the make-up of today's NHS in England with analysis of trends.[xxxiv]

Health workers from India, the Philippines, and Ireland are the most common nationalities represented in the NHS, followed by those from Poland, Portugal, and Italy. Nigerian health workers are the ninth most common, making up the largest number from an African country.

The inward movement of nurses to the UK peaked in 2002, at the height of the last round of active international recruitment, when international (EU and non-EU) sources accounted for more than half the total number of new nurses entering the UK register. It then dropped rapidly, but has increased since 2009, with EU countries accounting for most of the increase.[xxxv]

EU nurses have benefited from reciprocal arrangements allowing NMC recognition of EU registration. Latest NMC figures suggest increased numbers of EU nationals leaving its register and fewer joining, reflected in a small reduction in the number of EU nurses and midwives working in the NHS.[xxxvi] The impact of possible changes post-Brexit has been suggested as a contributing factor as well as improved working conditions and pay across Europe.

Ninety percent of clinical support staff who provide support to doctors and nurses, support staff for ambulances, support staff for scientific and therapeutic services, trainees, and healthcare assistants are reported to be British. An additional 4.1% (14,247) are from other EU countries. Of these, 56% are either from Poland, Ireland, Spain or Portugal. Of the 2.9% (10,044) that report an Asian nationality, 78% are either Filipino or Indian nationals. A further 2.0% (7,055) report an African nationality, of which half are either Nigerian or Ghanaian.

In terms of the medical workforce, 74% of doctors are British. This is lower than other NHS staff categories. Twelve percent (13,739) of doctors report an Asian nationality, of which almost two-thirds are Indian or Pakistani. There are 3,711 doctors with an African nationality, approximately 3%.

Data is also available on the country in which doctors gained their primary medical qualification. Twenty percent of doctors qualified in Asia, making it by far and away the largest source continent of NHS doctors. In total, over 17,000 doctors qualified in India or Pakistan, while just under 9,000 now report either Indian or Pakistani nationality. Six percent of doctors qualified in Africa, compared with 3% who now report an African nationality.

There are now substantially fewer Indian doctors in England's NHS than in 2009. In 2009, Indian doctors made up almost 12% of those with a known nationality – this has now fallen to 6%. There have also been reductions in doctors from other non-EU countries, such as Zambia, Syria, Iran, Zimbabwe and South Africa.

So, in the UK, we have a reasonably clear picture of who is practicing at any given time, but actual in and outflow or mobility of health workers varies over time.

The reasons for such movements are many and varied and may include wider economic instability, as well as natural disasters and conflict, all of which can have profound impacts on the flow of health workers around the globe.

And as we have noted, governments also have a significant influence on health worker mobility. One particular challenge for the UK is its decision to leave the EU. And as we have seen, the effects of this decision are already being felt.

The UK government is responding, however, and we will explore the policy measures that have already been taken, as well as those planned, later in the report.

2.4 THE CONTRIBUTION OF HEALTH WORKERS FROM DIASPORA COMMUNITIES TO THE UK HEALTH SYSTEM

Taken together, some 15% of the NHS workforce were trained overseas and might be referred to as belonging to a diaspora community.

We use the following broad definition of diaspora: a person who comes from one country but now lives in another. This definition does not specify the length of stay a health worker may make in any given country.

In order to better understand the motivations of health workers who have trained elsewhere, THET conducted a survey in the spring of 2019. The survey received 139 responses over an eight-week period.

Motivations

We asked what motivated health workers to move to the UK. Respondents gave multiple reasons reflecting the range of push and pull factors that have been explored above.

What motivated you to come to the UK?

Education and training, both short and long term, were the most common responses, with postgraduate medical education and training, membership of medical royal colleges, as well as higher study at UK institutions such as the Liverpool School of Tropical Medicine being mentioned.

Opportunities, both economic in terms of career prospects and quality of life more broadly, were the next most common motivating factors. And although our respondents commonly reflected pull factors, we can reasonably surmise that push factors were implicit in many answers. Respondents referred to 'staying alive', 'safety' and the need 'to seek refuge'.

When asked what motivates health workers who moved to the UK to stay, a strong sense of professional satisfaction emerged.

'Developing professional expertise', 'to complete my medical training up to consultant level', 'I enjoy my job and am enabled to carry out my job to the best of my ability', 'professional and economic growth, 'professional satisfaction, public service ethos' and 'freedom to excel' are representative of responses received.

The laying down of roots and family ties also emerged: 'I created a life for myself in this country.'; 'Work and family and being part of the community.'; 'I set up a family and set up a health company.'

These responses reveal a workforce who may have been born or trained elsewhere, but who play an integral part in the delivery of our public services, and who are part of the fabric of our society.

And many of our respondents are looking ahead: 'My children have a better future', 'excellent education and opportunities for my children' were typical responses.

Obstacles

We asked diaspora health workers whether they encountered any obstacles when making the move to the UK. Eighty percent of health workers told us that they had encountered difficulties, which is perhaps to be expected as most health workers who responded migrated independently of formal schemes.

Top of the list of technical difficulties was ensuring qualifications were suitable for the position being applied for, along with issues around registering with professional regulators. It is still extremely difficult for many LMIC nurses and midwives to obtain registration in the UK.xxxvii If evidence of attainment of NMC requirements cannot be demonstrated, the only option for many LMIC nursing and midwifery migrants is for them to join the non-registered health workforce.[5]

Obtaining visas and issues associated with immigration came next, followed by financial worries and language difficulties.

A sense of being a victim of racism or some form of discrimination registered amongst respondents, as did feelings of not being accepted, whilst at the same time dealing with the many cultural differences.

A little under half of health workers who responded felt that they had received some form of assistance in resolving the obstacles they faced. However, a clear majority told us that they experienced no formal process to prepare them for work in the UK.

Skills

We asked diaspora health workers whether they felt that what they had learnt in the UK was useful; 60% of respondents felt that the skills they had learnt were 'extremely useful.'

We also asked whether respondents plan to return to their country of heritage. Seventy percent told us that they plan to return and felt that they had skills to contribute. When further asked if they were considering permanently relocating to another country, only 16% suggested that they were, which perhaps reflects the earlier finding that many diaspora health workers have professionally and emotionally committed to pursue their futures in the UK.

Those respondents who identified as a member of a diaspora were asked if they felt that they could bring any particular skills if they were to return to either work or volunteer in their country of origin.

Ninety-four percent of those who responded told us that they felt that they had particular skills to offer. In particular, diaspora health workers felt that they could bring specific clinical skills to bear in the countries where they trained, with education and training, and managerial skills and leadership also cited as examples of hard skills that they could offer.

Greater confidence, resourcefulness, independence, flexibility and personal insight were all sighted as softer skills.

The role of diaspora in global health

A great deal of research and policy debate has already been undertaken regarding the role of diaspora in global health, with recommendations ranging from a call for high-income country governments to develop knowledge and capacity to engage diaspora effectively at scale; to nurture an enabling environment in both countries of origin and destination; to develop cross-sectoral facilitative frameworks; and to set up effective mechanisms to share best practices, such as a global database with up-to-date information on diaspora policies and programmes and relevant evaluation guidelines.xxxviii
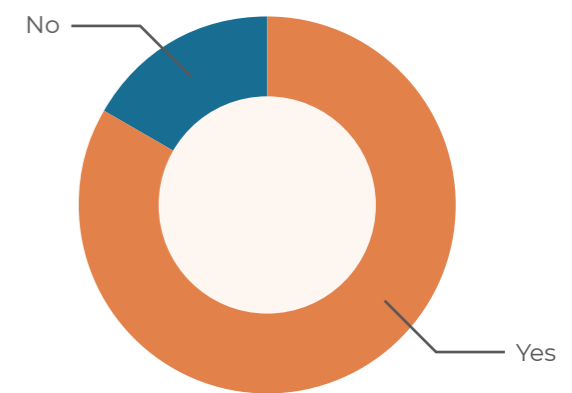
Communication and strategic outreach are also considered central to effective implementation of programmes and policies for diaspora engagement, with BOND recommending that international non-governmental organisations develop new communication strategies to improve their engagement with diaspora communities, with priority actions including:[6]

- Acknowledging the contribution of diaspora communities as a valuable component of the UK's overall international development offer.
- Committing to a trust-building strategy that listens to diasporas' concerns and aims to address these as much as possible.
- Focusing on common interest in fostering positive change in developing countries and identify specific initiatives on which to collaborate.
- Making an effort to refine development narratives so these can help break down negative stereotypes about developing countries.
- Taking into account the crucial role of faith in the life of diaspora communities.xxxix

The initial findings of the research presented in this report mark the beginning of THET's journey to deepen our understanding of the role of people from diaspora communities in health partnerships and will form the basis of a more in-depth study.
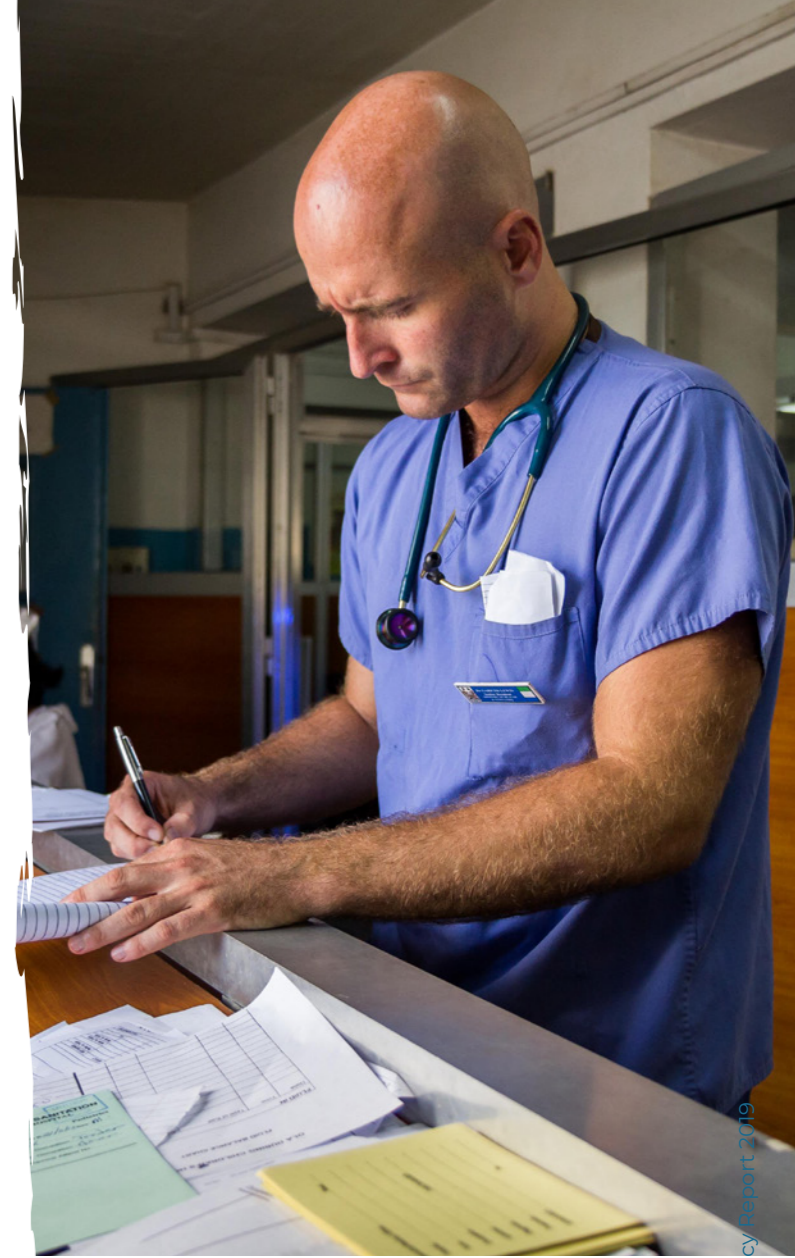
Do you feel the kind of training or study you are undertaking is relevant to the communities you would serve if you return to your country of heritage?

