



# FROM DRAIN TO GAIN

The role of the UK in building ethical international recruitment strategies for Quality Universal Health Coverage

## INTRODUCTION

In 2021, the Tropical Health and Education Trust ([THET](#)) worked in partnership with the African Centre for Global Health and Social Transformation ([ACHEST](#)) to run three symposia examining the role of the UK in relation to the international recruitment of health workers from Low- and Middle-Income Countries (LMICs).

A total of [36 experts](#) took part from 11 countries, including Ministries of Health in Africa and Asia, the World Health Organization (WHO) and all the major UK departments involved in shaping the UK's role in workforce development nationally, and globally.

*“More than 70 jurisdictions have amended their regulations so that they can attract foreign-born, foreign-trained workers. It is happening in Europe, in America and Asia, and Latin America and elsewhere, and has been described as a global scramble for health workers.”*

**Jim Campbell**

Director of Health Workforce, WHO

We are especially grateful to His Excellency Dr Omer Elnagieb, Minister of Health in Sudan, and Lord Bethell, Parliamentary Under-Secretary at the Department of Health and Social Care (DHSC) for their opening remarks.

The Sustainable Health Workforce Symposia built on the insights in THET's 2019 paper, [From Competition to Collaboration](#). This paper highlighted the long history of international recruitment to the UK's National Health Service (NHS), with one in seven NHS staff now reporting a non-British nationality.

*From Competition to Collaboration* called on the UK to recognise the contradiction between its role in advancing health and wellbeing in LMICs using Official Development Assistance (ODA) and its recruitment of health workers to the NHS, often from the very same countries. It went on to argue that the UK is well placed to provide ethical leadership in shaping the migration and mobility of health workers, as the first country in the world to deliver Universal Health Coverage to its citizens in 1948, and a country that is making a sustained contribution to the development of LMICs health systems through use of ODA.

The Sustainable Health Workforce Symposia built on these themes with the goal of advancing our common understanding of those schemes which bring mutual benefit in this era of unprecedented health workforce mobility.

***"I want the UK to continue to be a leader in global health workforce planning, working in collaboration to ensure the world has the professionals, it needs for the future. I want to be sure that all countries benefit from this global migration, and I believe that they can."***

**Lord Bethell**

Parliamentary Under-Secretary of State,  
Department of Health and Social Care

## Governments have crucial role to play



The high level of engagement from the UK Government in the design and execution of the symposia, demonstrated that the symposia organisers are not alone in our desire to position the UK as an ethical partner to LMICs.

In the first two mornings of the symposia, we examined education and training initiatives already being offered by the UK, looking across the UK's health-related ODA and the work of the NHS. In the third and final symposium we opened the floor to new ideas.

Any discussion about managing the movement of health workers in an ethical manner inevitably takes place under the shadow of widespread shortages faced by all health systems, [estimated to reach 18 million staff by 2030 according to the WHO](#). Few countries are investing adequately in the training of health workers to meet this shortfall.

In our view, however, this does not invalidate this discussion. Mobility and migration are inevitable, driven by the choices individuals make, and we need to engage in the complexity of how health systems can work together to shape migration in ways that benefit the training, retention, and development of health workers in all settings. This involves looking beyond remittances, a powerful source of economic support as they are, towards new forms of partnership between governments and health systems.

The value of these symposia can be found, therefore, in the act of bringing together diverse stakeholders to discuss this ground, and in the process giving energy to the UK's role in providing ethical leadership in this space.

It brings together examples of managed migration in one place, documented here, thereby increasing the transparency of such initiatives. Ultimately, it is our hope that these symposia allow Governments and non-governmental actors such as THET and ACHEST, to work together to tackle the acute crisis of health worker shortages facing all health systems whilst recognising the right of individual health workers to be mobile to improve their lives and skills.

We are grateful to those who participated in the symposia, and to [Health Education England](#) who both participated and provided modest funding to support this work.

The level of engagement we received from partner countries is also deeply gratifying. It suggests there is a significant appetite to engage with the UK on this topic and, as Professor Omaswa indicates in the foreword which comes next, to engage collaboratively with the NHS and its staff for the improvement of health systems everywhere.

