



The Health Worker Crisis: an analysis of the issues and main international responses



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Health Poverty Action is grateful to all organisations who contributed to this report.

October 2013

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Design: www.revangeldesigns.co.uk

**Health Poverty Action works to
strengthen poor and marginalised
people in their struggle for health.**

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Acronyms & abbreviations

DAH	Development Assistance for Health
DALY	Disability-Adjusted Life Year
DoH	Department of Health
DFID	UK Department for International Development
EEA	European Economic Area
EC	European Commission
EU	European Union
GDP	Gross Domestic Product
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
NCD	Noncommunicable Disease
NHS	National Health System
MDG	Millennium Development Goal
NMC	UK Nursing and Midwifery Council
PMQ	Primary Medical Qualification
PROMeTHEUS	Health Professional Mobility and Health Systems
JLI	Joint Learning Initiative
OECD	Organisation for Economic Co-operation and Development
UK	United Kingdom
WHA	World Health Assembly
WHO	World Health Organization

Summary

Health workers are essential for healthcare. Their absence threatens the health of individuals and populations, destabilises health systems, and further deepens existing global health inequalities, resulting in more unequal societies.

According to the latest available global estimates, the world faces a shortage of 4.2 million health workers (WHO, 2006a) with countries in Africa hit hardest by this Human Resources for Health (HRH) crisis. Africa is home to only 3% of the world's health workers who are fighting 24% of the global disease burden, with less than 1% of world health expenditure (WHO, 2006a: xix).

In many countries in the Global South¹, the HRH crisis is exacerbated by the migration of health workers to wealthier countries in the Global North, where their demand is driven up by technological advances and aging populations (EC, 2012). This 'brain drain' or 'skills drain' is often driven by a combination of 'pull factors' in destination countries – such as better remuneration and living conditions – and 'push factors' in source countries – including lack of infrastructure, few training opportunities and low wages (WHO, 2006a: 99). Consequently, although the migration of health workers might be a predictable aspect of globalisation, it also reflects and sustains the predominant high levels of global inequality (Mensah *et al.*, 2005).

Four case studies in this report highlight the ways in which low numbers of health workers threaten the adequate provision of healthcare in specific countries in sub-Saharan Africa. The case studies do not imply that conditions in these countries are representative of the global HRH crisis but draw attention to various aspects of the crisis and provide country-specific strategies to address these. What the case studies do highlight is that tackling the HRH crisis in countries of the Global South is neither easy nor cheap, and should be supported by an internationally-coordinated effort that pays particular attention to the responsibilities of the Global North. Calculations for the potential loss of human capital from sub-Saharan Africa alone as a result of this 'brain drain' vary but are estimated to be in the billions of US dollars. The benefits of this investment are then acquired by destination countries. Significantly, the investment lost by source countries may even exceed the monies received in health aid from destination countries. Although it is broadly acknowledged that this 'perverse subsidy' from poorer countries of the Global South to wealthier countries of the Global North contributes to the HRH crisis, efforts to address the challenges related to the international migration of health workers have so far been limited.

This report gives an overview of the impact of the brain drain on health care provision in source countries and current key international strategies to mitigate its effects. It will argue that these strategies are faced with severe challenges and present some alternative approaches to address the health worker shortage, based on acknowledgement of the Global North's contribution to the current crisis.

1. Although most of the literature sourced for this report refers to 'developing countries' or the 'developing world' as the group of poorer countries bearing the brunt of the Human resources for Health (HRH) crisis, this report will consistently refer to this group as countries of the Global South. All of the terms commonly applied to this group of countries – others include 'low-income' or 'third world' countries – have been criticised in regards to their usefulness and appropriateness (Chant and McIlwaine, 2009: 6). Although the terms 'Global South' and 'Global North' are imprecise – due to the fact that there are of course wealthier countries in the geographical global South, such as Australia, and poorer countries in the geographical global North, such as China – Chant and McIlwaine have pointed out that these terms should not be understood as purely geographical descriptions. Instead, they can be understood as definitions that are "based on global inequalities albeit with some spatial resonance in terms of where the countries concerned are situated" (Chant and McIlwaine, 2009: 11). In the social sciences, these terms have therefore increasingly become the preferred option (Chant and McIlwaine, 2009: 11), over the term 'developing countries' and its implicit "transition narrative" (Chakrabarty, 1992).

1. The Human Resources for Health (HRH) Crisis and its impact

In 2006 the World Health Organization (WHO) estimated a global shortage of 4.3 million health workers, with poorer countries in the Global South particularly hard-hit (WHO, 2006a: 12). Among the 57 countries identified with a *critical* health worker shortage, 36 were in sub-Saharan Africa² (WHO, 2006a: 220). Table 1 (over) shows the latest WHO estimates for the size of the international health workforce.

Whilst the WHO estimates highlight the unequal distribution of health workers between different WHO regions, their aggregate character still obscures the fact that within those regions, the density of health workers both between and within countries varies greatly. Disaggregated data for specific countries in Table 2 shows that even though the average density of health workers in Africa may be 11.2/10,000 – already below the WHO level defining a critical shortage – the numbers for some individual countries in the region are far lower. Within countries rural and remote areas often experience the worst shortages.

Box 1: Defining Health Workers

The latest available global figures estimate that there were a total of 59.2 million full-time paid health workers worldwide in 2004. Among these, health service providers comprised approximately two thirds of the global health workforce, while health management and support workers constituted the remaining third. However, within and between individual countries there were wide variations in regards to the numbers, the specific skill mix (for example in regards to the physicians/nurses ratio) and the distribution of health workers (WHO, 2006a: xvi-xvii; WHO, 2007).

Internationally, the definitions of health workers and of specific health worker occupations vary. Such a lack of harmonisation is not only confusing, but can also complicate the survey and comparison of health workforces across different countries (WHO, 2007: 1). In its World Health Report 2006, the WHO defined health workers as “all people primarily engaged in actions with the primary intent of enhancing health” – a definition that is consistent with the WHO definition of health systems (WHO, 2006a: xvi). However, due to limited availability of data and the ambiguity that results from such a wide-ranging definition, published data sets on the global health workforce typically only include health workers that are engaged in paid activities (WHO, 2006a: 211; WHO, 2007: 1). Among paid health care professionals, the WHO and other official sources, such as the European Commission, often differentiate between *service providers* (i.e. nurses, doctors, midwives, pharmacists, lab technicians, etc.) and *health management and support workers* that support the health service without directly providing health services (i.e. managers, computing professionals, trades people, clerical and service workers, etc.) (WHO, 2007: 2-3; European Commission, 2012: 1). For data collection purposes, most sources today further propose using health worker classifications based on the International Standard Classification of Occupations (ISCO). The latest revision (ISCO-08) categorises health-related occupations based on five broad groups: health professionals, health associate professionals, personal care workers in health services, health management, support personnel, and other health service providers not classified elsewhere (ILO, 2008).

Despite these harmonisation attempts, difficulties regarding the categorisation and survey of health workers remain, making it difficult to obtain an unequivocal picture of the global health workforce (WHO, 2013).

2. Countries were defined as having a ‘critical shortage’ when they had fewer than 23 health care professionals – including doctors, nurses and midwives – per 10,000 population. Research studies had indicated that below this threshold countries were likely to fail to achieve an 80% coverage rate for deliveries by skilled birth attendants or for measles immunization (Chen et al., 2004; WHO, 2006a: 220).

Table 1: Latest WHO estimates for the size of the international health workforce

WHO Region*	Number of doctors/10,000	Density	Number of nurses and midwives/10,000	Density	Total density doctors, nurses and midwives
African Region	118,621	2.2	467,487	9.0	11.2
Region of the Americas	1,555,428	20.0	4,749,397	72.5	92.5
South-East Asia Region	901,006	5.6	1,736,755	10.9	16.4
European Region	2,942,286	33.2	5,766,646	65.0	98.2
Eastern Mediterranean Region	626,923	10.9	856,744	15.6	26.5
Western Pacific Region	2,507,843	14.8	3,112,221	18.4	33.3

* For a definition of the WHO regions please refer to WHO, 2006a: 174. Source: WHO, 2012a: 130

Table 2: The 11 countries with the lowest health worker density worldwide, and the seven EU countries with the highest*

Country	Doctors /10,000**	Nurses & Midwives /10,000**	Total**
Norway	42	319	361
Finland	29	240	269
Denmark	34	161	195
Ireland	32	157	189
Sweden	38	119	157
Germany	36	111	147
United Kingdom	27	101	128
Mozambique	<0	3	3
Mali	<0	3	3
Malawi	<0	3	3
Liberia	<0	3	3
Bhutan	<0	3	3
Tanzania	<0	2	2
Sierra Leone	<0	2	2
Ethiopia	<0	2	2
Somalia	<0	1	1
Niger	<0	1	1
Guinea	1	<0	1

* Including doctors, nurses and midwives only; only including countries for which data was available

** Please note that these numbers are subject to rounding.

Source: The Kaiser Family Foundation, 2013; WHO, 2012a



Photo: © Health Poverty Action

Case study 1: The HRH crisis in Mozambique

Mozambique, in East Africa, has a population of approximately 24 million people, the majority of whom live in rural areas, and a GDP of just US\$460 per capita in 2011 (World Bank, 2013a).

Barriers to accessing healthcare in Mozambique are high, particularly for the rural population. While reasons are manifold, a lack of qualified health workers significantly contributes to the problem: with only 0.3 doctors and 3.4 nurses and midwives per 10,000 people, Mozambique has one of the lowest densities of health workers worldwide (World Health Statistics, 2012). The international migration of health workers exacerbates this problem: in 2010, the OECD counted Mozambique among the few countries with expatriation rates of doctors above 50% (OECD, 2010). As a result, under-five, infant and maternal mortality in Mozambique remains high – although recent years have seen some improvement – while immunisation coverage rates fall below international targets (WHO, 2012a). With a life expectancy at birth of 50 years, Mozambique ranks far below the average life expectancy in other low-income countries and in sub-Saharan Africa (World Bank, 2013a).

One region that is hit hard by the current shortage of health workers is the Tete province in central Mozambique, recently visited by a group of Action for Global Health (AfGH) staff. In Tete there are just 2,000 health staff – of which only 63 are qualified doctors and 300 are nurses – to serve a large population of 2 million people that mainly live in rural areas. That means that on average, one medical doctor is responsible for the care of 30,000 people, while one nurse covers 8,000 people. The situation is further aggravated by the fact that over 50% of the population live more than 8km from a health facility. This critical lack of health staff contributes to the high barriers in accessing healthcare: for example, just 55% of women in Tete give birth in a health facility, and many of these facilities are under-staffed and lack drugs and equipment.

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When AfGH visited one health centre in Tsangano near the border with Malawi, they found the doctor had long abandoned his post and dozens of women were queuing outside, sitting on the ground with their children. The health staff running the centre worked hard, but anyone needing urgent hospital assistance faced a long journey to Malawi in a pick-up truck, as no ambulance was available.