No

Yes

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5 Professional registration requires the International English Language Testing System (IELTS) test 7.

6 BOND is the UK Network for Organisations Working in International Development.

CASE STUDY

Zambian health workers – a lower middle-income country perspective

In comparison with Uganda, Zambia has a reasonably well-developed private and public health care system which provides medical services to its population.
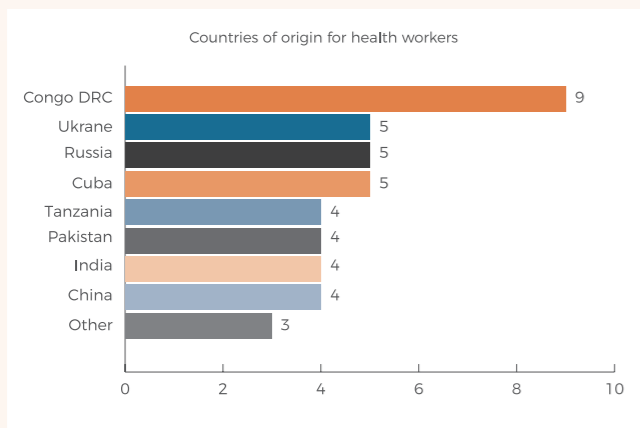
The health system in Zambia can be classified into three main categories: first level, comprising health posts, rural health centres, and district hospitals, where primary health care and preventive health services are provided; second level, comprising the provincial and general hospitals which provide curative care; and tertiary level, comprising the central hospital and the national university teaching hospital which provide specialised care.

The Zambian government's underinvestment in health has, however, led to insufficient health workers trained, with those who do go on to work in government institutions facing poor supervision, poor working conditions and occupational safety hazards.

Amref in Zambia has produced an in-depth analysis of health worker migration, canvasing the opinions of 190 nurses and doctors as part of this process.[xl] The following findings from this study reveal a picture of health worker mobility that is due partly to the Zambian government's underinvestment in the health system.

If we first highlight those health workers entering Zambia, 36% of respondents said that they knew someone in their institution who had joined them from another country.

Almost a third of health workers entering Zambia came from another African country. Top of the list were people from the Democratic Republic of the Congo (DRC), at 20%. This is an interesting insight into how conditions in a stable African country, such as Zambia, act as a pull factor for others from a less stable country, such as the DRC. Countries in the 'other' category included Nigeria, Egypt and the UK.

The survey also found that the majority of Zambian health workers canvased knew of a colleague who has migrated overseas.

### Figure 2. Percentage of health workers willing to migrate given an opportunity
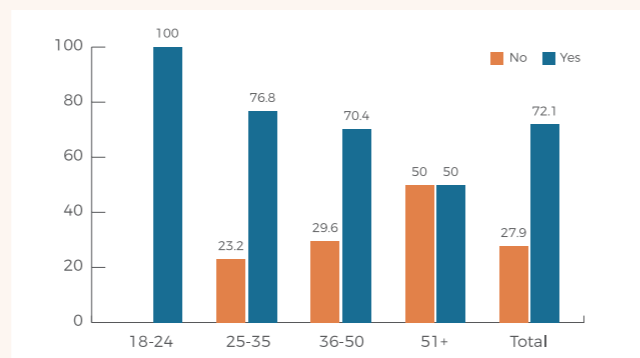
In addition, over 70% of all health workers surveyed said that given the chance, they would be willing to migrate to another country. And it is those younger health workers – an incredible 100% of 18-24 year-olds who are studying or in training – that are particularly willing to do so.

Figure 1. Health workers entering Zambia

Countries of origin for health workers

Figure 3. Measures to stem health worker emigration
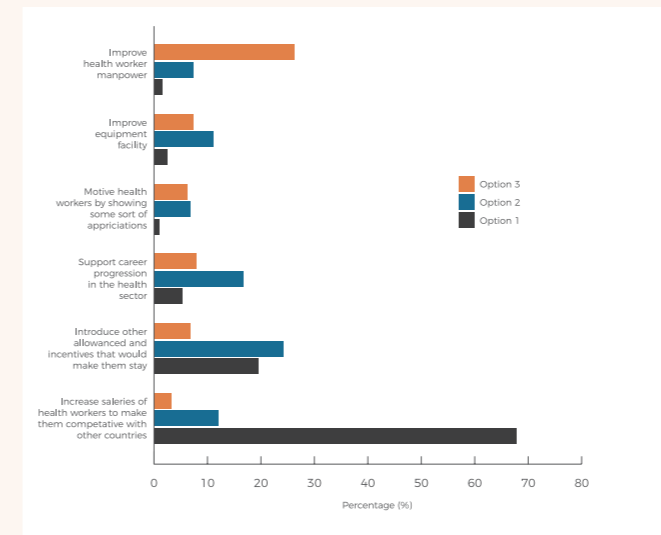
When health workers in the survey were asked what could stem health worker migration, the most important change stated was perhaps unsurprising – an increase in salaries. This is despite the fact that Zambian health workers are relatively well paid compared to colleagues in neighbouring countries. Career progression, better supervision, better working conditions, and improvements in equipment were also considered necessary.

Figure 4. Main destination countries for health workers
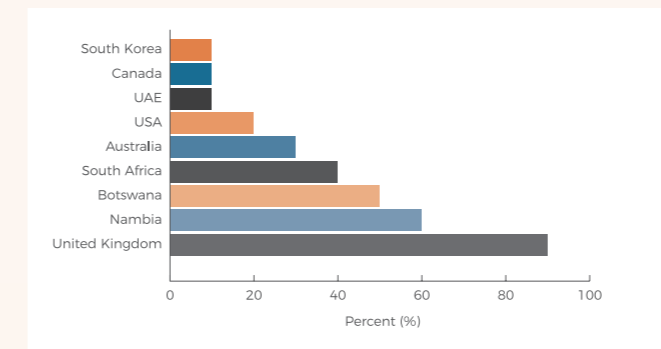
Of those who have migrated to another country, the report revealed that the UK is the most favoured destination amongst high-income countries, followed by Australia, USA, Canada and South Korea.

Of African countries, Namibia, Botswana and South Africa were the most popular, making-up almost half of all Zambian health worker migration.

3. The need for health workforce sustainability in an increasingly mobile world

3.1 INTRODUCTION

The previous sections have highlighted the global shortage of health workers and the increased likelihood that people trained in one country will end up living and working in another. This section speaks to the growing interdependence between countries and their respective health systems, and how our policies should reflect this.[xlii]

As we argued in the introduction, there are perhaps two outstanding characteristics which make the UK of particular interest globally:

First, the scale at which we are operating. In the different nations of the UK, we are striving to sustain the oldest and the largest national health services the world has ever seen, employing more than 1.2 million people. The UK's NHS is both an exemplar to countries across the world, and a leading competitor for workforce both because of its size and because it has one of the highest levels of reliance on internationally trained health workers of any OECD country.

On the other hand, the UK is playing a leading role internationally in contributing to the advancement of health and wellbeing in LMICs. In 2017, the UK spent £14.1 billion through ODA, with 14.7% being spent on supporting health.[xlii] It is an impressive commitment which flows both from a recognition of the moral value of assisting LMICs, and from the vested interest the UK has in building a world that is equipped to tackle challenges such as disease and antimicrobial resistance which know no borders.

Our concern in this section is that the synergies between how the UK invests in workforce development in LMICs, using ODA funding, and how the NHS sets about meeting recruitment targets for the NHS are not sufficiently spelt out, despite an impressive commitment on the part of the government to pursue an ethical approach.

At its core, this section explores the steps we think this process should include:

1. A workforce strategy to deliver the NHS Long-Term Plan which acknowledges the likely long-term dependence on international migration and highlights the continuing need to build systems that guarantee mutual benefit.

2. UK ODA investments in workforce development that continue to focus on LMICs but that are shaped to reflect the reality of an increasingly mobile workforce.

There is, in short, a need for all departments of government, both at the UK level and at the level of devolved administrations, to recognise their responsibilities to shape an ethical and coherent UK response. This is vital if we are to shift the compass from competition to collaboration, and to begin to work more in partnership to create health workforce sustainability that benefits both LMICs and the UK in an increasingly mobile world.

In this section we look at each of these pillars in turn.

3.2 A UK WORKFORCE STRATEGY THAT DELIVERS MUTUAL BENEFITS

A plan to develop a sustainable domestic health workforce is a vital policy ambition for the UK.[xliii]

However, unlike other countries such as Australia, Germany and Canada, the UK has a poor track-record in this regard. Nursing is a good example: in 2014 the UK had 29 nursing graduates per 100,000 population; the OECD average was 45 per 100,000.[7][xliv] Analysis suggests that because of recent changes in funding arrangements for educating nurses, we have seen a further decline in the undergraduate population.[xlv] More than 41,000 registered nursing posts are currently reported vacant in the NHS in England. This represents more than 1 in 10 posts.