## FOREWORD

*“With the global shortage of health workers estimated at 18 million by 2030, there is a fierce competition to fill the gaps. Rich nations are scrambling for the available health workers through unregulated recruitments and clandestine migrations, leaving poor nations at a disadvantage.”*



As a young doctor at Makerere University Medical School in Kampala, Uganda, I recall being supervised by specialists from the UK. This was made possible by the long-term tradition of collaboration between the UK and low-income countries.

Through a government- to-government arrangement, doctors and nurses from the UK came to work in Uganda, and vice versa. There was a mutual benefit for both countries. And so, along the way, I travelled to the UK to train as a cardiovascular surgeon. My consultant at the Royal Postgraduate Medical School, Hammersmith Hospital, London held an honorary position at Makerere University Medical school where I came from. One of my supervisors at Makerere Medical School, Sir David Carter, returned to the UK and later became Chief Medical Officer for Scotland, presumably having benefitted from his experience in Uganda as a young surgeon.

However, this type of collaboration has dwindled over the years. With the global shortage of health workers estimated at 18 million by 2030, there is a fierce competition to fill the gaps. Rich nations are scrambling for the available health workers through unregulated recruitments and clandestine migrations, leaving poor nations at a disadvantage.

This challenge is most felt in sub-Saharan African countries that together bear 24% of the world's disease burden and employ only 3% of the world's health workers. The UK has been at the forefront of efforts to recruit health workers from overseas, contributing to a broader trend which has

seen a 60% rise in the number of migrant doctors and nurses working in OECD countries. The UK has simultaneously been at the forefront to do this ethically, both before and after adoption of the WHO Code of Practice for the International Recruitment of Health Personnel and care workers, in place since 2010. At the same time, the UK has also pioneered the world's oldest health system delivering Universal Health Coverage to its citizens through its National Health Service, with a workforce of 1.3 million. Equally, through its commitment to ODA and the work of the Foreign, Commonwealth and Development Office in particular, the UK has shown itself a generous and intelligent partner to LMIC governments in the development of their health systems.

In recent years, the UK has also created approaches which recognise the value of working together to train health workers through mutually collaborative global partnerships.

So, how can countries revive and strengthen government-to-government collaboration on the shared challenge of workforce shortage, in an era of unprecedented mobility? These were the themes of our Symposia. Thank you to all who engaged.

**Professor Francis Omaswa**  
Executive Director, ACHEST



## CONSENSUS

### **Health workforce shortages are affecting every country in the world.**

We met in the middle of the COVID-19 pandemic, a pandemic which has seen additional pressure fall on health workers and led to increased work-related illness and absences. We have witnessed labour protests and strikes in many countries and, eighteen months in, we continue to witness disruptions to essential health services. Health promotion and routine procedures have reduced. Ill health and mortality from other diseases has increased.

Participants reflected on the ways in which countries have seized opportunities to increase the size of their health workforces, from the deployment of students and retirees, through to increased international recruitment. It was noted that more than 70 jurisdictions have amended their regulations to make it easier for health workers to gain an entry visa and a license to practice.

All participants agreed with the need to radically increase the numbers of people being trained in healthcare careers.

This was touched upon (by for example, the DHSC in relation to their work with refugees – see below), but it was not the focus of the symposia.

**“Sudan developed a policy to appreciate mobility as something natural and inevitable and adopts measures to manage migration to maximize gains and mitigate adverse effects.”**

**Dr Amal Gesmalla**  
Director General, Ministry of Health, Sudan

### **Governments have a crucial role to play.**

Participants accepted that a certain level of health worker migration is inevitable.