To tackle the massive shortage of trained health workers, the Mozambican government launched the Human Resources Plan 2012-2015 (HRP), aimed at improving access to healthcare by increasing the number of health workers from 30,000 to 45,000 by 2015, in addition to encouraging health workers to work in rural areas.

European donors, including Italy, have focused on supporting this plan to increase the number of health workers available and to bring qualified workers to work in areas that are in need. In an interview with AfGH, Giulio Borgnoli of the Italian Embassy in Mozambique explained how Italy aligns its priorities with the Ministry of Health and supports the government's HRP, by working within the collaborative Health Partner Group (HPG) – a group representing all development partners supporting the Mozambique health sector – and providing funding through the pooled funding instrument PROSAUDE. He said: “We have seen enormous changes in recent years, for example in the number of deliveries with a skilled birth attendant. We are now monitoring and evaluating this area and are positive.”

While in Tete, AfGH visited the Tete Health Training School, where classrooms full of students were being trained as the country's future health workers. Like other training centres, the Tete Health Training School trains medical staff from the local area as part of an attempt to retain health workers, rather than see them migrate to large cities such as Mozambique's capital Maputo, or to other countries.

Dr Rezique Uaide, the director of the centre, said: “We need this training centre, because Mozambique is facing a huge lack of health workers on all levels, which is one of the main barriers to accessing healthcare.”

Currently, about 70% of courses at the Tete Health Training School are funded by the Ministry of Health, the rest is funded by the province and by other partners, such as international donors.

“A newly trained health worker can make a big difference in a rural area,” Dr. Uaide added. “Not only can they give treatment, they can also give advice and education on issues like water and sanitation.”

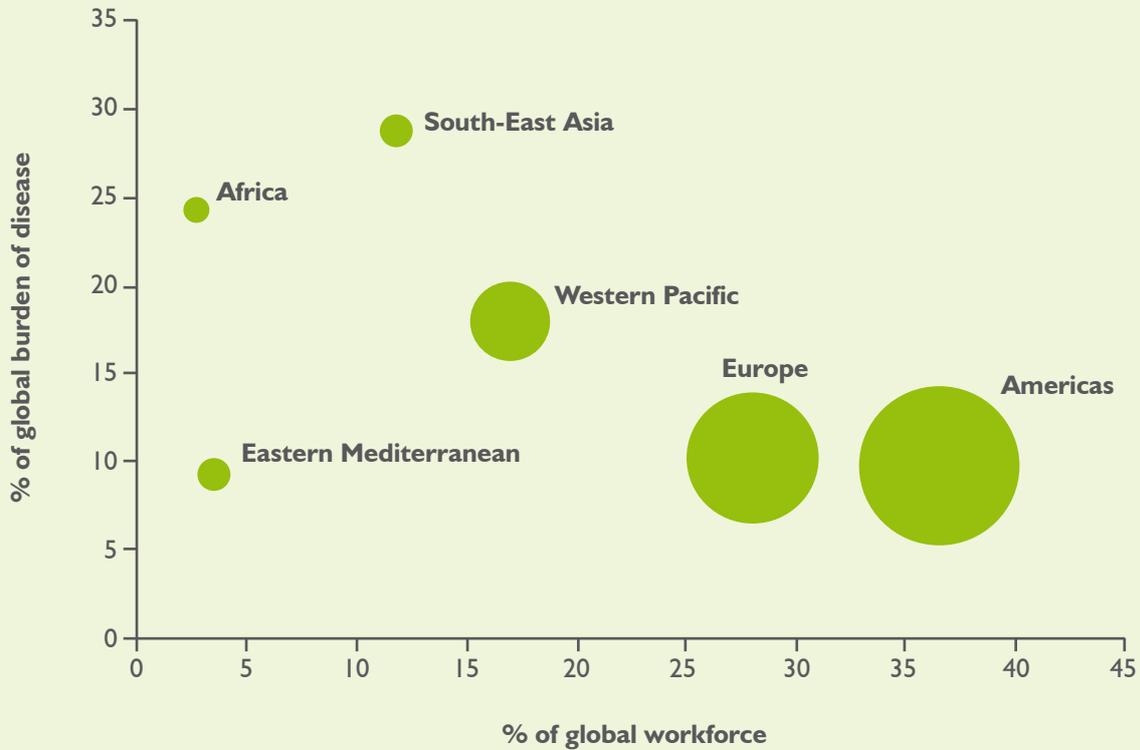
Francisco (29), who is studying at Tete Health Training School to be a technical general health assistant, said: “I will work where there is a priority. I think one of the solutions is to train more people in the health sector to improve the health of the people of Mozambique.”

Several other initiatives have also been taking place across other regions of the Tete province to increase access and take-up of services. In Tsangano, the local authorities have joined forces with Danish donor Danida and with the International Centre for Reproductive Health (ICRH) to work with the community to ensure their contribution in designing the next five-year health plan. The collaboration not only encourages the community to come together to tackle the human resources for health problem, but also to identify other barriers to wellbeing that exist within the community and to develop strategies to ensure that health, nutrition and water and sanitation are all prioritised and planned for in the future.

The Tsangago project is just one example of several encouraging initiatives that are implemented across Tete and other rural areas in Mozambique. As Giulio Borgnoli pointed out to AfGH, simply training health workers will be insufficient to deal with Mozambique's HRH crisis: “Apart from training we focus on how to retain health workers and motivate them to work in rural areas. This is a much broader question, including building houses for health workers, starting agricultural programmes near health facilities, rehabilitating institutions, but also further developing training materials.”

Note: Unless indicated otherwise, all information has been provided by courtesy of Action for Global Health

Figure 1: Distribution of health workers by level of health expenditure and burden of disease, by WHO region



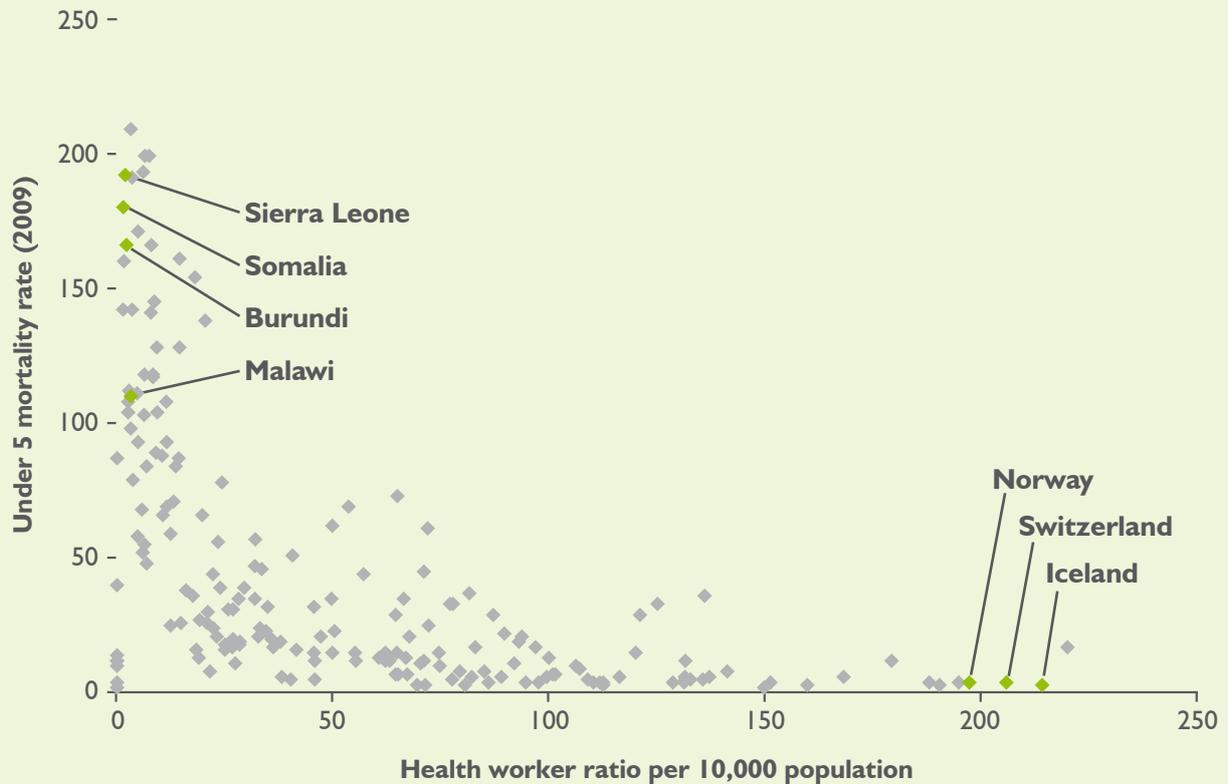
Source: WHO, 2006a: 218

The international distribution of health workers and the available financial resources for health often not only reflect predominant global inequalities but are also negatively correlated to the prevailing disease burdens in these countries. The World Health Report 2006 showed that the WHO Region of the Americas (covering the U.S. and Canada) had only 10% of the global burden of disease, but had 37% of the world’s health workers and spent more than 50% of the world’s health expenditures. In contrast, the African region had 24% of the disease burden, but only 3% of health workers that commanded less than 1% of world health expenditure (WHO, 2006: xix).

Although the number of health workers is not the only determinant of health outcomes (other determinants include, for example, access to water and sanitation, and wider socio-economic and political determinants, such as poverty, education, discrimination and cultural barriers to accessing health services³), the scarcity of health workers constitutes a major barrier to the provision of essential health services, such as safe delivery, childhood immunisation and the prevention and treatment of HIV/AIDS (WHO, 2006a: xv; Taylor *et al.*, 2011). This has devastating consequences.

3. Please refer to http://www.who.int/social_determinants/en/ for the latest WHO publications on the social determinants of health.

Figure 2: Health worker density versus child mortality rates



Source: Save the Children, 2011: 1

Figure 2 highlights the correlation between the number of health workers and under-five mortality rates.

Worldwide, maternal, neonatal, communicable, and nutritional causes accounted for 24.9% of deaths in 2010. Although globally there has been a slight decrease in the last decade (down from 34.1% of deaths in 1990), in sub-Saharan Africa these factors still account for the majority (76%) of premature deaths (Lozano *et al.*, 2012). Furthermore, recent data also shows that in sub-Saharan Africa, despite some progress, the factors addressed by the 3 health-related Millennium Development Goals (MDG 4: reducing child mortality; MDG 5: improving maternal health, and MDG 6: combating HIV/AIDS, Malaria and other diseases) still accounted for 60% to 70% of Disability-Adjusted Life-Years (DALYs) in 2010 (IHME, 2012: 38).

Already, 80% of NCDs occur in low and middle-income countries and the WHO expects that by 2020 African countries will face the largest increase in NCDs (WHO, 2011). The rapid rise of non-communicable diseases (NCDs) in these countries means that they are increasingly faced with a rapidly growing double burden of disease (Marshall, 2004). Ultimately, the fact that many countries with the lowest density of health workers suffer the highest burdens of disease means that the HRH crisis plays a huge role in deepening already existing global health inequities.