Staffing levels in the NHS in Scotland are at the highest level ever, with 139,431 whole-time equivalent (WTE) staff employed, but the country continues to face challenges associated with an ageing workforce, increased use of agency staff, and persistent vacancies in certain positions and specialties.[xlvi] In Wales, the NHS employs around 89,000 people.[xlvii]

Nursing staff comprise 30% of the workforce, with shortages noted in critical care, mental health and advanced practice such as endoscopists.

Policy context – England

The NHS in England faces a shortage of more than 100,000 staff. If the emerging trend of staff leaving the workforce early continues, and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030.[xlviii]

And while these shortages and the associated ratios of staff to patients are of a lower order of magnitude to that faced by patients in low-income countries and rural areas of middle-income countries, they clearly pose a major risk to the UK.

The response from NHS England has been to publish *Facing the Facts, Shaping the Future*.[xlix] This is the first workforce strategy in almost 25 years, and builds on the NHS Long Term Plan launched by the former British Prime Minister in January 2019.[l]

International recruitment runs like a silver bullet through both documents.

> *"International recruitment will be significantly expanded over the next three years", the NHS Long Term Plan states.[li]*

What is to be welcomed is that both documents are not just a clear admission that the UK's efforts to train health workers will take time, they also place a strong emphasis on the ethics of international recruitment. For example:

"Looking ahead, as the sixth largest economy in the world and as an ethical global citizen, England should not be relying on net inflows of healthcare professionals."

"We must also continue to ensure that high-skilled people from other countries from whom it is ethical to recruit are able to join the NHS… This will mean a step change in the recruitment of international nurses to work in the NHS and we expect that over the next five years this will increase nurse supplies by several thousand each year."

There is also acknowledgement of the need to better manage mobility of an increasingly global workforce:

"Health workers are also globally mobile, highly trained, qualified professionals and we need to better manage these flows whilst supporting clinicians moving in both directions."

The strategy's global health strand concludes with a vision of the NHS as a "global learning hub", promoting the education and training benefits of closer relationships between the NHS and overseas partners, underpinned by a set of principles.

Such ambitions and ethical considerations are to be welcomed. And while it is true that this explicit openness to mutual learning through an ethical approach is refreshing, there is still a shortage on detail – a point we will return to in the next section of this report.

Policy context – Scotland

In Scotland, the Scottish Government's *Health and Social Care Delivery Plan* sets out how Scotland plans to deliver high quality services that have a focus on prevention, early intervention and supported self-management.[lii]

Within this policy context, The Scottish Government's National health and social care workforce plan has been developed in three stages: NHS Scotland, the social care workforce and, most recently, primary care.[liii]

Consideration has been given to "international flows, including the impact of Brexit, on recruitment and retention, and how to make more effective use of international recruitment opportunities."[liv]

There are clear signs in Scotland, as there are in England, of plans to expand international recruitment.

The former Health Secretary, Shona Robison, commented in June 2018 that "Scotland's NHS benefits enormously from the contribution made by staff from outside Scotland."

She noted that NHS Scotland would be stepping up efforts to recruit internationally "to deal with the potential effects of Brexit" following the relaxation of UK visa rules with a focus on nursing, midwifery, social care and GPs and an ambition to expand to other specialisms.

NHS Scotland careers website has a dedicated section focusing on Scotland as a desirable lifestyle choice with advantages over more expensive parts of the UK, such as London. Social media handles such as #ScotlandIsNow and promotional videos entice further.[lv]

[7] OECD data also shows that the USA trained more than twice that of the UK (63), while Australia trained even more, at 76 per 100,000 population.

However, Scotland has also been increasingly active in the sphere of global citizenship, with the Government's strategy now followed by a framework, an NHS Global Health Co-ordination Unit, and a programme board with an explicit objective to encourage policy coherence to ensure LMICs, as well as Scotland, benefit from international efforts.[lvi]

Objectives include to:

- Set the direction for the NHS Scotland Global Citizenship Programme by approving strategies and plans that support the policies and priorities set by the Scottish Government's International Development Strategy (2016).
- Ensure that our policies and approaches align and support the needs of the developing countries involved with the NHS Scotland Global Citizenship Programme.

Policy context - Wales

In Wales, *A Healthier Wales: our plan for health and social care* is the Welsh Government's long-term plan for health and social services.[lvii] The *NHS Planning Framework for 2019-22* provides direction on the production of clear and deliverable shorter-term plans.

And as Vaughan Gething, the Welsh Cabinet Secretary for Health and Social Services, reminds us in his written statement accompanying the issuing of the *Framework*, the Welsh health system continues to remain refreshingly outward looking with planning requirements including:[lviii]

- Further embedding of the *Well-Being of Future Generations Act* (2015), including the adoption of the sustainable development principles and active contribution towards the well-being goals;
- Strengthening partnership working by promoting prosperous partnerships to ensure future sustainability, regionally, sub regionally and across public sector and other boundaries.

The Charter for International Health Partnerships in Wales, now marking its fifth year, further cements a commitment from the Welsh Government and Welsh health organisations to support the international health agenda in Wales through a coherent policy landscape.[lix] The Charter also commits Wales to a programme of global citizenship training.

Established on 1 October 2018, Health Education and Improvement Wales (HEIW) are leading on the education, training, development, and shaping of the healthcare workforce in Wales.

Following recommendations from *A Healthier Wales*, the Welsh Government has commissioned Social Care Wales and HEIW to develop a long-term workforce strategy in partnership with the NHS and local government, the voluntary and independent sectors, as well as regulators, professional bodies and education providers.[8]

Currently out to consultation, this new workforce strategy will notably cover both health and social care.

However, as in England and in Scotland, Wales also struggles to fill vacancies in its health workforce and is also using international recruitment as one way of filling the gaps.[lx]

Shaping Migration

So, what options exist for governments in relation to recruitment of health workers who have trained elsewhere? Limiting migration is a common approach taken by destination countries like the UK, with highly targeted skilled worker migration becoming increasingly common. However, if allowed to increase unchecked, this type of skilled worker migration can be viewed as a 'win-lose' where the losers are potentially those countries, including LMICs, from whom health workers leave.

James Buchan, Senior Policy Associate, European Observatory on Health Systems and Policies at WHO, suggests that, "essentially there are two viable options for policy-makers and international bodies faced with in-migration and/or out-migration of health workers. They can decide not to intervene – to moderate flows with some type of code of practice – or to manage the migration process actively to enable approximation to a 'win–win', or at least not exclusively 'win–lose' situation."[lxi]

Another policy response, which in theory could be in the interests of both source and destination countries, a so-called 'win-win' scenario, is to shape some form of controlled migration, which requires individuals to return. This form of circular migration is of increasing interest and we will explore this approach further.

Source countries, on the other hand, may well consider compensation as a reasonable policy response.[lxii] The theory being that the destination country compensates the source country for the loss of its health worker, with the amount being related to the length of stay, cost of training or cost of employment. But the evidence suggests that this rarely, if ever, has actually occurred.

Even if this model were to work, the health worker remains far removed from where they are most needed. And there exists a further risk that such an approach encourages policy dialogue that is adversarial rather than consensual, echoing earlier patterns of health worker movement from the Global South to the Global North, which we have illustrated no longer reflect our complex, increasingly mobile world.

However, no matter what the response of governments is to migration, it is clear that greater coherence in decision making made at a national level can potentially enhance the role they seek to play at an international level, and can lead to mutual benefits for countries like the UK as well as LMICs.

3.3 UK ODA INVESTMENTS THAT BENEFIT LMICS AND REFLECT THE REALITY OF AN INCREASINGLY MOBILE WORKFORCE

As we have seen, LMICs face major challenges. Many low-income countries are not able or willing to employ the health workers that they have trained and so many go without healthcare especially in rural areas. Even a middle-income country such as India, which lacks no ambition when it comes to delivering UHC, is short of a substantial four million health workers.[lxiii]

The UK has a distinguished track-record of contributing to the development of resilient health systems in LMICs through ODA and the work of DFID and the Scottish Government in particular.[lxiv]

DFID's commitment to health system strengthening in LMICs has been sustained over several years. The UK was a signatory of the IHP+ Global Compact which committed the UK and partners to "tackle the challenges facing country health systems – particularly having enough trained health workers, in the right places and with the motivation, skills, equipment, commodities and medicines to do their work." The IHP+ has subsequently transformed into UHC2030 to respond to the health-related Sustainable Development Goals, with scope expanded to include health systems strengthening to achieve universal health coverage.[lxv]

Managed by THET, the DFID-funded Health Partnership Scheme (HPS) has been training health workers through partnerships since 2011. The HPS is a notable example of an ODA-funded programme that focuses on workforce within a health system strengthening context. Over a period of eight years (from 2011 to 2019), HPS disbursed grants to link health institutions (such as NHS hospital trusts or UK Medical Royal Colleges) with their counterparts in LMICS, sending UK NHS volunteers overseas to train colleagues and strengthen capacity with partner organisations. DFID provided funding for 180 partnerships; in turn this trained 93,000 health workers across 31 countries.

DFID increasingly works with the Department of Health and Social Care (DHSC) and other government departments to facilitate and finance institutional and professional linkages that build sustainable partnerships between UK health agencies and their counterparts overseas.

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[8] This health and social care workforce strategy developed by Health Education and Improvement Wales (HEIW) and Social Care Wales is being supported by the Institute of Public Care at Oxford Brookes University.

The partnerships forged with agencies such as Public Health England, Health Education England[9], the NHS and UK professional and regulatory bodies help build leadership, management and clinical and public health skills in our partners and in our own health workforce in a mutually beneficial way. To do so, DFID is actively engaged in supporting a process of reallocating 30% of ODA spend through other government departments, which is increasing opportunities for a greater range of actors to engage in support of the UK's ODA agenda.[lxvi]

For example, The Fleming Fund (led by the Department of Health and Social Care) is providing technical assistance for strengthening the response to Anti-Microbial Resistance (AMR). The Fund and workforce development programmes – like the THET-managed Commonwealth Partnerships for Anti-Microbial Stewardship programme – will build capacity for surveillance and for stewardship of the responsible use of medicines in around 25 countries.

All UK institutions involved in dispersing ODA have increasingly recognised and encouraged a consideration of the benefits to the UK from deploying health workers from the NHS to volunteer in LMIC health systems, themes explored in THET's 2017 report *In Our Mutual Interest*.

However, the UK has not made sufficient connections between its investments in health through ODA and the migration of health workers out of LMICs to the UK.

For example, DFID has been working on a Health System Strengthening strategy for some years now.