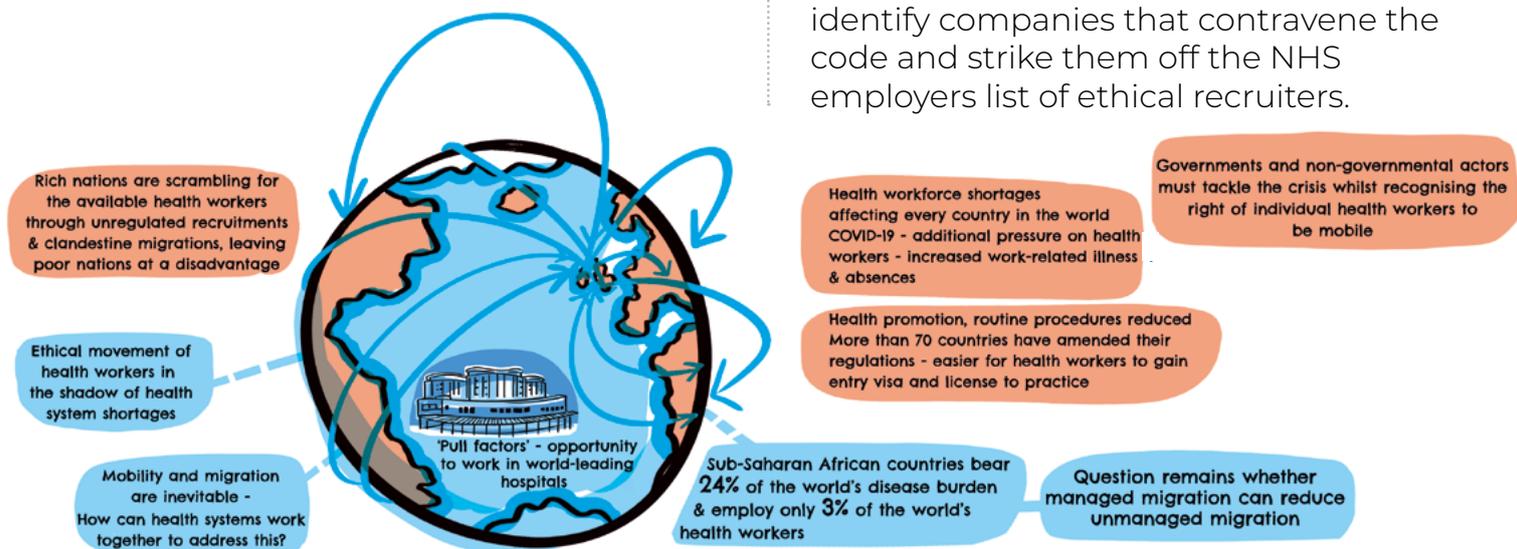
These are the ‘pull factors’ which make a certain amount of migration desirable for individuals, including the opportunity to work in world-leading hospitals, with excellent equipment and good pay; the support through remittances to families and local communities at home;

access to opportunities for professional development and leadership.

Acknowledgement was also given to the 'push factors' that need to be addressed by national governments in all parts of the world, including unemployment and poor working conditions. For example, in Sudan, newly qualified doctors may have to wait two years or more before they secure an internship placement. During this period, they may have to take alternative forms of employment. Even when a doctor secures employment uncertainties persist over how long the role may be funded, and whether they will be able to undertake further specialist training.

Participants reflected on the vital role of government in regulating migration, recognising that what is good for an individual may not be good for a health system. Managed migration allows the sending country to retain some control over key factors such as the number of health workers migrating in any given period, the nature of such migration (permanent or temporary), and the type and level of experience of the health workers targeted. This is best guided by health labour market analysis and expressed through the development of bilateral agreements at a governmental level.

**"I would argue that the pressures that drive this migration aren't going away anytime soon."**



## Adherence to the WHO Code on the International Recruitment of Health Workers is vital.

The symposia took place immediately following the publication of the revised [UK Code on the International Recruitment of Health Personnel](#), itself based on the [WHO Code](#) of the same name, which was reviewed in 2020.

Participants agreed that strong partnerships facilitate a focus on fulfilling the needs of sending countries and such partnerships should adhere to the WHO Code. They reflected that there is a continued need to popularise the Code and to continue to disseminate the call for reporting on its implementation, especially in African countries. There also exists a necessity to better understand the needs of both sending and destination countries, and to use the WHO Code to draft agreements for coordinating the sharing of the available pool of health workers while planning for future needs.