Case Study 2: High barriers to accessing healthcare in Somaliland

Background

The Federal Republic of Somalia is located in the Horn of Africa. The collapse of its central government in 1991 was followed by a period of civil war that led to the destruction of many of the social, economic and political institutions of the country, as well as of the public healthcare system. Following the collapse of the government, the Republic of Somaliland (formerly North West Zone of Somalia) declared its independence from Somalia in 1991.

While Somaliland has since enjoyed relative peace and stability, the years of war and underinvestment have left Somalia a fragile state, with among the worst poverty and health indicators in the world. UN OCHA estimates that by the end of 2010, up to 1.5 million people were displaced due to the conflict (IDMC, 2011), and many internally displaced people and returnees have moved to the urban areas as a result of the conflict and the loss of their livelihoods. Due to insufficient data Somalia is not included in the UN Human Development Index (HDI), but it is estimated that if internationally comparable data were available, it would have featured in the bottom 5 of 170 countries in the 2010 Global Human Development Report (UNDP, 2012). The World Bank lists Somalia as a low-income country, with a GDP per capita that is among the lowest worldwide (World Bank, 2013b).

At 51 years in 2010, the average life expectancy at birth in Somalia is among the lowest in the world (World Health Statistics, 2012). Similarly, the contraceptive prevalence rate is low at 15% (WHO, 2012a), while maternal mortality (1,200 per 100,000), and under-five mortality (180 per 1,000 live births) are among the highest in the world. Data from 2010 shows that only 9% of women in Somalia receive skilled attendance at birth (UNICEF, 2013).

The provision of essential healthcare in Somalia is threatened by a critical shortage of health workers. Somalia has just 0.4 doctors per 10,000 people and only 1.1 nurses and midwives (WHO, 2012a). The 2006 WHO EMRO health systems profile of Somalia highlighted that since 2001, the majority of Somalia's health workers have migrated overseas, calling this loss the 'severest blow' to the country's health system (WHO, 2006b: 55). As a result, access to healthcare is severely restricted for many Somalis.

The situation in Somaliland is equally difficult with many people experiencing one of the lowest health statuses in the world. According to preliminary results of the 2011 UNICEF Multi-Indicator Study (MICS), in the 5 years preceding the survey the under-five mortality rate was 91 deaths per 1,000 live births, and infant mortality 72 deaths per 1,000 live births. This means that one in every 14 children die before their first birthday, and one in every 11 before their fifth birthday (UNICEF 2011:2).

Many of Somaliland's health centres are dilapidated, poorly stocked, poorly equipped with unmotivated staff. Lack of public transport has also been identified by the MOHL as a barrier to health workers accessing the health centres.

While the Somaliland Ministry of Health and Labour (MOHL) is committed to providing a minimum essential package of health services and human resources for health (HRH) policies such as standard salary levels, it has insufficient capacity and financing to implement them. The public health referral system is a loose hierarchical arrangement with minimal supervisory and operational linkages between primary units and hospitals. Furthermore, many health facilities are managed by independent organisations and MOHL cannot regulate the quality of services they provide.

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In 2012, there were only 2 medical schools and 5 schools of nursing in Somaliland. The problem is further aggravated by the fact that some of the nurse/midwife training institutions produce ‘nurses’ without any professional examination or registration.

For qualified health workers in the public sector the remuneration is very low. A medical doctor, for example, receives 51 USD per month. In addition, health staff often fail to receive their salaries on time. In comparison, private sector salaries are much higher and many health workers work in or run private clinics to supplement their income.

As one result – and despite the MOHL strategy’s target of health centres being open 24 hours a day, 7 days a week – most health centres are only open from 9am to noon. In addition to staff taking extra jobs to make ends meet, reasons include prevalent low levels of motivation and supervision, which limit the time available for community members to access health services and contributes to the escalating preference of women and girls to use Traditional Birth Attendants (TBAs) and deliver at home.

But even for women who deliver in health facilities, the utilisation of sexual and reproductive health (SRH) services is low in health centres that are not covered by NGO support. As a result, the majority of pregnant women that face complications do not receive the emergency obstetric care (EOC) that they require. Survivors of sexual and gender-based violence (SGBV), particularly rape, may have severe physical injuries such as fistulas or tears, which leave women with chronic urinary incontinence and often ostracised by their families and communities. However, many health centres lack the equipment and supplies to provide basic EOC for these women.

A 2009 study by Health Poverty Action (HPA) in Maroodi Jeex, Somaliland found that lack of health care providers is a key reason for failure to access maternal and child health services; 75% of deliveries were carried out at home, usually attended by a TBA, and awareness of maternal and child health (MCH) issues was low.

Health Poverty Action’s work

Health Poverty Action has been working in Somalia since 1994 to support the provision of primary health care services. Since 1997, it has broadcasted the Saxan Saxo radio programme throughout the Somali-speaking Horn of Africa, a health education radio soap aiming to highlight issues around safe motherhood and reproductive health. In 2008, Health Poverty Action also became a consortium partner to the Health System Strengthening Project funded by the UK Department for International Development (DFID), with the specific aim of leading efforts to increase public awareness for the two-year period.

Currently Health Poverty Action is operational in two main regions of Somaliland, Maroodi Jeex and Sahil, where its support is focused on internally displaced people and people living in hard to reach areas. In both regions, Health Poverty Action has been implementing two major projects. In Maroodi Jeex, HPA is implementing the five-year (2008-2012) EC-funded project *Improving the Reproductive and Sexual Health of Internally Displaced People in Maroodi Jeex region of Somaliland*. The project was conducted in partnership with the Somaliland Ministry of Health (MOH) and the Liverpool School of Tropical Medicine (LSTM) and was completed in December 2012. Its central aim was to address the basic Sexual and Reproductive Health (SRH) needs of the internally displaced people and returnee (IDP/Returnee) communities of the Maroodi Jeex region, through improving access to information, services and products to improve reproductive health outcomes. The second project in Maroodi Jeex is the three year (2011-2013) project *Expanding Sexual and Reproductive Health Services for IDPs / Returnees*, funded by the European Union. This project aims to extend the same interventions to a wider geographic area within Maroodi Jeex. It will be completed in December 2013.

In Sahil, Health Poverty Action is supporting the Essential Package of Health Services (EPHS) pilot project – a Health Consortium Somalia project with a particular focus on maternal and child health, led by Population Services International (PSI) and funded by DFID for five years (2011-2015), as well as the EC-funded *Promoting SRH rights in Sahil* project (2011-2014). In addition, in January 2011, HPA also signed partnership agreements with the United Nations World Food Programme (WFP) and UNICEF to implement Maternal, Child Health and Nutrition (MCHN) and Targeting Supplementary Feeding Programme (TSFP) projects to complement these larger programmes.

Together, these projects have shown promising results, some of which are highlighted below.

Altogether, the projects have so far contributed to:

Creating an enabling environment for essential obstetric care. This was achieved through repairs and refurbishment of health centres; installation of solar panels, water and electricity; provision of supplies such as family planning commodities, emergency contraceptives for rape survivors, supplies and equipment, blood giving sets; and provision of an ambulance based at the hospital for referral from the target health centres.

Boosting skills of health professionals and their supervisors. As part of the project extensive training for medical staff was provided on topics including: family planning/birth spacing; counselling; emergency obstetric care; life-saving skills for obstetric emergencies; management of fistula, injuries from female genital mutilation (FGM) and gender-based violence (GBV); health education/promotion; and the development of information, education and communication (IEC) materials, in addition to two quality improvement trainings. Key MOHL staff were also trained and coached to provide supportive supervision to their medical staff.

In addition, traditional birth attendants (TBAs) were trained as safe motherhood promoters. This was part of a scheme to redefine their traditional role to facilitate referral for mothers to deliver in the improved health facilities.

Creating incentives for health workers - such as performance based payment schemes were introduced to motivate staff to keep the facilities open 24 hours a day 7 days a week and provide quality services. This innovative model continues to yield remarkable results, stimulating enthusiasm in the work itself and commitment amongst staff without compromising on quality of service.

One project also implemented a scheme whereby incentives were offered to both pregnant women and those TBAs who refer them for delivery in health facilities, as a mechanism to increase skilled deliveries. In target health centres the project offered cash incentives to TBAs for every mother accompanied for skilled delivery to the health centre. Mothers were also provided with baby gifts (blankets, nappies, soap, etc.) during postnatal visits to encourage utilisation of post-natal care services to avoid post-delivery complications.

Enhanced community knowledge and ownership – Including the promotion of culturally-sensitive health messages on family planning, safe motherhood, STI/HIV/AIDS prevention and awareness of sexual and gender-based violence including FGM. This was facilitated through the provision of educational materials, community outreach drama and the broadcasting of the *Saxan Saxo* radio programme.

The projects also support Clinic Health Committees, attached to each health facility, in their role as representatives of the community. They provide a link between the community and the Regional Health Office/MOHL to provide feedback on services; mobilise communities; improve community level referrals for obstetric emergencies, FGM complications, and SGBV; and resolve conflict and misunderstandings between service providers and the community.

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Photo: © Health Poverty Action

The impact

The success of the projects has been visible at different levels. On a health-indicator level, the projects have proven hugely successful in increasing skilled birth attendance from 23% to 75% and opening hours from 2 hours per day to 24 hours a day, 7 days a week at its associated health centres. Since the start of Health Poverty Action's work, the number of deliveries at health facilities associated with the project has increased from 993 in 2009 to 5,939 in 2012; family planning has increased from 350 clients in 2009 to 1,710 clients in 2012; total antenatal care visits increased from 8,143 in 2010 to 17,122 in 2010 to 22,476 in 2012 and postnatal care attendance rose from 1,072 in 2010 to 2,492 in 2012.

The projects have also led to several positive changes for the health workers involved. For example, health workers have reported that an improved working environment – through the better availability of medical supplies and equipment, but also a generally improved working environment at the health facilities – motivated them to provide a high quality service. The implementation of performance-based payment schemes has resulted in longer opening hours of health facilities and greater motivation amongst health workers, leading to improved access to skilled delivery for women. Health workers were also particularly motivated by the enhanced training possibilities.

Other successes of the projects have included the improvement of the referral system at associated health facilities and the provision of the ambulance, which have been useful in ensuring that those who require emergency evacuation receive it.

Finally, the close collaboration between Health Poverty Action and the Somaliland MOHL has provided a positive environment to engage on both operational and policy issues.

Note: Unless indicated otherwise, all information has been provided by courtesy of Health Poverty Action.

2. International migration of health workers as a contributing factor to health inequalities

Whilst reasons for the shortage of health workers vary by country, four common underlying reasons for the global HRH crisis have been identified: the insufficient supply and training of health workers, their inadequate distribution, their inefficient utilisation⁴, and migration. While this chapter will predominantly focus on the international migration of health workers, these four reasons are intertwined and mutually reinforcing (for example, see case study three below).

Health workers often move from rural to urban and from poorer to less poor areas, as well as from the public to the private sector or to programmes funded by donor organisations and Non-Governmental Organisations (NGOs) (Mackey and Liang, 2013). In many poorer countries the problem is further exacerbated by international health worker migration, typically from poorer countries in the Global South to wealthier countries in the Global North. These migration patterns are often driven by a combination of ‘push factors’ in source countries – including lack of infrastructure and training opportunities and low wages and ‘pull factors’ in destination countries, which include the prospect of better remuneration and living conditions (WHO, 2006a: 99).