The draft strategy mentions mobility of health workers – and the associated challenges to affected low-income countries – only in passing. It provides no further analysis or clarity on how it is working with other UK government departments or countries to articulate its role in joining-up efforts to develop a sustainable and increasingly mobile health workforce.

And when most recently asked in parliament by the Shadow Secretary of State for International Development when the strategy would be published, the previous Secretary of State for International Development responded as follows:

"We cannot say at the present time in which month the health systems strengthening position paper will be published. We are committed to publishing the position paper in 2019."

3.4 THE FOCUS ON ETHICS

A bewildering number of people and institutions have a stake in the movement of health workers, not least the individuals themselves. The large numbers involved, the lack of coherence around professional qualifications and public safety through registration, and a lack of data clearly documenting migratory paths all add to the complexity. The latter has improved over recent years facilitated through initiatives such as the International Platform on Workforce Mobility[10].

Stakeholders include international organisations, migrant health workers and patients, government authorities, trade unions, professional organisations, and regulatory bodies in both destination and source countries.[lviii]

This leads to the challenge of balancing the many competing agendas including:

- A patient's right to healthcare
- The risks to patients and health workers
- The impact of universal health coverage
- The needs of health systems as well as broader competing priorities
- The labour rights of migrant health workers
- The economic impact of migration

The UK was the first nation to adopt a Code of Practice for International Recruitment in October 2001[11] (Scotland followed in 2006).[lxvii] This laid the foundations for the Commonwealth Health Ministers' adoption of a Code of Practice in 2003 and led, in turn, to the development of the WHO Global Code in 2010.[12]

Adopted by WHO Member States, the WHO Global Code highlights that countries should implement effective health workforce planning, education, training and retention strategies to sustain a health workforce that is appropriate for the specific conditions of each country, and to reduce the need to recruit migrant health personnel.

It also calls for bilateral agreements, coherence across government agencies, including on ODA, with priority focus on health systems in LMICs.

The WHO's Code aims to shape rather than prevent migration in ways that emphasise the positive benefit for individuals and health systems.

A number of other regulatory measures have been proposed. For example, the Sustainable Development Goals and the UN's new Global Compact for Safe, Orderly and Regular Migration provide an overarching framework, with many other supportive instruments.[13][lxviii]

In essence, such codes respect the right of health workers to move to other countries whilst discouraging active recruitment by high-income countries of health workers from countries with critical shortages of health workers.

Code adherence

NHS Employers, under the auspices of the Department of Health and Social Care, is responsible for the implementation of the UK Code for healthcare organisations involved in the international recruitment of healthcare professionals. They also manage the list of commercial recruitment agencies that adhere to the UK Code.[lxix]

But it remains the case that although many policy frameworks exist, the ability to enforce sovereign states such as the UK to adhere to guidance is limited.

During research for this report the authors witnessed a very clear example of a recruitment agency called Adevia trying to actively recruit Ugandan nurses for the UK and USA.[lxx]

Investigative work conducted by the UK's Daily Telegraph found the "NHS breaking recruitment rules with one in four new doctors coming from 'banned' developing countries."[lxxi] They found that in total, 27% of all doctors registering to work in the UK came from countries on the 'banned' list of countries.[14] In 2014, just 13% of doctors starting work in Britain came from these countries. The investigation went on to state that "NHS trusts have used agencies to recruit doctors from such countries."

NHS Employers responded as follows to allegations that a London based recruitment agency, Remedium Partners, have been actively recruiting for the NHS:

"NHS Employers manages a list of commercial recruitment agencies that have committed to adhering to the UK Code of Practice. Remedium Partners are not currently included in this list."

NHS Employers have told the report author that they issued a message to employers to profile the three resources employers and any agencies they contract should use to work within the expectations of the Code of Practice and to only use agencies who adhere to the Code.

London North West Healthcare NHS Trust reported that they had recruited 47 doctors from India and seven from Nigeria using Remedium, stating also that it had not targeted areas in India which are covered by restrictions. Another Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, stated this:

"It had not targeted any countries listed in the national guidance but said eight doctors from Myanmar had contacted it directly, and now begun work."

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No NHS Trust was willing to go on record as saying that they had used agencies to recruit from banned countries and the Daily Telegraph's findings came from unnamed NHS sources. The fact remains, however, that the number of doctors coming from banned countries to work in the UK has doubled in the last five years.

It would appear, therefore, that parts of the NHS are colluding with recruitment agencies to, at the very least, contravene the spirit of the UK Code of Practice for International Recruitment and the WHO's Global Code of Practice on the International Recruitment of Health Personnel.

If this kind of practice goes unchallenged then we can readily imagine a world where health inequalities accelerate out of control and where a form of 'health apartheid', far worse than already exists, prevails within and between nations.

The UK is, therefore, increasingly open to criticism for the impact its recruitment is having on LMICs, as we gleaned from this research and our interactions with Ministries of Health in Africa.

The concern of this report is that, as the UK further relaxes migration policies, with no restrictions on visas for doctors and all nurses, and with further sweeping changes proposed with the UK's departure from the EU, the UK won't need to actively recruit from LMICs:[15]

Health workers from LMICs will be increasingly attracted to apply to work in the UK of their own volition, or with the support of private agencies, and they will be welcomed by an NHS that is increasingly fraught in its efforts to attract staff.

Consider for a moment, the pressures on the NHS as relayed to us by a specialist recruitment consultant:

"His predecessor was sacked because of failing on A&E figures and A&E is the number one thing that the Chief Executive has to hit, if not you don't have a job. So, he'll pay whatever it takes to get the people in place."

This is a significant concern when considering the ethics of the UK's approach to the development of the global health workforce. Not only do we risk exacerbating inequality and poor health outcomes in LMICs, we risk damaging our reputation.

As we look to strengthen relationships internationally, exert our influence through soft power and increased commerce, positioning ourselves as a trusted partner to national governments will be increasingly important.

Building an evidence base to underpin our ethical stance

Evidencing the efficacy of international recruitment codes, the importance of agreements between governments which build trust and good will, and the partnerships fostered by such agreements that encourage health worker mobility, are all important measures in the UK's quest to pursue an ethical approach that is supportive of health workforces in LMICs.

There is also an urgent need to be honest with language and to refrain from prefixing everything with the term 'ethical', in the hope that this will suffice rather than to denote any substantive ethical approach. Such usage risks more harm than good as we strive to build partnerships based on honesty and with the needs of patients in LMICs as well as in the UK front and centre.

In the next section we will look at what this ethical approach supportive of health workforces in LMICs may look like. But first, we look at the example of the Medical Training Initiative.[16]

The Medical Training Initiative (MTI)

The ethical challenges explored above are illustrated in the current MTI programme.

The NHS Long Term Plan showcases one particular circular migration model, the MTI 'train and return' programme. This may be expanded "so that more medical trainees from both developed and developing countries can spend time learning and working in the NHS."[lxxiii]

The UK government positions the MTI as an ethical approach to developing the experience of health workers from overseas whilst gaining the benefit of their skills for a prescribed time. The UK government believes that this programme will not prompt a political backlash because doctors who come to the UK must return to their countries of heritage and therefore do not count towards the UK immigration total.

This move towards expanding this more targeted migration of health workers has been widely reported as a good thing for NHS organisations and patients alike:

"This government welcomes the role of the MTI in allowing overseas medical staff the chance to train in the UK, observe clinical practice and to learn vital skills. While they are training in the UK, these international doctors gain state-of-the art skills and experience, which they can take back and use to benefit healthcare globally. We are absolutely clear that these roles are not designed to fill substantive vacancies but offer a valuable training opportunity for doctors from overseas. As with the other government authorised exchange schemes, the MTI scheme is subject to regular review to ensure it continues to meet its aims and those of the immigration system."[lxxiv]

UK Government spokesman.

"We don't know what's in the long-term plan, but if this increase is true, it's good news. The academy has long argued for an increase in the number of MTI doctors who can contribute to the NHS as they come to the UK to expand their training. The MTI scheme is a win all round. An increase in international trainees will help alleviate the pressures on the frontline in the NHS,"

Professor Carrie MacEwen, Chair, Academy of Medical Royal Colleges, interviewed for this report.

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[15] In July 2018 the Home Office removed all doctors and nurses from the Tier 2 visa cap. Tier 2 visas are for workers who have an offer of employment and a certificate of sponsorship from their prospective employer.

[16] The MTI Scheme was established by the UK Department of Health in February of 2009. The scheme allows trainee doctors from countries outside the European Economic Area to come to the UK to learn from experienced consultants and teams within the UK health system. The scheme is designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months so that they can benefit from training and development in NHS services before returning to their home countries. Most recently it has targeted doctors from Department for International Development (DfID) priority countries, or the Low and Lower Middle-Income countries as defined by the World Bank. The NHS Long Term Plan signals a possible widening of target countries to include developed as well as developing ones.

But how well does this work for LMICs, and for the individual health workers involved, and can improvements be made?

We identified the following challenges with MTI during our research for this report. We also took the opportunity to study the Irish equivalent of MTI, the International Medical Graduate Training Initiative (IMGTI) and clearly state where we include these in our findings.

Pastoral and training challenges for trainees

"Trainees had a short lead-in time, reporting that they started work in the designated hospital within a few days of arriving in Ireland, despite not having much knowledge of the health care system in the country" (WHO/RCSI, 2017).

"One of the challenges of the IMGTI: engaging trainers who were willing to dedicate sufficient time to trainees, whether Irish or Pakistani trainees. Some stakeholders stated that the needs of Irish and Pakistani trainees were different, and more dedicated programme support was needed for the Pakistani trainees" (WHO/RCSI, 2017).

Insufficient follow-up of trainees after they return to their countries of origins

"We do email them all after they've left. We email them about a year later by which time a lot of them are lost you know; we have no other way. It would be nice; it is a criticism perhaps that we don't have a sort of alumni station of doctors who've been to the UK." Senior Medical Director.

"Conducting questionnaires with returning graduates will become part of our annual internal audit process." A Royal College.

How appropriate is training for return?

"In terms of making sure that their training is relevant to their setting, that's not something that the employer in the UK, the Trust would be particularly concerned with. These are trainees that will train alongside UK trainees and EU trainees and their exposure to the same opportunities." A Royal College.

"We must discuss the suitability of UK posts with the donor country and focus as much on generic training in clinical and communication skills, management, public health and teaching as on highly specialised and expensive investigations and procedural skills which may be of less relevance to the graduate of their return." Senior Medical Director.