Under the Code, active recruitment should not take place from countries on the WHO Health Workforce Support and Safeguard list. However, many LMICs observe active recruitment efforts by private companies from High-Income Countries (HICs). The UK's recently revised recruitment code aligns with the WHO's Safeguard list and may prove more effective at targeting private recruiters into the NHS, and the private sector: The revised UK code covers all private and social care recruitment. The language has also been tightened to make it easier to identify companies that contravene the code and strike them off the NHS employers list of ethical recruiters.



## DOUBT

Any discussion about managing the movement of health workers in an ethical manner inevitably takes place under the shadow of widespread shortages faced by all health systems, estimated at 18 million by the WHO.

This has contributed to a hesitancy both from LMIC and HIC governments to enact bilateral agreements which encourage mobility of health workers. This is perhaps due to concerns that even managed migration of health workers may lead to brain drain from LMICs.

Further uncertainty exists around whether such arrangements provide real mutual benefits. And indeed, the question remains unanswered as to whether managed migration can reduce unmanaged migration.

Given that a growth in unmanaged migration is happening, and is clearly detrimental to LMICs, it is vital that we

explore partnership programmes which support managed migration based on priorities of LMICs, and which are bespoke to that country.

Causal links between these programmes and reduction in unmanaged migration can be explored simultaneously.

The following section documents some of the initiatives underway.

*“Recruitment agencies are actively recruiting from source countries, facilitating their migration to destination countries...How can we actively manage this, especially since they’re based in destination countries?”*

**Symposia participant**

### Case study 1: UK-Philippines skilled worker nurse migration – Brain gain not brain drain.

Presented by the DHSC.

Nurses from the Philippines have long migrated to the UK and contributed to healthcare provision here. In 2019 there were 30,000 registered Filipino nurses in the UK, working in the NHS and private sector.

The Philippines has prioritized the creation of overseas employment opportunities for health workers trained in the country. With more than 10 million Filipinos now overseas, remittances make up more than 10% of that country’s economy.

Expansion of training opportunities has

also increased the local health workforce: research has found that 10 nurses were recruited in the Philippines for every one who migrated into the US health system.

This is an example of skilled worker migration from LMIC to the UK. The UK government has a Memorandum of Understanding with the Philippine Department of Labour and Employment and its Ministry of Health. Cooperation allows careful background checks on individuals and the regulation of the numbers of individuals emigrating at a given time.



**Brain gain not brain drain**

## CASE STUDIES



## Case study 2: Medical Training Initiative (MTI) Scheme.

Presented by the Royal College of Physicians.

Established by the Department of Health in February 2009, the MTI facilitates movement of trainee doctors from countries outside the European Economic Area to work for up to two years in the UK. The Royal College of Physicians' scheme is the largest of all UK College programmes, with more than 300 international medical graduates currently working in the UK.

The scheme aims to enable a diverse group of people to access the highest standards of UK medical training. The short-term visa encourages these professionals to return to their country of origin, thereby making a significant impact on healthcare provision in the UK's partner countries.

## Case study 3: Global Learners Programme (GLP) for Clinical Radiology

Presented by Health Education England.

Health Education England is working with Apollo Radiology International in India and the Royal College of Radiologists, on a Global Learners Programme for clinical radiology. This provides in-service subspecialty training and experience for Indian radiologists, working on a 3-year contract at short-staffed NHS Trusts in England. The programme currently has 15 radiologists in post in England and 12 further radiologists arriving over the coming year, if the pandemic allows. This model provides valuable support for NHS Trusts while providing opportunities for the radiologists to access training not available in India, without the need to migrate permanently.