Many countries of the Global North rely on internationally-trained health workers⁵ to fill gaps in their healthcare provision. In 2006, it was estimated that 25% of all doctors and 5% of nurses that were trained in sub-Saharan Africa were working in countries of the OECD (Organisation for Economic Co-operation and Development) (WHO, 2006a: 99). Although more recent data suggests that the influx of internationally-trained health workers has stabilised or declined in some OECD countries, overall migration of health personnel to OECD countries is increasing (OECD, 2010:2).

It is expected that in the future the HRH crisis will further intensify, driven by an ever-growing demand for health workers in both wealthier and poorer countries (WHR, 2006a: xix). In wealthier countries changing demographics and health needs are among the key factors expected to boost the overall demand for health workers in the long term (OECD, 2010: 4; Dussault *et al.*, 2009). At the same time experts have warned that the number of health workers being trained domestically in many of these countries is threatened by the strain on public finances inflicted by the ongoing economic crisis (OECD, 2010: 4). Together, this may well mean that in the future wealthier countries have an even greater reliance on internationally-trained health workers than they already do – advancing the HRH crisis in source countries and widening global inequalities.

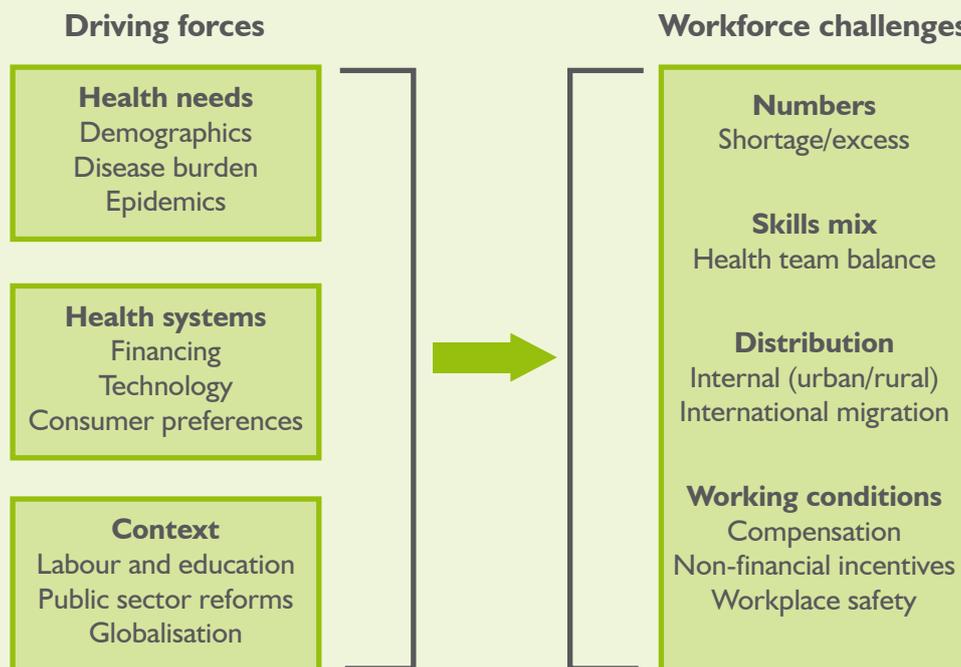
4. One often cited example are the Philippines, where inadequate health workforce planning, combined with scarce domestic job opportunities and the promotion of temporary migration has contributed to a cyclic oversupply of nurses, despite a failure to address domestic health needs (Lorenzo *et al.*, 2007; Cheng, 2009; The Guardian, 2011; University of the Philippines, 2012).
5. In the literature, migrating health workers are mainly referred to as either foreign-trained or internationally-trained health workers. For consistency, the term internationally-trained health workers (or internationally-trained doctors, internationally-trained nurses, etc.) will be used throughout this report.

3. Workforce challenges/push factors

Health workers everywhere are exposed to a number of challenges and forces that impact on their wellbeing, as well as on their ability to deliver high-quality care. Figure 3 highlights some of these factors, divided into external forces that impact on the demands of the workforce and workforce-specific challenges that have a huge impact on the challenges that health workers face.

These challenges might not only affect health workers' wellbeing, but crucially also impair their ability to provide adequate health services. The Ugandan case study highlights how health workers in poorer countries struggle when faced with high workloads, limited availability of equipment and essential medical supplies, lack of adequate training opportunities and low salaries. This both impacts negatively on healthcare delivery, and in many cases likely contributes to health workers' desire to migrate in search of improved working conditions.

Figure 3: Forces driving the workforce



Source: WHR 2006a: xvii

Case Study 3: Valuing Health Workers in Uganda

Background

Uganda is located in sub-Saharan Africa, within the region of East-Central Africa. It is classified by the World Bank as a low-income country (LIC) with a gross domestic product (GDP) per capita of US\$ 511 in 2011 (World Bank, 2013c). With an estimated population of roughly 35 million, in 2012 Uganda had the fourth-highest growth rate and the third-highest birth rate in the world (CIA Factbook Uganda, 2013), demographic trends that pose a severe challenge for the Ugandan health system (VSO, 2012: 15). Another big challenge is the exceptionally high proportion (estimated 87%) of the Ugandan population that live in rural areas, where access to electricity, water and healthcare is limited (CIA Factbook Uganda, 2013; VSO, 2012: 15-17, 22).

Health spending in Uganda has never exceeded 10% of total public expenditure, and is far below the 15% Abuja Target (VSO, 2012). The last available census data from 2002 shows that Uganda had only 1.2 doctors and 14.5 nurses, midwives and nursing assistants per 10,000 population (VSO, 2012: 22). Uganda therefore is one of the countries that – according to the WHO classification – has a critical shortage of health workers, where the provision of high levels of coverage for essential health services seems unlikely (WHO, 2006a: 14).

In terms of internationally agreed indicators for health outcomes, Uganda's maternal, infant and under-five death rates remain high, despite recent improvements (Uganda Ministry of Health, 2011: 2-3; World Health Statistics, 2012; VSO, 2012: 15; Uganda Ministry of Health, 2011/2012:7). On average, only 42% of births are attended by a skilled health professional, and at 55%, measles immunisation coverage among one-year olds remains low (World Health Statistics, 2012). Furthermore, only 9% of under five-year olds sleep under a mosquito net (World Health Statistics, 2012). In 2010/2011 Malaria was the leading cause of death in Uganda, followed by HIV/AIDS and Pneumonia (Uganda Ministry of Health, 2011: 3-3). At 53.45 years, Uganda has one of the lowest life expectancies in the world (CIA Factbook, 2013).

Although a comprehensive Human Resources for Health (HRH) policy and a strategy to address priority HRH constraints are in place and training of health workers has improved in recent years, the shortage of health workers and their unequal distribution remain major obstacles to access to quality health care, particularly in rural areas (Uganda Ministry of Health, 2011: XVIII). In 2011, only 58% of approved posts in health facilities were filled by trained health workers (Uganda Ministry of Health, 2011/2012:7). For the existing health workers, working conditions have been described as challenging, with high workloads, limited availability of equipment and essential medical supplies, lack of adequate continuing professional development and training opportunities, and salaries that rank among the lowest in East Africa (VSO, 2012: 7, 9, 13). On the other hand, health workers' behaviour and insufficient service provision – as well as the media's negative portrayal of these – seem to further obstruct access to health care (VSO, 2012:9, 12).

The VSO Valuing Health Workers Initiative

Between February 2010 and February 2011, VSO in partnership with the Coalition for Health Promotion and Social Development (HEPS- Uganda) conducted research among Ugandan health workers and managers to elicit their views on the effect of working conditions on their attitudes, behaviour and practices (VSO, 2012: 6). The overall aim of the project was to 'make health workers' voices heard' and to use the findings to improve relationships between healthcare users and workers, as well as to advocate for improved conditions for health workers in Uganda (VSO, 2012:12).

Continued over...

The qualitative research methods included interviews, discussion groups and workshops with 122 health workers – medical doctors, clinical officers, nurses, midwives and nursing assistants – and 24 stakeholders from civil society organisations, trade unions, professional associations and regulatory councils. Their documented views and experiences were published by VSO in the report *Our Side of the Story – A policy report on the lived experience and opinions of Ugandan health workers* (VSO, 2012).

The research revealed the main areas of satisfaction for health workers were helping others, doing a good job and being valued for what they did (VSO, 2012: 28). Furthermore, many health workers stated that they were predominantly driven by the desire ‘to make a difference’, rather than financial incentives (VSO, 2012: 30). Nonetheless, health workers were frustrated, distressed and demoralised by an often overwhelming workload, inadequate infrastructure and lack of medical equipment, supplies and medicines. In addition, they also felt unrewarded and undervalued for the work they did (VSO, 2012: 53). The research also revealed a vicious circle: inadequate working environments in combination with low pay negatively impacted the quality of patient care; patients blamed this on the health workers, which in turn boosted the health workers’ distress and frustration (VSO, 2012: 53).

To encourage positive change, the research identified two priority areas for action: firstly, health workers should be more valued for the work they did; and secondly, working conditions that prevented health workers from providing good-quality healthcare should be exposed (VSO, 2012: 57). In addition, the research produced a set of recommended strategies to address these priorities, including the improvement of in-service training (continuing professional development), raising the voice of health workers (for example through unions, membership associations, as well as civil society organisations), strategies to try to improve public perception of health workers, and approaches to foster the relationships between health workers and communities (VSO, 2012: 55-57).

Conclusion

While the research presented in this case study was not focussed on eliciting the push factors that potentially drive the migration of health workers, it nonetheless gives a good insight into ‘what life is like as a health worker in Uganda’. It highlights how challenging working conditions impact on health workers’ wellbeing and their ability to provide adequate health services (VSO, 2012: 12-13). As such, it not only exposes the impact that the HRH shortage has on health workers and their patients, but it also hints at some of the factors that might play a role in health workers’ decisions to migrate. On the positive side, the identified problems and potential solutions can play an important part in attempts to develop the HRH strategies that are necessary to improve healthcare provision in Uganda.