"The things we teach aren't appropriate really for managing such large numbers of patients." Senior Medical Director.

Are there policies in place, which recognise relevant experience for trainees returning to their countries of origins?

"And the training here is provided in such a way as to fit in with that training programme so it's recognized as part of specialist training programme that they're doing in their own country... they come here for two years, that counts as two years towards their postgraduate specialisation in their country. And that obviously then has to be worked out by an agreement between the training colleges of Ireland and the training colleges in the countries." IMGTI.

"The Sri Lankan Department of Health continues to employ (a particular cadre of trainees) while they are in the UK. But it's a very tiny salary but they're still on their books. They still have conversations with their educational supervisor every six months, they ask for a progress report. And then those doctors go back and do their thesis and they complete their training. So that's a model that we really like, that worked really well for the MTI scheme." A Royal College.

Do trainees return to the UK and what role does the NHS play in encouraging trainees to return to the UK?

"So, we had about 20 doctors who came in 2015 so they should have left in 2017. And of those 20, yes there are still 50% that still have addresses in the UK and are employed here in the UK. And then the other 50% have gone home." A Royal College.

4. What the UK's role could look like

4.1 INTRODUCTION

We have explored why the UK should shift the compass from competition to collaboration, and the complexity of the ethical arguments associated with this.

In this final section, we examine what an ethical approach could look like in practice, one that is supportive of health workforces in LMICs, whilst also addressing the challenges faced in the UK. Our recommendations are built around three pillars: Ethical Leadership, Ethical Recruitment and Ethical Partnerships.

4.2 ETHICAL LEADERSHIP

Introduction

Throughout this report, we have pointed to the considerable influence the UK has by virtue of the size of the NHS and the generosity of its ODA expenditure.

The UK government has an opportunity to play a leadership role on the national and international stage.

The aim of our report is not to critique the UK's domestic ambitions, for this has been done elsewhere.[lxxv] Rather, in this section we explore how the UK Government can shape the movement of health workers in a way that both delivers to the UK and supports its ambitions to better support LMICs.

Policy coherence

When further considering a workforce strategy that works for LMICs as well as for the UK, the issue of coherence between the UK government's development cooperation policies and domestic policies and practices that aim to strengthen the UK's health workforce is vital.

Greater emphasis should be placed by DFID on working with other governments, notably in Scotland and Wales, and UK departments, such as the Department of Health and Social Care, to ensure a more joined-up, ethical approach to health workforce development.

And while tensions exist to developing coherent positions between governments in the UK, there are common themes to explore and interesting lessons to learn.

Recommendation 1

There is currently little policy coherence at the UK government level between NHS international recruitment strategies that encourage health worker migration for training opportunities within the NHS, and ODA used to strengthen health systems in LMICs.

To the UK Government:

1.1 Establish a unified health workforce strategy at the national level which maximises the synergies between UK ODA funding and NHS investments in workforce, allowing for the meaningful circulation of health workers.

As illustrated in this report, there is a real risk that current policies will encourage an increase in the number of health workers migrating from LMICs to the UK which will threaten DFID investment in health system strengthening efforts in these countries, through the HPS and beyond.

A health workforce strategy which maximises the synergy between ODA funding and NHS investments in workforce will only be possible if DFID takes a leadership role in this process, working in close partnership with the Department of Health and Social Care, the Home Office, the Foreign and Commonwealth Office, The Department for International Trade, and in close consultation with Health Education England and other arms-length bodies such as Public Health England.

This new approach would help support health workforce sustainability that benefits both LMICs and the UK in an increasingly mobile world. Ensuring this mutually beneficial cycle will be essential if the most effective use is to be made of the UK's spending on health and on ODA.

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Areas of particular focus of the strategy, as highlighted by many low and lower middle-income countries in the third round of WHO Global Code reporting, should include:

- Support in developing policy to regulate the migration and retention of health workers.
- Promotion of policy coherence in countries, and regionally, which is supportive of sustainable workforce planning that address push factors.

Measures could include:

- Diversifying skills mix to harness the potential of community-based health institutions.
- Developing non-wage retention strategies including improving working conditions.
- Support in developing, implementing and monitoring bilateral agreements.
- Support in strengthening data information systems to address data management gaps.

To the Department for International Development:

1.2 Use ODA to support the continued professional development of health workers on their return from training in the UK and align this with bilateral programmes to support LMIC health system strengthening.

We have seen that the UK government positions train and return schemes, such as the MTI, as an ethical approach to developing the experience of health workers from overseas whilst gaining the benefit of their skills for a prescribed time.

However, we have also noted the lack of a coordinated approach to tracking progress of LMIC health workers who train in the UK on their return to their country of heritage.

Ensuring that the skills gained by health workers while training in the UK are fully utilised on their return, and that the professional development of these health workers is carefully managed, will help to maximise the impact of the training they receive in the UK.

The Royal College of Physicians has played a leadership role in establishing a more formalised pathway which considers the career aspirations of individuals who train on such schemes, and the critical role they can play in building LMIC health systems on their return. DFID should therefore also invest ODA in these health workers on their return to LMICs.

This will help to maximise synergy between UK ODA funding and NHS investments in mobile workforces.

This should be aligned with bilateral programming as part of a unified health workforce strategy at the national level which also takes note of absorption issues highlighted in this report.

To Health Education England, NHS Improvement and NHS England:

1.3 Work with civil society to develop a best practice toolkit for NHS employers that ensures supportive policies and processes for the induction and ongoing pastoral care of international health workers in the UK.

The Interim NHS People Plan highlights the need for the NHS to focus regionally on international recruitment which is effective, supportive of employers, and which reaps benefits from economies of scale.

We welcome the Plan's proposal to develop a best practice toolkit, with NHS Employers and other national partners. This will support employers by highlighting good practice in terms of practical and pastoral support for international health workers.

However, when reflecting on the experience of health workers from diaspora as we do in this report, for example, it is still apparent that there are areas of improvement that can be made when engaging with health workers trained in LMIC health systems to ensure supportive induction processes and the ongoing pastoral care of these health workers.

We therefore propose that civil society organisations be engaged in supporting the development of the emerging NHS Employers best practice toolkit.

Recommendation 2

As we have highlighted in this report, health is an investment that both underpins economic growth and is a major part of our national economies – an investment which also contributes to the economic empowerment of women and young people.

But many LMICs still do not assign the 15% of annual budgets for health as recommended by the Abuja declaration.[lxxvi] And so governments in many LMICs, such as in Uganda and Tanzania as noted earlier, struggle to educate, train and employ sufficient numbers of health workers.

And many of those health workers who are trained are being forced to either work in other sectors, move to practice in countries within the region, or migrate to high income countries (HICs) such as the UK.

To LMIC Governments:

2.1 Assign health budgets that deliver health workforce strategies at the national level which optimise existing workforces and promote health system sustainability.

The issue of absorption of health workers into LMIC health systems is fundamental. We call on Ministries of Finance, Ministries of Labour and Employment as well as Ministries of Health to focus on addressing this issue.

However, LMICs cannot compete with HICs on remuneration, opportunities for specialised training, or research.

Emphasis should therefore also be placed on:

- Developing non-wage retention strategies, including improving working and living conditions.
- Harnessing the potential of community-based health workers as the credentials awarded to these cadres are typically recognised only in their own country, making them less vulnerable to international migration.
- Promoting a triangular flow of talent and skills by encouraging some migrant health workers to return to their home country.
- Investing in strengthening national institutions for tracking internal and international migratory flows and to enable evidence-informed planning and policymaking.

4.3 ETHICAL RECRUITMENT

4.3.1 Recruitment codes

As we have seen, the UK has been competing for international health workers for many years. Progress has been made over the last twenty years, with active recruitment from countries with critical shortages of health workers by UK based organisations becoming increasingly rare.

However, it is becoming apparent that such codes are being flouted, as illustrated in the previous section. Unethical recruitment practices are now threatening to undermine LMIC health systems. The UK should enforce its own international recruitment codes and from there work towards becoming an ethical leader that is open to share its experiences of the NHS as well as to learn from others.

4.3.2 Bilateral agreements

There has been a great deal of analysis of bilateral agreements between high income countries such as the UK and LMICs over recent years.[lxxvii] And while little evaluation of the impact of bilateral agreements has been conducted, there is a growing body of knowledge resulting from the growing requirement for member states to regularly report on the implementation of the WHO Code. This has led to improved information sharing on bilateral agreements, with the second round of reporting identifying more than 60 examples of bilateral agreements on health workforce mobility and migration.[lxxviii]

A German Triple Win

Germany's nursing sector is feeling the impact of a significant shortage of nurses. At present, vacancies outnumber the amount of qualified job seekers on the job market, with demographic changes exacerbating this situation, meaning that 150,000 new nurses will be required by 2025.

Germany has become one of the OECD member states with the fewest legal obstacles for the immigration of high-qualified employees. In 2012, the 'Blue Card' was introduced to reduce barriers for the migration of foreign physicians and other high skilled personnel to Germany.

The German government has initiated pilot projects to study the design of migration schemes for the health care sector to reduce the health workforce shortage, with projects also intending to have development impacts on the origin countries. German policies for managed migration have been designed around the WHO Code, with pilot projects including work in countries such as Vietnam, China, Tunisia, Egypt, Morocco and the Philippines.

The "Triple Win" project facilitated by the German Society for International Cooperation (GIZ), bilaterally with the Philippines, Georgia, Vietnam and Tunisia, is a noteworthy example of a government signing bilateral agreements which facilitate mobility skills partnerships with controls in place to address questions of equity.[lxxix]

The triple win is described as follows:

- Pressure is eased on labour markets in the countries of origin.
- Migrants' remittances provide a developmental stimulus[lxxx] in their countries of origin.
- The shortage of nurses in Germany is alleviated.

Criticism of this programme includes how much of a 'win' it is for the countries who export their nurses. Indeed, the programme has not always given sufficient attention to the rights of the nurses involved, but with greater involvement of unions

from both sides – Ver.di (Germany) and PSLINK (Philippines) with support from Public Services International (PSI)[17] and the International Labour Organization (ILO) – this has improved over recent years. There are further questions around the overall impact to the source health system within the wider bilateral context of the programme.

However, with more than 2000 nurses having been placed with German employers, the programme can be seen to be one of the more successful models of skilled worker migration underpinned by a bilateral agreement.

Saudi Arabia-Sudan Co-operative Agreement

Sudan and Saudi Arabia have been collaborating on the training of Sudanese doctors for many years now, with recent regional developments witnessing a strengthening of ties between the two countries across a wider national security agenda.