## Case study 4: Health Partnerships

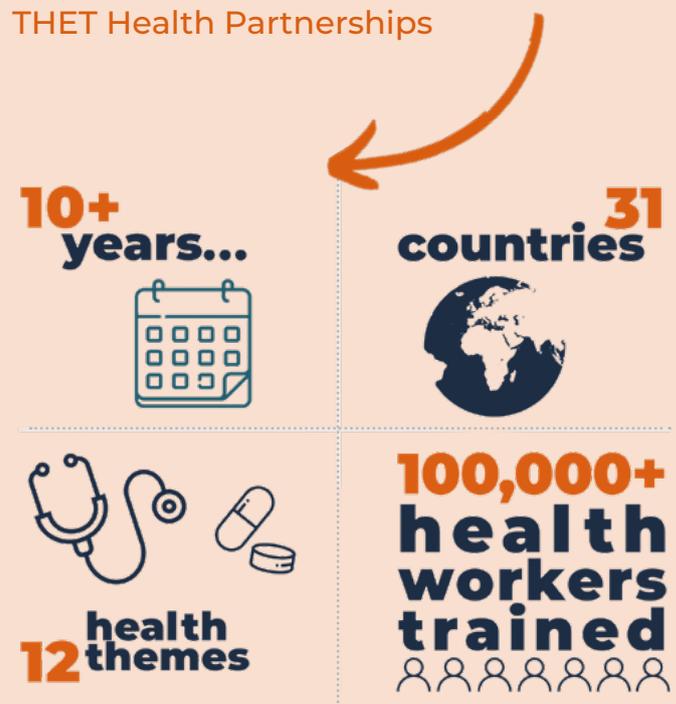
Presented by the Tropical Health and Education Trust (THET).

THET presented on the model of **Health Partnerships** between UK and LMIC institutions.

These allow for short-term exchanges of personnel within a long-term framework of on-going partnership. Often funded using UK ODA, these strengthen the health workforce in LMICs while reaping benefits for the UK health system by investing in the skills and outlooks of participating NHS staff.

In recent years, such exchanges have been funded by non-ODA funds, notably by Health Education England which has recognised the educational value of partnerships for individuals, and for the NHS more generally, as it seeks to learn from other health systems. The peer-to-peer connections help to foster mutual respect and sustainability.

## THET Health Partnerships



## Case study 5: Managed Educational Partnerships

Presented by the Health Education England.

Health Education England presented on the model of Managed Education Partnerships (MEPs), a developing model for government-to-government bilateral healthcare staff exchanges. These are designed to create cyclical, sustainable and mutually beneficial partnerships between the English NHS and international health systems.

MEPs are a response to specific requests from partner governments and are tailored to suit the needs of both health systems. Exchanges include doctors, nurses and other clinical professionals moving in both directions, on placements from six months to up to three years.

An existing MEP between Saint Vincent and the Grenadines and the UK was presented. This partnership offers both a structured way for nurses to permanently migrate to the UK and temporary placements. The latter encourage senior nurses to undertake formal training in the UK to address specific skills gaps, returning to support Saint Vincent and the Grenadines health system with those skills.

Shared governance and accountability, which ensures the appropriateness of placements and learning outcomes for both parties, was noted to be a key ethical feature of this arrangement.

### Managed Educational Partnerships (MEPs)

A structured way for nurses to permanently migrate to the UK and temporary placements

Cyclical, sustainable & mutually beneficial partnerships between the English NHS & international health systems



## NEW IDEAS

In the final symposium, participants focused on some of the new ideas for partnership.

### Example 1: The SCALE Programme.

Presented by the [Uganda-UK Health Alliance](#).

This is a Health Partnership model developed by HEE and the Ugandan Ministry of Health as a “mutual win”. It aims to address gaps and challenges in five critical medical disciplines, in order to improve health care delivery. There will be temporary movement of healthcare workers in both directions, and a virtual learning element will encourage shared learning between UK and Ugandan participants.

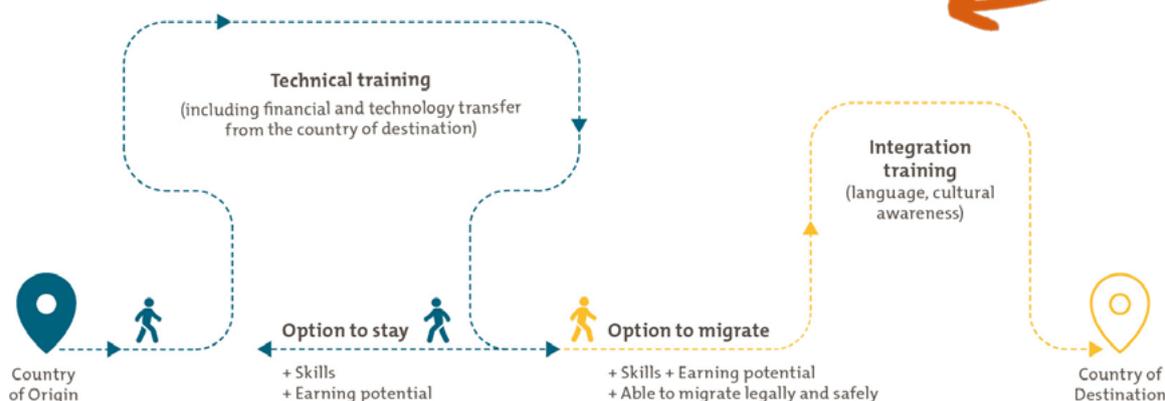
Implementing partners are institutions in the UK and Uganda, including Royal Colleges, universities and hospitals.