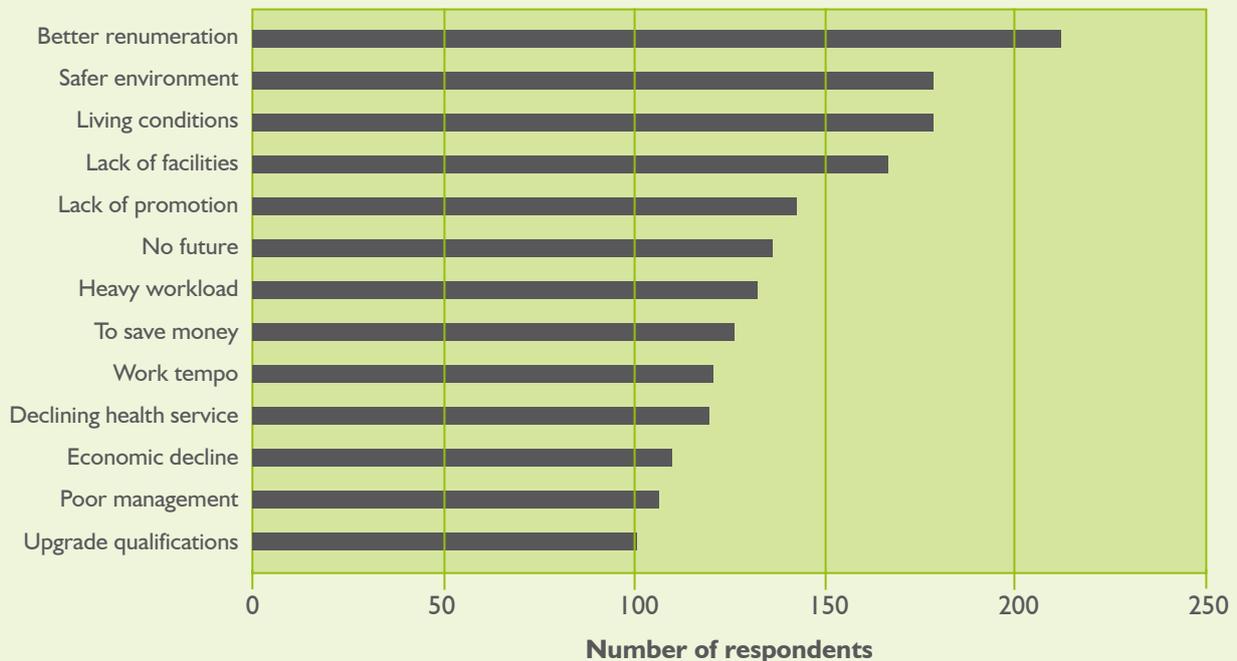
On a more general scale, research like this can help to initiate or improve the dialogue and the relationships between different stakeholders that are responsible for the delivery of health care in a particular country. It also highlights the importance of assessing the challenges of HRH shortages from the perspective of the involved individuals, instead of only focussing on the challenges to the health system as a whole (VSO, 2012: 13). VSO is currently preparing to publish the results of a similar study conducted in Cambodia.

Note: Unless indicated otherwise, all information has been provided by courtesy of VSO.

The Ugandan case study highlights that the specific reasons health workers migrate from poorer countries are manifold and context-specific. Nonetheless, over the years research has identified a number of ‘push factors’ that have been shown to regularly rank high among health workers’ reasons to migrate including poor pay, bad working conditions, poor facilities, discrimination, lack of funding, limited career structures, poor intellectual stimulation, lack of security, the wish to provide a good education for children, an oppressive political climate, and persecution of intellectuals (Mensah *et al.*, 2009: 29; Pang *et al.*, 2002; Hardill and Macdonald, 2000; VSO, 2010). Figure 4 shows study results highlighting the reasons for health worker migration in four African countries.

These ‘push factors’ in source countries are complemented by a number of ‘pull factors’ in destination countries, such as higher income, greater security and better training opportunities. Considering that like everybody else, health workers have the right to freely leave their own countries⁶, these might seem legitimate reasons that destination countries (or source countries) ultimately have little control over. Nonetheless, critics have argued that destination countries of migrant health workers contribute to the global HRH crisis.

Figure 4: Health workers’ reasons for migration in four African countries (Cameroon, South Africa, Uganda and Zimbabwe)



Source: WHO, 2006a: 308

6. In addition to an ethical argument that can be made, Mensah and colleagues point out that the International Covenant on Civil and Political Rights (article 12.2) recognises the right of everyone to leave any country, including his/her own. They also cite other human rights instruments that recognise this right, such as Universal Declaration on Human Rights (article 13) and the African Charter on Human and Peoples Rights (article 12(2)) (Mensah *et al.*, 2005: 6).



Photo: © Health Poverty Action

4. Responsibility of destination countries

It is widely agreed that the international migration of health workers exacerbates the HRH crisis and contributes to the widening global (health) inequality. Calculations for the potential loss of human capital from sub-Saharan Africa alone as a result of this ‘brain drain’ vary but are estimated to be in the billions of US\$. (Mensah *et al.*, 2005; Mills *et al.*, 2011).

Although international migration has been described as an inevitable aspect of globalisation, two key arguments have been used to highlight the responsibilities of destination countries to address the negative impact of health worker migration: Firstly, global inequalities contribute to the desire for health workers to migrate; secondly, countries of the Global North often contribute to the ‘pull factors’ of health worker migration through ‘unethical’ recruitment practices.

In regards to the latter, critics have accused active recruitment practices of leading to the enticement of health workers from countries experiencing a health worker shortage. In 2007 for example, there were 270 agencies specialising in the recruitment of nurses from abroad in the US alone (Eckenwiler, 2009). The UK too has periodically actively recruited internationally-trained health workers to overcome its domestic shortages whilst putting strict restrictions on such recruitment at other times, such as during the current economic downturn – an approach that has been described as ‘boom and bust’ with severe consequences for some source countries.

Health workforce and health worker migration in the European Union (EU)

In the European Union (EU) approximately 17.1 million people were employed in the healthcare sector in 2010, accounting for 8% of all EU jobs (EC, 2012: 2). Between 2000 and 2010, employment in the healthcare sector grew by 21% and – unlike in other sectors – even continued to grow after 2008, despite the economic crisis (EC, 2012: 2). The European Commission (EC) expects these employment trends to continue, but also to be insufficient to keep up with technological advancements and demographic changes, which are expected to challenge current healthcare delivery models not only through the resulting increased utilisation of health services by an ageing population, but also because insufficient numbers of people are currently trained to compensate for retiring health workers (EC, 2012: 6). As a result the EC estimates that the EU will be faced with a shortage of 1 million health professionals by 2020 – or 2 million if long-term care and auxiliary professions are also taken into account (EC, 2012: 8). Table 3 shows the estimated shortage of health workers in EU member states by 2020.

Already, many EU countries experience an under-supply of health workers in rural areas. To address the shortages of their own workforce, many EU Member States are relying increasingly on internationally-trained health workers: according to 2008 data from the Health Professional Mobility and Health Systems (PROMeTHEUS) project⁷, reliance on internationally-trained medical doctors among EU countries ranges from low reliance (<5%, for example Italy and France) to very high reliance (up to 36.8% in the UK) (Wismar *et al.*, 2011: 26; EC, 2012; Dussault *et al.*, 2012: 6) (please refer to the next section of this report for the latest available data on the number of internationally-trained health professionals registered in the UK). Figure 5 shows the level of reliance on international medical doctors in selected countries.

Other data suggest that between nearly 30% (Austria, Belgium, Denmark, Germany, Netherlands and Poland), 60% (France and Italy) and even 80% (Ireland and the UK) of these internationally-trained doctors come from non-EU countries (EC, 2012: 9; Dussault, Fronteira, and Cabral, 2009: 13). Similar patterns have been shown to exist for the reliance of EU countries on internationally-trained nurses (Wismar *et al.*, 2011: 27-28; Dussault, Fronteira, and Cabral, 2009: 15).

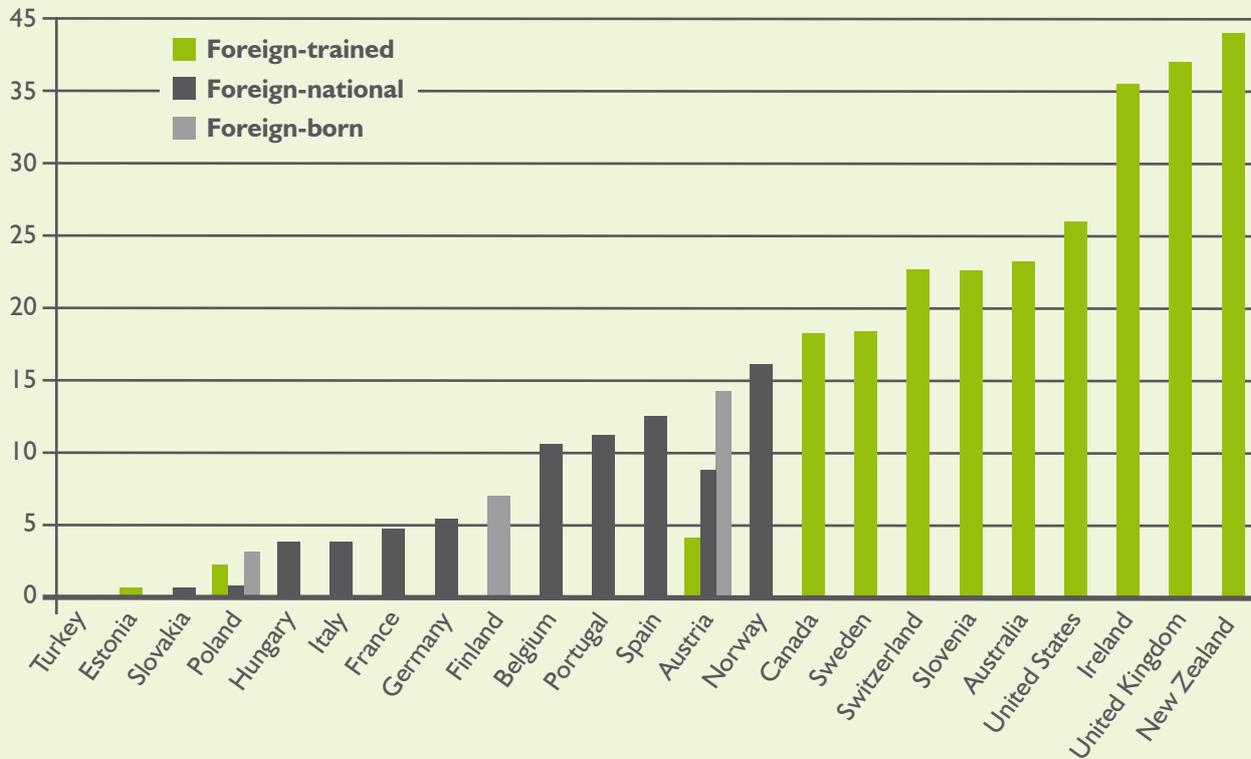
Table 3: Estimated shortage in the EU healthcare sector by 2020

Health professionals or other health workers	Estimated shortage by 2020	Estimated percentage of care not covered
Physicians	230,000	13.5%
Dentists, pharmacists and physiotherapists	150,000	13.5%
Nurses	590,000	14.0%
Total	970,000	13.8%

Source: EC, 2012: 8

7. Funded by the EC's 7th Framework Programme for Research, PROMeTHEUS was launched in January 2009 as a 3-year research study on the migration of health professionals, covering all EU Member States and selected neighbourhood countries (European Observatory on Health Systems and Policies, 2013).