Sudanese doctors spend two years of their five-year training in Saudi Arabian hospitals. And in return for the service they provide the Saudi health system, Sudanese doctors are paid Saudi rates of pay during their two years.

In addition, the agreement allows the Sudanese government to reward those who have undertaken training in remote, underserved rural areas of Sudan with access to specialist training in Saudi Arabia.

The Sudanese ambassador for Saudi Arabia suggests that Sudan's health services would not be affected by the departure of 5,000 doctors, "We have 5,000 graduates every year, so we will share them between our two countries."[lxxx]

However, as a country with "frail health information systems" and reported "failures of deployment and poor distribution" of health workers, and with a recent estimate showing that 30% of the 3000 annual medical graduates migrate every year, there is a concern that such initiatives ultimately undermine the Sudanese health system.[lxxxi]

Recommendation 3

In past years, the UK has played a leadership role in contributing to the development of resilient health systems in LMICs. However, unethical recruitment practices, driven largely by the behaviour of private recruitment agencies, are increasingly undermining LMIC health systems.

To the Department of Health and Social Care:

3.1 Strengthen implementation of the UK Code of Practice for International Recruitment and ban international recruitment agencies from the NHS Employers approved list who use sub-contractors to recruit from LMICs.

We welcome the Interim NHS People Plan's recommendation to develop a new procurement framework for NHS England and to publish a full list of approved international recruitment agencies for 'lead recruiters' to draw on, ensuring consistent operational and ethical standards.

However, recruitment agencies on the approved list will still be able to actively recruit from LMICs through the use of sub-contractors who are not on the approved list.

There is, therefore, an urgent need to ensure transparency on whether or not approved international recruitment agencies are using sub-contractors to recruit from LMICs.

3.2 Strengthen implementation of the WHO Code of Practice on the International Recruitment of Health Personnel.

The UK has consistently reported on the WHO Code but there is further potential to strengthen effectiveness, especially around negotiation of bilateral agreements. This is particularly relevant given the likelihood that it will be LMIC countries filling future gaps in the NHS workforce, rather than health workers from Europe once the UK has left the EU.

3.3 Encourage other WHO member states to strengthen implementation of the principles and recommendations of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including incorporation into national laws, polices, and international cooperation.

As of March 2019, 80 Member States of the WHO had submitted a national report. This represents over two thirds of the world's population.[lxxxii]

Data on health worker migration, which all countries have committed to providing via the WHO Global Code, will also help countries better understand the regional and global flow of health workers.

This filling of gaps in data will help realise strategies supportive of cost-effective retention of health workers in LMICs.

4.4 ETHICAL PARTNERSHIPS

Introduction

Ethical partnerships are a powerful way of maximising the synergy between ODA funding which benefits LMICs, and NHS investments that ensure delivery in the UK.

In this concluding section we survey the different ways in which the UK can encourage not only outward but inward mobility within the context of an evolving partnership landscape.

4.4.1 Education and training

THET, in *Transition from Aid*, highlighted the importance of maximising learning opportunities between health systems. We argued that we are not doing enough of this, nor doing it well enough. [lxxxiii] THET believes that we should be clear about the mutual benefits achieved, but that we must also ensure that we strike the right balance between LMIC and UK interests to ensure that our approach is ethical.

NHS as a beacon for UHC

In the field of global health, the NHS is universally recognised as a highly effective model for ensuring that everyone can access healthcare without the fear of incurring catastrophic health expenses. The NHS's core values serve as a highly valued model for ensuring that the poor don't get left behind.

Education and learning are a great strength of the UK

In this report, we reiterate our message that the UK should play a role in the development of the increasingly mobile health workforce, and that collaboration rather than competition is vital for a sustainable future as this can benefit both LMICs and the UK.

A global learning hub

In THET's policy report, *In Our Mutual Interest*, which gathered learning based on our experience of managing the Health Partnership Scheme (HPS), we posed the following question:

"If the UK health system knows how to provide universal health coverage, is a health systems expert, can train an effective workforce but is increasingly looking outward to seek greater efficiencies and new ways of delivering care, then what part can health partnerships play in this future NHS?"[lxxxiv]

And so, the emergence of Health Education England's Global Engagement Directorate, with an ambition to promote this country, in the words of the new NHS workforce strategy, as a "global learning hub", encouraging not only outward and inward mobility, is to be welcomed.

Recommendation 4

The UK has the experience and potential to position the NHS as a global leader in workforce development. However, progress in shaping the NHS's engagement with LMICs is currently haphazard, expressed through a tantalising patchwork of initiatives.

To the Department of Health and Social Care and the Department for International Development:

4.1 Invest in the UK health system to become a global centre of excellence for workforce development by promoting both outward and inward mobility through partnerships with LMIC countries that are defined by mutual benefit.

The UK has begun to set out its vision of this country as a world leader in health workforce development, a global learning hub nurturing an increasingly flexible NHS workforce with the capacity and capability to respond to the future needs of patients and the public, and to provide integrated whole person care.

Becoming a global learning hub will involve supporting local NHS organisations to engage in global activity, embedding global skills, learning and innovation as well as bringing experienced overseas staff to work in the NHS.

This approach should be delivered within an ethical framework that ensures benefits to LMICs, as well as to the NHS, and addresses the challenges that we highlight in this report.

'Everything I learned in the UK is applicable in Uganda'

Dr. Felix Bongomin trained as a medical doctor in Gulu University, in the north of Uganda, between 2009 and 2014. Dr. Bongomin then followed-up his studies with a one-year internship at St Mary's Hospital, Lacor – one of the biggest hospitals in northern Uganda.

Having completed his internship, Dr. Bongomin enrolled at Manchester University in a one-year Master's programme in Medical Mycology and Immunology, funded through a competitive 'equity and merit scholarship'. He became aware of the opportunity through a health partnership between Gulu and Manchester, and the sponsorship of the University of Manchester eased the process of successfully applying for a Tier 4 visa to enter and study in the UK.

Dr. Bongomin's learning experience in Manchester was quite different from his earlier experiences in Uganda, with 'a far less hierarchical structure' evident. And although Dr. Bongomin acknowledged a certain amount of loneliness initially, with a tendency of people to 'mind their own business' in England, he valued his colleagues pastoral support as he adjusted to life in the UK.

Having completed his Masters, Dr. Bongomin was then successful in applying for a role with the University of Manchester as a clinical research associate based at Wythenshawe Hospital in the south of the city, with the University once more providing a certificate of sponsorship to help him apply for a Tier 2 visa to allow him to remain and work in the UK.

Dr. Bongomin's research focused on chronic fungal diseases of the lungs, evaluating treatment outcomes, studying how patients tolerate different treatments, as well as fungal resistance to treatments. This line of research was very much driven by Dr. Bongomin's experiences of treating patients with a high prevalence of HIV in Northern Uganda, where he experienced first-hand fungal diseases as a significant cause of fatalities. For in Uganda, unlike bacterial infections such as TB where there is more awareness and where diagnostics are in place, there exists very little expertise of fungal diseases. There are, in fact, only three specialists in Uganda at present, Dr. Bongomin and two other colleagues who both trained in the UK, one at Manchester, the other at Aberdeen.

On returning to Uganda last year, Dr. Bongomin enrolled in a three-year Master of Medicine degree in internal medicine in the capital, Kampala, where he is currently in his first year. Dr. Bongomin is not only deepening his clinical expertise of multi-morbidities associated with viruses such as HIV, but also plans to gather research evidence to establish the true burden of fungal diseases across Uganda. From there, he plans to present evidence to decision makers at Ministry level to help them understand the importance of this issue, as well as to persuade them to build the country's expertise in this field by training and employing enough specialists.

And for good measure, Dr. Bongomin is not only lecturing back home at Gulu University in the north of the country, but also plans to set-up a Medical Mycology Society in Uganda to ensure his evidence-informed advocacy efforts grow and grow.
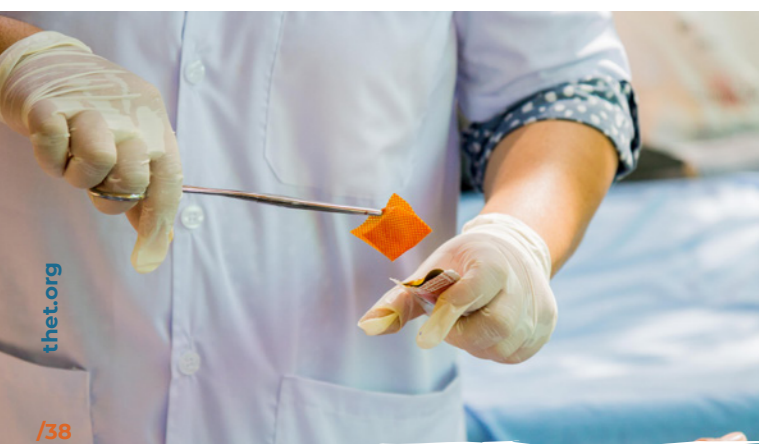
4.4.2 Skills Mobility Partnerships

International partnerships that allow for skills development and cost sharing and which ensure that some benefits accrue to the origin country have been characterised by the OECD as Skills Mobility Partnerships.[lxxxv]

The OECD identifies the following key features of such partnerships:

Skills development and recognition, in which the migrant acquires new professional skills or improves existing ones, building upon prior experience and training.

Partnership, in which mobility is organised generally within existing legal migration channels, and the costs of training and matching are at least partially borne by the country of destination and/or employers.

Mutual benefit, in which benefits are provided for all involved: countries of origin (by increasing the potential pool of skills); the destination country (by facilitating access to skills in demand); and migrants (by enabling them to acquire and market new skills).

The OECD highlights one particular Skills Mobility Partnership model, *Global Skills Partnership*, as a way to associate migration and skills development for the mutual benefit of origin and destination countries, as well as migrants themselves.

Definition of a *Global Skills Partnership:*

A *Global Skill Partnership* is a form of (or could be part of a) bilateral agreement. It is a way for migrant destination countries and migrant origin countries to work together to maximise the potential contribution of skilled migrants, and to sensibly share the benefits of skilled migration.[lxxxvi]

And indeed the *Global Skills Partnership* model was included in the Global Compact for Migration in December 2018 under objective 18, with the aim to:

"Invest in skills development and facilitate mutual recognition of skills, qualifications and competence."