### Example 2: The Global Skills Partnership.

Presented by the the Centre for Global Development.

A migration model that ensures mobility contributes to development for all. Both countries of origin and destination get new workers, with needed skills, to help health systems to grow and thrive.

### Global Skill Partnership Model



### Example 3: The Kenya – UK Health Alliance.

Presented by the University of Manchester.

KUKHA is the latest in a series of health alliances established between the UK with partner countries. Others exist in Myanmar, Tanzania, Uganda and Zambia. They are playing a pivotal role in spotlighting the contribution the UK health system can make globally.

### Example 4: Training health workers in refugee settings.

Presented by DHSC.

This example was of the support given to 40 displaced nurses from Lebanon and Jordan into NHS employment, using the Health and Care visa. This scheme allows nurses to resume their careers and acquire new skills working in the context of the NHS.

## DHSC programme to support refugees into jobs in the NHS

### Talent Beyond Boundaries (TBB) Pilot

#### WHO?

TBB, NHS EMPLOYERS, DHSC

#### WHAT?

Support 40 displaced nurses from Lebanon & Jordan into NHS employment

#### HOW?

- Using Health and Care Visa, recruit using usual 'international recruitment' channels.
- Language skill training & OSCE support.
- Bespoke support from TBB for individuals.
- Links with local support groups.

#### NEXT STEPS

- Nurses being recruited - coming to UK by October.
- Assess time/costs/efficacy and feedback from nurses and Trusts.
- Potential to scale up.

### North West Refugee Support Programme

#### WHO?

Pan Mersey Group, TBB, RefuAid, DHSC, NHS EI, LUMI

#### WHAT?

100 UK-based refugees and displaced people (5 cohorts) into nursing/HCA roles.

#### HOW?

- Language skills improvement & testing.
- Residential clinical skills development & assessment programme at LIMU.
- Guaranteed job offer(subject to skills assessment & interview).
- Cohort 1 completed April - 14 jobs.

#### NEXT STEPS

- Assess time/costs/efficacy of pilot.
- Seek out other Trust engagement for future cohorts.

## PROPOSED ACTION

A range of actions were suggested during the symposia, but we have not sought institutional support for these, not least because the development of Government policy is beyond the remit of THET and ACHEST. These actions are therefore shared to give insight in to how THET and ACHEST will work with our partners to take this agenda forward.

1. Promote and advocate for awareness of these approaches, with a view to encouraging the discussion of other examples and international comparisons, working in close partnership with WHO to increase the number of countries applying the principles of the WHO Code.

2. Offer a continued partnership with the UK Government to look at how UK ODA can be used as a basis for up-skilling workforces in partner countries, drawing on the expertise and experience across all four nations of the UK.

**3.** Contribute to the evaluation of these approaches. Many of the initiatives underway are new, some less so. The MTI Scheme has been operating since 2009 and yet not enough is known about the extent to which graduates of the MTI scheme benefit their countries of heritage. We propose such an evaluation take place and that it examines the role the UK can play in supporting the career progression of returning doctors.

**4.** Engage private recruitment companies. As we have seen, such companies must follow the WHO Code to recruit into the NHS and private sectors in the UK. We will engage with these companies to go beyond implementation of the Code, to look at how they can bring benefit not just to individuals but to the health systems of the countries in which they are recruiting.



## PARTICIPANTS

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