Figure 5: Reliance on international medical doctors in selected European and non-European OECD countries, 2008 or last year available



Source: Wismar et al., 2011: 27

Health workforce and health worker migration in the United Kingdom (UK)

In the mid-2000s it was widely reported in the media that there were more Malawian doctors in Manchester than there were in Malawi (i.e. The Guardian, 2005; The Economist, 2004). Although recent investigations indicate that this specific claim might be exaggerated (BBC, 2012), and despite recent downward trends due to decreased demand and stricter immigration and regulation requirements, it nevertheless remains undisputed that the UK National Health Service (NHS) relies heavily on migrant health workers to deliver its high-quality healthcare (Wismar et al., 2011: 26). Indeed, data shows that the UK has long been a primary destination country for internationally-trained doctors and nurses in the EU, as well as among OECD countries (OECD, 2010: 2; Wismar et al., 2011) (see also Figure 6).

The UK has a long history as a destination country for migrating health workers, particularly from India, Pakistan, Nigeria and South Africa, influenced by previous colonial links and English as a common language (Wismar et al., 2011b: 70). Whilst the NHS has depended on migrant health workers fairly consistently in hospital services, the reliance in other areas such as nursing and general practice has fluctuated depending on domestic shortages (Wismar et al., 2011b: 295) causing its very own set of problems in source countries of migrating health workers.

In the period between the late 1990s and the mid 2000s, the number of internationally-trained doctors and nurses migrating to the UK increased rapidly when the Department of Health (DoH) actively recruited international health workers as part of an attempt to scale up the numbers of NHS staff (Buchan et al., 2009; Wismar et al., 2011b:

315-316). New full registrations of internationally-trained doctors and nurses peaked in 2003⁸, after which they started to decline again in recent years (Wismar *et al.*, 2011: 32; Buchan *et al.*, 2009; GMC, 2012), although the numbers of nurses has risen slightly since 2010 (Buchan and Seccombe 2012: 14).

Despite this recent decline in new registrations, the UK remains one of the largest destination country for migrant health workers (Wismar *et al.* 2011: 70) with more than 30% of all doctors and 10% of all nurses in the UK internationally-trained (GMC, 2013; NMC, 2013, personal communication). Furthermore, more than twice the number of those internationally-trained doctors gained

their Primary Medical Qualification (PMQ) from a country outside the European Economic Area (EEA)⁹ (GMC, 2013) (Figure 6). Among registered internationally-trained nurses, four times as many were trained in a non-EEA country (NMC, 2013, personal communication).

Figure 6 below summarises the latest available data from the General Medical Council (GMC) that show that in March 2013 63.16% of doctors working in the UK had gained their PMQ in the UK, while 10.21% gained their QMC in a non-UK country of the EEA, and 26.63% outside the EEA (listed on the GMS register as 'international' (GMC, 2013).

Figure 6: Registered Doctors on the UK medical register by World Region of Primary Medical Qualification (PMQ), March 2013



Source: GMC, March 2013

8. Although data from the UK General Medical Council (GMC) suggest that new full-time registrations of internationally-trained doctors peaked in 2003, it has been suggested that – rather than representing an actual spike in new registrations – this is an artefact resulting from changes to registration procedures (Buchan *et al.*, 2009).
9. The European Economic Area (EEA) comprises the countries of the EU (Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom), plus Iceland, Liechtenstein and Norway.

Table 4 lists the top 10 non-EEA countries of PMQ of doctors registered with the GMC. The table also lists the number of doctors and their density in the respective source countries. Although the data reported in the World Health Statistics 2012 are just an indication and should be interpreted with caution, they nevertheless highlight how the international migration of doctors to the UK is likely to further deepen the already unequal distribution of health workers between the UK and source countries.

With just over 10%, the share of registered internationally-trained nurses is lower than the share of registered internationally-trained doctors (>30%). However, proportionally more nurses come from countries outside the EEA (twice as many doctors received their PMQ from non-EEA compared to EEA countries, while more than four times as many nurses come from non-EEA compared to EEA countries) (GMC, 2013; NMC, 2013, personal communication).

Figure 7 shows the number of new full-time registrations with the UK Nursing and Midwifery Council in 2012. It highlights that amongst newly registered nurses in 2012, 17.6% were trained outside of the UK, with 4.3% coming from EEA countries and 13.3% trained outside the EEA (Figure 7 NMC, 2013, personal communication).

Although overall, the number of internationally-trained nurses registered to work in the UK is lower compared to internationally-trained doctors, Figure 8 shows that it has undergone an equally substantial 'pendulum swing' over the last decade: from low levels of recruitment of internationally-trained nurses in the late 1990s to very high recruitment activity in the early 2000s and back down to low recruitment levels in recent years (Buchan and Seccombe, 2010: 14).

Table 4: Top 10 non-EEA countries of Primary Medical Qualification (PMQ) of doctors working in the UK

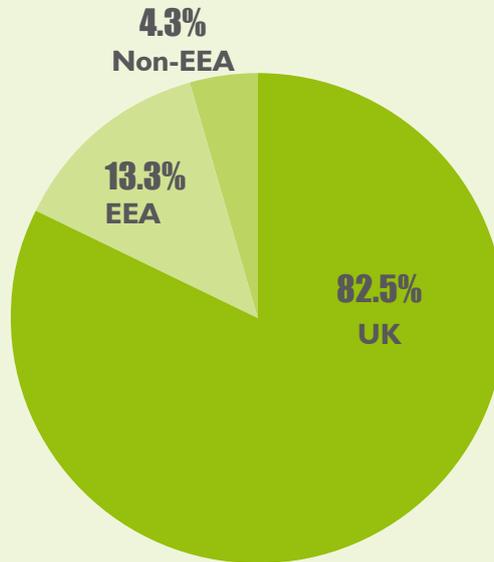
Country of PMQ*	Number of doctors in UK (and % of total)*	Number of doctors in country of PMQ	Density per 10,000
UK	159,511 (63.2%)	252,560*	27.4**
India	25,295 (10.0%)	757,377**	6.5**
Pakistan	9,082 (3.6%)	139,555**	8.1**
South Africa	5,650 (2.2%)	n/a**	n/a**
Nigeria	3,956 (1.6%)	55,376**	4.0**
Egypt	3,158 (1.3%)	225,565**	28.3**
Sri Lanka	2,330 (0.9%)	10,279**	4.9**
Iraq	2,309 (0.9%)	21,925**	6.9**
Australia	2,016 (0.8%)	62,800**	29.9**
Sudan	1,432 (0.6%)	10,813**	2.8**
Bangladesh	867 (0.3%)	43,315**	3.0**

* GMC, March 2013

** World Health Statistics 2012 (WHO, 2012a). Please note that these estimates are just an indication and should be interpreted with caution. Due to the wide diversity of available information sources used in these statistics, there is considerable variability in the coverage and quality of data (WHO, 2012a: 120). For the UK, for example, the report lists a total number of 166,006 physicians – which is far below the 252,560 registered doctors reported by the UK GMC.

Source: UK GMC March 2013

Figure 7: Percentage of new full-time registrations with the UK Nursing and Midwifery Council by country of qualification, 2012



Source: UK NMC March 2013, personal communication

Figure 8: International versus UK sources as % of total new admissions to the UK nursing register, 1989/90-2008/9



Source: Buchan and Seccombe, 2010:14)

It is widely accepted that the UK's high reliance on internationally-trained health workers has contributed to the international HRH crisis (see for example: Financial Times, 2005; Crisp, 2007) (see also: Box 2). But the cyclic recruitment of health workers in the UK – also described as a 'boom and bust' approach (The Guardian, 2011), has led to its very own set of problems. Several sources describe the devastating effects of the UK cyclic recruitment demands in some of the traditional source countries of international nurses, particularly those that have encouraged temporary migration of health workers as part of their own national development plans (The Guardian, 2011; Cheng, 2009, see also footnote 4 and footnote 13 for an example of the impact that this approach has on a country like the Philippines).

Box 2 summarises the UK's attempts to limit the negative effect of its recruitment practices through the use of voluntary codes of practices.

'Ethical recruitment' and Codes of Practice

Recent years have seen some internationally-coordinated efforts to address the HRH crisis, including initiatives to expose its negative impact; strategies to improve workforce management in source and destination countries; legally binding bilateral and/or multilateral agreements between source and destination countries; and international Codes of Practice to promote the 'ethical' recruitment and treatment of international health workers. Donors and international health actors have also increased their commitment to support the strengthening of health systems (including the health workforce) in the Global South. Nevertheless, critics have lamented that overall efforts to address the challenges related to the international migration of health workers have been limited (Mensah *et al.*, 2005; The Aspen Institute, 2012).

Box 2: Ethical recruitment in the UK

The UK Department of Health first attempted to limit the negative effects of its recruitment practices on source countries with health worker shortages in 1999, with the launch of guidelines to limit recruitment from South Africa and the West Indies (Buchan *et al.*, 2009). In 2001, it subsequently launched a Code of Practice for international recruitment for NHS employers (Department of Health, 2001), the first of its kind on a country-level. By adhering to the code, employers pledged to refrain from 'active recruitment' of health professionals from developing countries, unless there was a government-to-government agreement. Such bilateral agreements existed between the UK and India, the Philippines and China, while the list of countries to be covered by the code – a list developed by the DoH and the Department for International Development (DFID) – included 154 countries by 2007 (Buchan *et al.*, 2009). In addition, the Code also set out procedural guidelines for international recruitment, covering aspects of recruitment, selection, induction and equal opportunities in employment, pay and career prospects (Department of Health, 2001; Buchan *et al.*, 2009). In 2004, the Code of Practice was strengthened, to extend to recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector organisations providing services to the NHS (Department of Health, 2004; Buchan *et al.*, 2009).

As a member state of the World Health Organization (WHO), the UK adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel at the 63rd World Health Assembly in May 2010 (WHO, 2010). In addition, it has signed a number of bilateral cooperation agreements with Brazil, China, Libya, Saudi Arabia, and South Africa, which include collaboration on "human resources for health issues, focusing particularly on health workforce analysis and planning" (Dussault *et al.*, 2012: 14).

One key strategy that destination countries have employed to address the negative effects of international migration is the commitment to 'ethical recruitment' practices, as set out in voluntary codes of practice. Several countries have subscribed to such codes, ranging from country-specific (such as in the UK) and regional (such as the Commonwealth Code of Practice) to the WHO Global Code of Practice on the International Recruitment of Health Personnel ('the WHO Code'). In addition, many countries employ bilateral or multilateral agreements and memoranda of understanding to encourage circular migration (Dussault *et al.*, 2012: 9-10).