More precisely, as to strengthen:

"training capacities of national authorities and relevant stakeholders, including the private sector and trade unions, and foster skills development of workers in countries of origin and migrants in countries of destination with a view to preparing trainees for employability in the labour markets of all participating countries."

This particular model of skills mobility partnership has been studied in detail by fellow civil society organisation WEMOS,[18] and they have concluded that such public-private partnerships will not lead to sustainable solutions from a global health workforce development, migration or social perspective.[lxxxvii]

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18 WEMOS is a Dutch non-governmental organization - Werkgroep Medische Ontwikkelingssamenwerking (Working Group on Medical Development Cooperation).

Different types of Skills Mobility Partnerships have, in a broader sense, been around for a long time, with such approaches underpinned by UN General Assembly resolutions on human resource development which promote exchange.[lxxxviii]

We will now explore two forms of Skills Mobility Partnership: 'train and return' schemes that encourage mobility of health workers from LMICs to the UK, and health partnership programmes that mainly encourage mobility of health workers from the UK to LMICs.

4.4.3 Mobility from LMICs to the UK - Train and return schemes

Earn, Learn, Return, like the *Medical Training Initiative (MTI),* is a UK led global workforce initiative that promotes a form of circular migration. Managing such schemes ethically to ensure LMICs and health workers get as much out of these schemes as the UK is essential if the UK is to be a trusted partner of choice.

Mindful of the need to respect the rights of individuals to migrate, often for economic reasons, Health Education England are aiming to "create new pathways which aim to be 'win-win' for each partner and ultimately benefit all health systems."

"I am getting lots of support from my ward manager, my colleagues at work and, in fact, the entire staff at the hospital and every person I have met in the town and in the church.

I feel very special and welcomed. I am learning a lot of things in my profession: key professionalism in nursing, importance of accurate precise documentation I have never learnt before, it's very exciting." **Nurse on Health Education England's Global Learners Programme.**

Health Education England emphasise the importance of partnership and mutuality in this process:

"How we as a country, a health system, and an organisation interact with partners in low- and middle-income countries matters."

"Our engagement strategy must be two-way, transparent, encourage learning both in the NHS and partner healthcare systems and attempt to use migration to enhance bilateral relationships, not disrupt them."

And co-development is also highlighted as being an important element:

"Health Education England's work recognises throughout the need for co-development. Our programmes are constructed following a wide stakeholder consultation which included international stakeholders and NHS partners."[lxxxix]

This is encouraging and, in many ways, reflects the values expressed in WHO's Twinning Partnerships for Improvement framework and THET's Principles of Partnership.

Earn, Learn, Return – migration and mobility

Health Education England's *The Global Learners Programme*, commonly referred to as *Earn, Learn, Return*, promotes the movement of health workers to and from the UK and MICs.

The programme has been running for more than two years with agreements between the UK government and several MICs, including states in India, such as Kerala, with other states in the pipeline, Pakistan (both India and Pakistan are on the WHO list of countries where active recruitment is discouraged), St. Vincent and the Grenadines, and Jamaica. The Philippines will also become a recruiting partner in the near future.

Five hundred nurses are currently enrolled in the programme, with 160 now in the UK and 400 preparing in-country. Health Education England has ambitions to grow the programme to recruit 1500 nurses next year, with many more planned in the future to address the 40,000 and growing gap in the UK nurse workforce. Nurses are recruited via suppliers that have been sanctioned by LMIC's governments.

Nurses on this scheme enter the UK via a Tier 2 visa, which allows them to work for three years in the UK. They may extend this for another two years before considering applying for British citizenship.

Health Education England's ethos is to support nurses to stay or return as they wish, with those who do consider returning being offered roles commensurate with competencies gained in the UK, negotiated through agreements with employers in LMICs.

Many individual Trusts have undertaken their own international recruitment for many years, managing travel and logistics, and sometimes contracting third party agencies to source candidates. With *Earn, Learn Return*, Trusts can now consider candidates via a centralised database without having to actively recruit themselves. Health Education England makes sure that nurses don't have to pay for the opportunity, and NHS Trusts pay for flights and their first three months accommodation in the UK.

The nurses themselves go through a rigorous testing process, including English language skills assessments and clinical competencies testing through objective structured clinical examinations (OSCEs) to meet the Nursing and Midwifery Council's standards. And if successful, they are provided with a thorough induction process similar to a nurse trained in the UK. Additionally, mentors and pastoral care are provided to support nurses to settle-in.

As such, *Earn, Learn, Return* can be viewed as a centralised approach to managing the mobility of an international workforce at the national level. It may be a more economical way for the NHS to recruit internationally. However, the programme hasn't been evaluated as it is still in its infancy and so it is unclear how many nurses will return to their countries of heritage.

It is, therefore, difficult to assess this programme, but the approach may end-up being a 'win-lose' model as the scheme is not explicitly designed as a skilled migration model like Germany's *Triple Win* programme (see case study – **Germany's Triple Win** on page 36).

This programme, like the MTI, does have its critics:

"Well if I get accustomed to a certain way of earning, what would make me want to return to less earnings? Is it just about education? If it's a two-year visa and I've learnt that skill which is currency for the country that I've learnt it in am I really not going to find a way to stay?"

"They're not here permanently so they'll give their best to our workforce and then at any time we can pull the rug from under their feet and send them back home."

"But are they learning a particular cultural approach to delivering care? This worries me."

So, what is happening in reality? It's hard to say, as the programme is in its early stages and systematic studies are still to become available on what individuals are learning or how they will use their skills on return.

Health Education England does, however, acknowledge much of this criticism and appears committed to addressing some of the more pressing issues in line with their principles of having an ethical approach and practicing co-development.

For example, follow-up with nurses once they have returned to their countries of origin:

"One of the things we would hope to do over the coming years is to evaluate our schemes and see what the different rates of returns are and also seek to follow those nurses up once they return back. There are some interesting longitudinal studies that can be done both on the nurses that chose to remain and chose to return and the motivations for both would support us in structuring future schemes." Senior public servant.

And the need to nurture relationships with an origin country's health system to ensure nurses are rewarded for overseas work:

"We believe in the importance of the models we developed where we have partners in India who have committed to not just taking the nurses back, but taking them back into roles that are rewarded, remunerated and utilised respectively." Senior public servant.

"But unless we both work with our partners to develop our programme over the coming years and analyse why it has or hasn't been attractive we are not going to be able to improve it … if we wanted to be a long term partnership between countries with a circular migratory pattern, we have to make sure

that return element works or the source of nurses coming to the UK will I suspect relatively quickly dry up" *Senior public servant.*

In addition, trade unions and other health system stakeholders haven't always been involved when the UK has been pursuing train and return programmes like Earn, Learn, Return. This is an important feature of such agreements, as illustrated in the Germany-Philippines Triple Win case study above, as full stakeholder involvement helps to ensure social protection and labour rights of the health workers involved.

"I suspect it could be better than this, if it was organised and we had something around ethical recruitment." Senior trade union representative.

"They haven't dealt with our domestic supply of workforce and they haven't been explicit about what it is they're trying to do to combat some of those issues. So, if 'earn, learn, return' is one of the strands of how Health Education England supplement our domestic workforce they need to be very transparent in what they're doing." Senior trade union representative.

Further,

"They'll have a conversation with the Minister out there and no nursing union representatives are involved. So, by the time that the chief nurses are aware that their workforce is being drained to 'earn, learn, return', it's problematic. And they will abide by it because their Minister wants them to do it." Senior trade union representative.

Jamaica – Leeds
Earn, Learn, Return

Also running under the banner of *Earn, Learn, Return* is a new partnership between Leeds Teaching Hospital and the Jamaican Ministry of Health.

Fifteen Jamaican nurses spent seven months studying and preparing in Jamaica for a learning experience in the UK.

The nurses are now spending five months in England rotating around three intensive care units, focusing on general intensive care, paediatrics and cardiothoracic medicine to develop their critical care competencies.

Each nurse will receive an induction, but this will be less in-depth than the nurses who may be making a permanent move to the UK, as featured in our ***Earn, Learn, Return – migration and mobility*** case study.

Each of the 15 nurses will be accompanied by mentors and will receive a structured educational experience supported by Health Education England. They will be expected to undertake a quality improvement project and to demonstrate what they have learned once they return to practice in Jamaica.

Health Education England plans to evaluate this programme with an eye on rolling it out more widely, both here and in other countries.

This example of *Earn, Learn, Return* can be seen to be a clearer 'win-win' way of supporting health workers to gain skills of use to LMICs, whilst promoting a circular form of migration.

Recommendation 5

There is a lack of clarity on how the design and implementation of current 'train and return' schemes benefit LMICs, and there is a lack of coordination in tracking the professional progress of LMIC health workers who train in the UK on their return to their country of heritage. This is undermining the synergy between UK ODA funding and NHS investments in workforce.

To the Department of Health and Social Care and Health Education England:

5.1 Conduct an evaluation of 'train and return' schemes to understand their impact on domestic and international health workforces.

The impact of the 'train and return' scheme, *Earn, Learn, Return*, on LMIC wider health systems should be better understood. This necessitates follow-up with health workers once they have returned to their countries of origin, and a clear emphasis on developing relationships with an origin country's health system to ensure health workers are rewarded for overseas work once they have returned are areas to further explore.

To the Department of Health and Social Care and Health Education England:

5.2 Engage trade unions, regulators, professional associations and international partners such as WHO inclusively in the design, monitoring and governance of train and return schemes.

The international non-governmental organisation, WEMOS, has recently conducted research which provides analysis and an evidence-base for Public Service International (PSI), and its health sector affiliates, on the concept of mobility of health workers through bilateral agreements.

Developing programmes through dialogue between governments, employers, trade unions and professional associations gives the UK the best chance of securing social protection and labour rights for the health workers involved, and of pursuing equitable health systems development in both source and destination countries.

Making these agreements transparent through reporting to the WHO Global Code would also advance global ethical behaviour.

To the Department of Health and Social Care and Health Education England:

5.3 Scale-up ethical programmes that actively encourage de facto circular mobility of health workers, which include the ethical improvements outlined in this report and which also ensure benefits to LMICs.

Train and return programmes such as *Earn, Learn, Return* are theoretically promoting circular migration – as the programme's name suggests – but in practice, an unspecified number of participants are likely to remain. Middle-income countries will therefore lose out if their workforce planning is based on the assumption that most nurses will return rather than stay.

There should, therefore, be greater clarity on whether the purpose of train and return schemes, such as *Earn, Learn, Return*, is to encourage skilled worker migration, rather than circular mobility.

To the Department of Health and Social Care and Health Education England:

5.4 Provide further guidance to ensure train and return schemes clearly benefit international health workforces.

Health Education England has recently developed the first set of standards to support delivery of the Medical Training Initiative (MTI).[xc] These standards include guidance on the provision of pastoral care, quality assurance processes, and correct use of the scheme as a training programme – not to cover rota gaps – and to ensure that individuals are given access to training, support, and study days to fulfill personal development plans.

In addition to the MTI guidance, we would recommend that Health Education England and the Department of Health and Social Care work with DFID – as part of a health workforce strategy – to ensure that the impact of MTI on the individual and on the LMIC wider health system is better understood to address the following challenges, and encourage the good practice, highlighted in this report:

i. Appropriateness of training for trainees returning to their country of origin

ii. Lack of policies in countries of origin which recognise relevant experience for trainees returning

iii. Insufficient follow-up of trainees after they return to their countries of origin

Other challenges include gathering information about:

iv. Do trainees return to the UK?

v. And, if they do, what role does the NHS play in encouraging trainees to return to the UK?

Recommendation 6

Public safety is being undermined by inefficiencies in processes to facilitate the transferability of registration of health workers between regions and countries.

To professional regulators:

6.1 Global regulators should work together to harmonise registration requirements and streamline processes to support the registration of migrating health workers.

For public safety, all health professionals should be required to be on the professional register of the country they are practicing in. This requires individual professionals to provide the in-country regulator with evidence that they meet, through training, education and practice, the standards required to practice in that country.

We welcome the Interim NHS People Plan's recommendation to support improvements to regulatory processes in relation to international health workers.

However, UK regulators should also work with global regulators to share good practice and harmonise registration requirements, streamline processes and, where possible, further develop bilateral agreements to accept, or to develop, efficient processes to facilitate the transferability of registration between regions and countries.

4.4.4 Mobility from the UK to LMICs

Publicly Financed Skills Mobility Partnerships

As noted in section three, the DFID-funded Health Partnership Scheme (HPS), managed by THET, has been training health workers through partnerships since 2011. As such, the HPS is a notable example of an ODA funded programme that focuses on workforce within a health system strengthening context.

THET has learned a great deal from managing the HPS. First and foremost, the enormous contributions health partnerships make to strengthening workforces in LMICs. And indeed, projects implemented by health partnerships have demonstrably improved and scaled up the quality of specific health services in the areas in which they are implemented and often have ensured sustainability by addressing national level policies, guidelines and protocols.

THET is also clear on the need for future health partnership programmes to give greater consideration to gender and other aspects of disadvantage or exclusion throughout project design, management and evaluation to ensure the needs of marginalised and hard-to-reach groups are met, and that no-one is left behind.

The values expressed in WHO's Twinning Partnerships for Improvement framework and THET's principles of partnership should be adhered to when considering the ethics of such a publicly financed approach.[19]

The findings of THET's *Scaling-up of UK health worker volunteering in Zambia* study - see case study overleaf – should also be heeded, particularly: the requirement for careful planning; alignment with country plans; compensation for the time invested in planning; longer term interventions; and a geographical focus on areas where the need is greatest.

During research conducted for this report we have also found other models of Skills Mobility Partnership that we think can strengthen the UK's ethical approach when designing future programmes. For example, The Royal College of Surgeons of Ireland (RCSI) and the College of Surgeons of East, Central and Southern Africa (COSECSA) Collaboration programme - see overleaf – has successfully addressed the issue of brain drain with 85% of surgeons who have undergone their specialist training in the East, Central and Southern Africa region being retained in the country where they trained.

And indeed, there exist other good practice examples of Skills Mobility Partnerships such as the Global Health Fellows programme as highlighted in the case study, GP training in South Africa overleaf.

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[19] The WHO'S Twining Partnerships for Improvement programme highlights several ethical values essential in building successful partnerships: 1. collaborative relationships, 2. trust, 3. Equality, 4. Mutuality, 5. shared accountability, 6. transparency. Such principles reinforce the principles set out in WHO's Global Code of Practice on the International Recruitment of Health Personnel and THET's Principles of Partnership clearly sets out an ethical framework for institutions from HICs and LMICs working through the partnership approach: 1. Strategic, 2. Harmonised and aligned, 3. Effective and sustainable, 4. Respectful and reciprocal, 5. Organised and accountable, 6. Responsible, 7. Flexible, resourceful and innovative, 8. Committed to joint learning.

Recommendation 7

Progress has been made on ensuring programmes that encourage mobility of UK health workers to and from LMICs are co-developed and deliver clear benefits to LMIC health systems. However, further work is required.

To the Department for International Development and the Department of Health and Social Care:

7.1 Scale-up, publicly financed Skills Mobility Partnerships which include the ethical mobility of UK health workers to and from LMICs as described in this report.

7.2 Promote more long-term, sustainable education programmes of cadres of health workers and less short-term interventions

7.3 Focus these longer-term education programmes in locations in LMICs where they are most needed, such as rural and regional centres.

CASE STUDY
Scaling-up of UK health worker volunteering in Zambia

Over 2,000 UK health workers have volunteered through partnerships in LMICs throughout the lifetime of the Health Partnership Scheme.

In Zambia, THET conducted a study to better understand the opportunities and the constraints of scaling-up the placement of UK health workers through health partnerships in healthcare facilities across the country.

The study identified two key factors shaping the context for any potential expansion of volunteering:

First is the shortfall in Zambian health workers. It is estimated that Zambia will need to train and recruit an additional 37,644 health workers by 2025. Volunteering can play a useful role, both with regard to training and assisting in the shortfall of health workers, especially in more specialised roles as Zambia introduces its Specialist Training Programme.

Secondly, the desire to host volunteers is considerable. The staff at the hospitals and clinics interviewed for the study estimated that they could make use of between 4 and 6 volunteers per institution. If extrapolated across the 1,956 health facilities in Zambia, it suggests a potential placement opportunity for 9,000 people per year.

However, it is also very clear from the study that scaling-up UK volunteering requires careful planning.

A clear message from Zambians across the health sector emerged. It took various forms, but can be summarised in one word: alignment.

Alignment with Zambian Ministry of Health and host institutional requirements is regarded as being vital. This not only allows for better coordination with other sending countries, such as the United States, Germany, the Netherlands, Japan, Canada, Ukraine, Argentina, India, Kenya, the Czech Republic and Cuba, it also means that the expectations placed on host institutions by volunteers can be more effectively absorbed.

A preference for long-term placements (defined as at least six months) was also registered, but evidence suggested that shorter placements can also be beneficial.

The report also explored budgetary considerations. From an ethical perspective, it made the point that hosting organisations should be compensated for the time invested in planning placements.

One final message was a strong preference for placing volunteers outside of Lusaka, where the shortfall of Zambian health workers is particularly acute, and where fewer volunteers are placed.

CASE STUDY
The Royal College of Surgeons of Ireland (RCSI) and the College of Surgeons of East, Central and Southern Africa (COSECSA) Collaboration programme

"A college without walls."

"RCSI could have given five scholarships a year to doctors and brought them to Ireland and trained them here. But for that amount of money, you could train so many more people in Africa, you're building up a system in a way that's most effective on the ground there and you're not taking people out of the hospitals where they're really urgently needed."
Deirdre Mangaoang, Programme Coordinator, RCSI/ COSECSA Collaboration Programme

Since 2007, RCSI and COSECSA have been working together on an Irish aid funded programme to increase the number of trained surgeons and to improve the quality of surgical care in sub-Saharan Africa.

The programme, which has a 50/50 split of African and Irish representation on its governing board, has graduated 158 specialist surgeons, with 391 (September 2016) current surgical trainees in 94 accredited training hospitals across East, Central and Southern Africa. In the seven years prior to the start of the Collaboration Programme, COSECSA had graduated a total of 17 surgeons. This has now grown markedly, with the 300th fellow graduated in December 2018. COSECSA is now the largest single contributor to the surgical workforce in the region, with 600 trainees enrolled across 12 member countries.

The programme has utilised a train the trainers model, with input and expertise from Irish surgeons, standardising surgical training across the region through the training and development of over 300 surgical trainers, including 28 master trainers.

And most of the accredited hospitals are situated in non-metropolitan areas.

Technology has been utilised with the joint development and administration of an Africa-centric surgical e-learning platform, *SchoolForSurgeons*, launched with a mandatory online training programme.

The importance of data has also been acknowledged with a jointly created surgical workforce mapping project which has allowed for the creation of a database containing information on every surgeon in the COSECSA region.

Research has shown that 85% of surgeons who have undergone their specialist training in the East, Central and Southern Africa region are retained in their country of training. In total, 93% of African-trained surgeons remain in Africa. 'Brain drain' of this cadre of health worker, therefore, is a thing of the past, which is quite an achievement.

CASE STUDY
GP training in South Africa

Health Education England offers over 100 prospective GP trainees the chance to take a paid year of work experience in South Africa as part of their training.[xci]

Health Education England has been running the *Global Health Fellows* programme since 2016. The scheme is run through Africa Health Placements, with trainees being paid by the government of South Africa a salary similar to the NHS. Trainees rotate through bespoke rural hospital posts in South Africa, such as obstetrics and gynaecology, paediatrics and emergency medicine, before returning to a guaranteed ST3 post[20] to complete GP training in the UK.

Designed as a structured part of a doctor's out of programme experience, *Global Health Fellows* is a good example of how the UK can encourage more medical students to specialise in GP specialist training, maximising learning benefits to the NHS whilst supporting the rural health system of an upper-middle income country like South Africa.

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[20] ST3 refers to the third year of specialty training.

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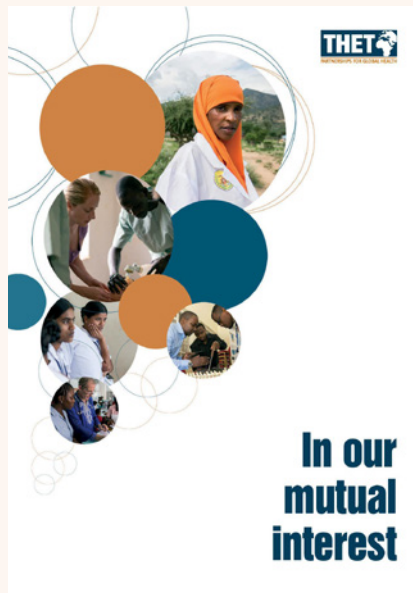
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