On an international level, the WHO Code of Practice has been the most prominent measure to address the problems associated with the international migration of health workers. The Code was unanimously adopted by the 193 WHO member states on May 21 2010 at the 63rd World Health Assembly (WHA) in Geneva (Resolution WHA63.16) as an instrument to establish and promote voluntary principles and practices for the ethical international recruitment of health workers¹⁰. It includes ten articles promoting a set of principles to guide the fair recruitment and utilisation of international health workers, taking into consideration the rights, obligations and expectations of source countries, destination countries and migrant health workers themselves. Key principles and recommendations of the Code include:

- The individual rights of health workers to migrate, in accordance with applicable laws;
- The duty of recruiters and employers to adhere to fair and just recruitment and contractual practices in the employment of migrant health workers;
- Migrant health workers should enjoy the same legal rights and responsibilities as the domestically trained health workers;
- Member States should discourage active recruitment of health personnel from countries that face a critical shortages of health workers;

- Encouragement of Member States to ensure the education, retention and maintenance of a health workforce appropriate for the specific conditions of each country, based on appropriate workforce plans;
- Member States should encourage and support health personnel to utilise work experience gained abroad for the benefit of their home country;
- Encouragement of countries in the Global North to provide financial and technical assistance to developing countries aimed at strengthening health systems, including health personnel development. (WHO, 2010)

By adopting the Code, WHO Member States have committed themselves to its promotion and implementation, and to take its principles into account when developing their national health sector employment policies and practices (WHO, 2010: 9; Dussault *et al.*, 2012: 6-7). In addition, countries have committed to designate a national authority to be responsible for the implementation of the Code and to periodically report on their progress in implementing the Code and its results (WHO, 2010: 9-11). To do this, countries are encouraged to use a National Reporting Instrument for self-assessment that covers the following areas: legal rights of migrants, bilateral agreements, research on health personnel mobility, statistics, and regulation of authorisation to practice (Dussault *et al.*, 2012: 7). More specifically, Member States are encouraged to collect and provide two specific types of information: 1) data directly relating to the migration and recruitment of health workers, such as health personnel migration data and data on laws and regulations related to health personnel recruitment and migration; and 2) information on how the principles of the Code are being observed by all relevant national stakeholders (WHO, 2013b).

However, the implementation of these measures has so far been poor. By May 2013 only 84 WHO Member States had designated national authorities for monitoring and reporting the implementation of the Code, and only 51 had submitted a report to the WHO (WHO 2013c: 2).

10. The Code's development built on Resolution WHA57.19 at the WHA in 2004, which instructed the Director General to develop a voluntary code of practice on the international recruitment of health workers (WHO, 2004), as well as the Kampala Declaration (Kampala Declaration, 2008) and the G8 communiqués of 2008 and 2009 that encouraged the WHO to accelerate the development and adoption of a code of practice (WHO, 2010).

The Limitations of Recruitment Codes of Practice

Several features of the WHO Code of Practice – and regional codes that were briefly introduced, for example in the UK – automatically restrict its potential impact, including its voluntary nature, the lack of sanctions for non-compliance, exclusion of the private healthcare sector (Connell and Buchan, 2011) and exclusion of compensation for source countries.

This leaves us to consider whether the WHO Code of Practice – and/or the national/regional codes that predate the WHO Code – is an effective tool to address the global HRH crisis?

The answer is contested, partly because the success of the Code is difficult to monitor; and more importantly, since it cannot by itself address the root causes of international health worker migration.

As an international agreement, the main objective of the WHO Code set out to be “a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening” (WHO, 2010: 2). As such, the success of the Code should theoretically be judged according to its ability to improve the HRH situation in poorer countries of the Global South (Taylor *et al.*, 2011). However, there are obvious limits to how this could be measured: firstly, because changes in international labour markets are subject to a variety of national and regional developments; and secondly, because the Code is also just one of many different measures by a range of actors that aims to address the HRH crisis in different contexts. Attributing success to the Code is therefore difficult and considering that the HRH crisis persists in many countries (see Chapter 2), it may be argued that as the key international tool to address the effects of migration the Code has so far failed – although such an analysis is perhaps too bold, considering the lack of appropriate data.

As a result of the difficulties associated with measuring the effect of codes on the HRH crisis, efforts have so far been mainly focussed on evaluating ‘surrogate’ markers for the success of the Code. In regards to national recruitment codes there have, for example, been attempts to judge their effectiveness based on analyses of health worker migration statistics. In the case of the UK, several publications have concluded that the decline in newly registered health workers over the last decade is not predominately due to national or regional Codes of Practice, but to declining demand and more stringent registration conditions and changes to visa and employment requirements (Buchan *et al.*, 2009; Blacklock *et al.*, 2012; GMC, 2012: 26-27)¹¹. Similar analytical approaches have been proposed to monitor the effectiveness of the WHO Code (Wismar *et al.*, 2011).

The WHO Code (as well as other regional Codes, such as the Commonwealth Code) is also explicit in its support of health workers’ freedom to migrate, making an analysis of its effectiveness based on its ability to limit health worker migration highly problematic. In addition, migration statistics typically fail to account for those internationally-trained doctors and nurses that migrate to the countries of the Global North but do not work in medical professions, although reports indicate that quite a high percentage of nurses in particular, work at least temporarily in private care homes or similar – trends that are likely to further intensify in view of the growing need for careworkers in the Global North due to ageing populations (VSO, 2010; Cangiano *et al.*, 2009).

The WHO’s National Reporting Instrument itself covers a variety of qualitative and quantitative indicators to assess different aspects of countries’ adherence to the Code, beyond migration statistics (WHO, 2012b; also see the section ‘Ethical Recruitment and Codes of Practice’ of this report for more details on this instrument).

11. For example, since 2006, NHS organisations that seek to employ a doctor from outside the EEA have to prove that the post could not be filled by a doctor who qualified in the UK or EEA (GMC, 2012: 2012: 26-27).



Photo: © Eric Miller

Nonetheless, it could be argued that 1) these are only surrogate markers that fail to assess the effect of the Code on the global HRH crisis; 2) many of the indicators have a strong qualitative component which complicates their evaluation and cross-country comparison; 3) it remains to be seen how WHO and national evaluations of these country assessments will use the obtained data, and how they will utilise migration statistics to attempt to evaluate the Code's success, and 4) very few countries have fulfilled the reporting requirements.

A second key limitation of the Code is that it largely fails to address the reasons underlying health workers' desire to migrate (Buchan *et al.*, 2010). Although the Code encourages wealthier countries

to support the strengthening of health systems in poorer countries (thus addressing some of the push factors), this has clearly not been given enough emphasis in the Code's implementation thus far. It could therefore be argued that implementation of the WHO Code needs to be rebalanced in favour of addressing the so-called 'push' factors, and moreover that the Code cannot be seen as a standalone international tool to address the problems of health worker migration – but rather needs to be seen as one of a series of measures that will together seek to address the health worker crisis in developing countries. Both of these criticisms will be returned to in Chapter 5.

Health Systems Strengthening (HSS) and workforce development

Countries of the Global South need to strengthen their health systems in order to tackle the HRH crisis. As previous chapters have highlighted, it is not simply enough to train adequate numbers of health workers, but it is equally important to maintain, manage, and monitor the health workforce. All of these measures require the availability of substantial funds: in 2006, the WHO estimated that every country had to spend on average US\$ 136 million per year to train enough doctors, nurses and midwives to eliminate the shortfall by 2015, as well as a further US\$ 311 million to then employ those newly trained health professionals (WHO, 2006a: 221-222). However, many countries of the Global South are limited in their ability to invest in their health systems, also as a consequence of debt obligations and decades of structural adjustment policies that restricted government spending (Chen *et al.*, 2004). The WHO has therefore identified two main sources for the funds necessary to achieve this: improved government budget and international development assistance (WHO, 2006a: 146).

Indeed, after years of disease-focussed vertical programming, health systems strengthening (HSS) has become a key objective of development assistance for health (DAH), boosted by the 2005 Paris Declaration of Aid Effectiveness¹² and subsequently promoted by most key development partners (WHO, 2006c: 4; Marchal *et al.*, 2009). While the WHO has even called for directing 50% of all DAH towards HSS, and in particular towards workforce support (WHO, 2006a: 146), in reality, the HSS agenda has encountered many challenges (Mackey and Liang, 2013; Marchal *et al.*, 2009; Labonte and Marriott, 2010; Kaplan *et al.*, 2013).

While there are many problems with the HSS agenda, a comprehensive discussion of which is beyond the scope of this report, it is now broadly agreed that HSS, including supporting workforce development, should be among donors' key responsibilities within the international aid

framework. Disagreement exists, however, regarding how far countries (and international donor agencies) might be obliged to support HSS and workforce development as a result of their contribution to the HRH crisis through their reliance on internationally-trained health workers.

The 2010 WHO Code of Practice, for example, states that Member States

[...] should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries. (WHO, 2010: 12).

In another section, the Code also states that

[...] the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel (WHO, 2010: 4).

Notably, the Code therefore indirectly links the call for financial support from destination Member States to their contribution to the negative effects of migration on source countries. It is vital that member states take this element of the Code seriously in their implementation efforts.

Interestingly, the Commonwealth Code of Practice for the International Recruitment of Health Workers and the 2007 Pacific Code of Practice went even further as they explicitly mentioned compensation as a potential mechanism to mitigate the negative effects of international migration on source countries (The Commonwealth, 2003: 5; WHO, 2007b: 8).

Ultimately, the Code will fail to address the HRH crisis if donor countries save more money by employing migrant health workers than they contribute to the workers' home countries in the form of DAH. This will be picked up in the following chapter, dealing with potential future steps.

12. The Paris Declaration of Aid Effectiveness was the result of Second High Level Forum on Joint Progress towards Enhanced Aid Effectiveness (Harmonisation, Alignment, and Results), which took place in Paris from February 28 to March 2, 2005. The Declaration established strengthened health systems as both, a key goal of more effective aid, but also as its pre-condition (OECD, 2012: 4; WHO, 2006c: 5).

5. The way forward

When considering the problem of international migration of health workers as a contributing factor to global health and wider inequality, it is important to keep in mind that migration can have significant positive effects for the health workers themselves, as well as for their families, the communities and the health systems. Families and communities often greatly benefit from remittances that are sent back by health workers to their home countries. For 2012 alone, the World Bank estimated that remittance flows to the Global South reached US\$ 406 billion (World Bank, 2012). Source countries' health systems can also benefit from the introduction of new skills and knowledge when migrating health workers return to their home country, i.e. in the case of circular migration. Remittances however, cannot compensate for the negative effects of health worker migration, since they primarily benefit individual households and not health systems (Mensah *et al.*, 2005: 4; OECD, 2008: 64¹³).

Taking consideration of the key underlying reasons for the current HRH crisis, the WHO identifies three possible targets for health workforce management

interventions: the entry (through planning, education and recruitment), the performance (through supervision, remuneration, systems support and training) and exit (through managing attrition due to career choice, safety, retirement and migration) (WHO, 2006a: xxi). This report has attempted to highlight ways in which countries in the Global North can support countries in the Global South in regards to all three of these target areas.

Table 5 lists some of the key common recommendations for actions to address the push factors for health worker migration in source countries.

Mensah and colleagues also mention compulsory public service schemes ('bonding') as widely used strategies, especially to increase the numbers of physicians working – albeit temporarily – in deprived or rural areas (Mensah *et al.*, 2009: 21). Nonetheless, they caution that these schemes might not always be successful, because high inflation in some countries may make these 'bonding schemes' ineffective; and secondly, because such an approach might effectively increase the barrier for circular migration¹⁴.

Table 5: Possible strategies to address the push factors for health worker migration

Actions in source countries
<ul style="list-style-type: none"> • Better health workforce retention, especially in rural and remote areas • Improved financial and non-financial incentives • Stronger protection and fairer treatment of health workers, who may face difficult and often dangerous working conditions and poor pay • Improved domestic training of health workers • Better adaption/substitution of skills • Continuous efforts to improve living conditions for health workers (and the general population) • Development of policies that facilitate the return of migrants • Improving the availability and international comparability of migration statistics for health personnel

Sources: i.e. WHO, 2006a: 312

13. The Philippines are often cited as an example for a country that has encouraged temporary migration by professionals and tried to use their remittances for national development (WHO, 2006a: 101). According to the World Bank, remittances to the Philippines hit US\$ 24 billion in 2012 (World Bank, 2012). Nonetheless, critics have lamented the resulting 'exodus' of health workers and claimed that migrant health workers have turned into a major export industry that in the case of the Philippines is "crippling the domestic health system" (Cheng, 2009).

14. Mensah *et al.* highlight, for example, a number of coercive measurements undertaken by the Ghanaian government to address the shortage of doctors that seem to have had detrimental effects in many cases (Mensah *et al.*, 2009: 21-22).

Case Study 4: Transforming Communities From Within: Health Extension Workers in Ethiopia

Background

Ethiopia is located in the horn of Africa. It is classified as a low-income country by the World Bank, with a GDP per capita of US\$ 370 in 2011 (World Bank, 2013d). Even compared to other low-income countries, health outcomes in Ethiopia are poor (WHO, 2010: 10). Despite improvements in the last few years, infant, under-five and maternal mortality remain high (WHO, 2012a). In addition, only 10% of births are attended by a skilled health professional (WHO, 2012a: 99). At 59 years, average life expectancy at birth is higher than the sub-Saharan average, but remains low (World Bank, 2013d). Preventable causes are responsible for the largest disease burden, including infectious diseases, nutritional deficiencies and complications during pregnancy and birth (WHO, 2010: 11). Recent data shows that non-communicable diseases are also on the rise, adding to the double burden of disease that Ethiopia, like many other African countries, is faced with (IHME, 2012b). High levels of ill health are aggravated by widespread poverty, low levels of education, and inadequate access to clean water and sanitation facilities, as well as limited access to health services (WHO, 2010:11).

Despite significant improvement in the last decade, Ethiopia continues to suffer from a severe shortage of human resources for health (HRH). It remains one of 57 countries listed by the World Health Organization (WHO) as having a critical health worker shortage. The latest available data shows that there are less than 1 doctor and only 2.4 nurses per 10,000 people – rates that are among the lowest globally (WHO, 2012a: 124). The situation is worsened by the fact that a large portion of health professionals – approximately 1/3 of doctors and 1/6 of nurses – work in Addis Ababa, where only about 4 % of Ethiopians live. As a result, accessing even basic health services can be a challenge particularly in rural areas, home to 85% of the country's population (WHO, 2010c: 2).

The shortage and unequal distribution of health workers in Ethiopia is further exacerbated by health workers moving both into the private sector and abroad. Ethiopia is one of the key sub-Saharan source countries for migrating doctors and data suggest that up to 25% of doctors and 9% of nurses migrate to other countries (OECD, 2007: 212). All of this has resulted in increasingly inequitable access to health care, within Ethiopia and in comparison with other countries.

The Health Extension Worker programme and its upgrade

As a key strategy to tackle its health worker shortage, the Ethiopian government introduced the Health Extension Programme (HEP) in 2002/03, as part of the second phase of its Health Sector Development Programme (HSDP II). The key aim of the HEP is to improve primary healthcare in rural areas through a community-based approach focussed on prevention, healthy living, and basic curative care (WHO, 2010c: 14). Underlying the approach is the assumption that by transferring appropriate health knowledge and skills to households, these can take responsibility for producing and maintaining their own health. To achieve this, a new category of health workers was introduced: Health Extension Workers (HEW), who are responsible for delivering a defined package of essential health interventions and guidance in rural communities (WHO, 2010c: 14). Beyond building up the HEW cadre, substantial investments were made to improve other areas of HRH, health infrastructure and pharmaceutical supplies, and to ensure the successful implementation and operation of the program. Indeed, the program quickly showed some success and HSDP III registered significant achievements in regards to the expansion of rural HEW coverage, as well as to the access and use of health services (WHO, 2010c: 16).

To build on these first successes – and hoping that HEWs could particularly support progress towards Millennium Development Goals (MDG) 4 and 5 – AMREF Ethiopia proposed to upgrade the knowledge and skill of Ethiopia’s HEW cadre in 2008. It partnered with the Ethiopian Federal Ministry of Health FMOH and the Open University in the UK to prepare learning materials and train tutors/mentors with the aim of establishing a unique North-South collaboration that could bring world-class health education to Ethiopia. The programme was also joined by UNICEF, the WHO and several Ethiopian Universities. Together, the organisations launched the pilot phase of the Healthcare Education and Training programme (HEAT) in February 2011. HEAT also aims to upgrade the skills of Ethiopia’s 33,000 HEW, with the help of 13 specifically developed modules and based on a ‘blended learning’ methodology, tutor-directed self-study and ‘hands-on’ practical skills training (<http://www.open.ac.uk/africa/heat/our-work/heat-ethiopia>).

Followed by a national assessment conducted in collaboration with the Ethiopian Ministry of Health, AMREF started to implement a project entitled ‘Strengthening Knowledge and Skill of Primary Health Care Workers’. The project aims to benefit 3,000 HEWs and improve the capacity of twenty training institutions through the development of curricula and learning material, and through ‘training of the trainers’. To date, 1,241 HEWs have already been upgraded to a higher training level (IV), and over 1,704 are enrolled in four regional states with a further 542 set to join in March in the remaining three regions.

Impact

Altogether, the HEW initiative represents an innovative approach to the HRH crisis in Ethiopia, by significantly increasing the number of health workers that can deliver basic healthcare. There are still concerns to address regarding the roll-out of the scheme in the most remote, and especially pastoralist regions, of the country, but by the end of the project, over 3,000 qualified HEWs will be deployed in 3,000 community-based facilities in rural areas, scaling up community-based health service to reach up to 5 million people by 2015. As a result, access to and quality of essential healthcare is expected to markedly improve, particularly in rural areas. Furthermore, the national upgrading programme promises to be a successful strategy to retain health workers: first evaluations indicate that the upgrading programme has increased the motivation among HEWs, as they see it as a mechanism to improve and further their careers. Their improved levels of training have also been reported to boost communities’ confidence in HEWs, which is likely to further increase the uptake of health services. By promoting ownership, participation and gender equality, the programmes can also indirectly benefit other development efforts in rural areas. As such, they not only represent an innovative and promising approach to improving the delivery of essential healthcare; but they might also address some of the root problems that drive the Ethiopian HRH crisis and the migration of its health workers more broadly.

Collaborating partners are also planning to roll out the HEAT initiative across several other countries in sub-Saharan Africa. With its aim of training an additional 250,000 community health workers by 2016, the programme could therefore make a huge contribution to supporting some of those countries that are hit hardest by the global shortage of health workers.

Note: Unless indicated otherwise, all information has been provided by courtesy of AMREF

Other popular attempts to address the HRH crisis in recent years have included schemes aimed at the development of alternative healthcare delivery models, for example through the substitution of health professionals by lower-cadre health workers. Case study 4 offers an example of this, highlighting the case of Ethiopia, where so-called health extension workers are trained to improve primary healthcare in rural areas.

Lastly, it must be noted that some commentators have argued that the difference in conditions, such as salaries, between some recipient and source countries are so steep, that no measurement to address the push factors can compensate for these (i.e. Vujicic *et al.*, 2004). However, research has shown that many migrant workers generally have a strong interest in returning to work in their home country (WHO, 2006a: 312; VSO, 2010; Buchan *et al.*, 2005), supporting the case to actively manage, support and encourage the circular migration of health workers as a strategy for long-term workforce strengthening in countries of the Global South. While circular migration is explicitly recommended in the WHO Code of Practice (as in other Codes, such as the Commonwealth Code), steps should be taken to ensure the implementation and monitoring of respective strategies by destination countries.

Actions in destination countries of migrant health workers/international instruments

As this report has highlighted, there seems to be general agreement that destination countries should 1) decrease their dependence on migrant health workers through better planning, training, monitoring and management of their health workforce; 2) ensure the fair treatment of migrant health workers; and 3) provide support to source countries in regards to health system strengthening activities generally, and HRH management specifically (WHR, 2006: 312). Extending bilateral agreements and memoranda of understanding – even though these are geographically limited – and support for other programs that encourage circular migration also seem to be generally accepted strategies to mitigate the effects of the skills drain to high-income countries.

Given the limitations of the WHO Code of Practice (as highlighted in Chapter 5 of this report), it can be argued that the Code in its current form cannot be the sole tool to address the responsibilities of destination countries' towards source countries of migrant health workers. There is a clear need for sustainable financing mechanisms to enable source countries to adequately address their health worker shortages (Mensah *et al.*, 2005; Mackey and Liang, 2013).

The call for compensation

Given this skills 'debt' owed by the Global North to the source countries of the South, some critics have argued that destination countries have an obligation to compensate source countries through the payment of a restitution (Mensah *et al.*, 2005; Bueno de Mesquita and Gordon, 2005; Mackintosh *et al.*, 2006).

Using the example of Ghana, Mensah and colleagues argue that the amount of money saved by the UK government through the employment of migrant health workers might in some cases even exceed the amount of development assistance for health paid by the UK to the source countries of these workers – underlining the argument that the international migration of health workers in fact constitutes a 'perverse subsidy' from poor to rich countries (Mackintosh *et al.*, 2006).

To rectify this Mensah and colleagues argue that compensation should be paid by destination countries to source countries of migrating health workers. Such compensation could be either paid as government-to-government transfers, or in the form of a restitution fund used to address the push factors for migration in source countries (Mensah *et al.*, 2005: 40; Mackintosh *et al.*, 2006: 762-765).

This could be understood as an attempt to combine addressing the causes and benefits of international migration (freedom of movement, knowledge exchange through circular migration, etc.) with arguments for a greater responsibility of destination countries. As highlighted previously, stakeholders already agree that addressing push factors through incentive schemes must be a key strategy in limiting the brain drain, and that destination countries should help to mitigate the negative effects by supporting

the strengthening of health systems and health workforces (WHO, 2004: 60; WHO, 2010: 4). Against this backdrop, the call for compensation could be promoted as a challenge to the assumptions that underlie the dominant ‘development aid’ or ‘charity’ frameworks, by acknowledging the debt owed by wealthy destination countries. In the words of Mackintosh and colleagues, the payment of compensation could:

shift development aid relationships away from a framework of charity towards a less neo-colonial commitment to progressive international fiscal transfers (Mackintosh *et al.*, 2006: 757).

As such, the call for compensation could shift the focus of the debate towards the responsibility borne by countries of the Global North. This would also offer opportunity for the development of new indicators as surrogate markers for the effectiveness of international responses to the global HRH crisis that might be more informative than health worker migration statistics.

However – while a few similar proposals have been published in recent years (see, for example: Mackey and Liang, 2013) – the call for compensation has so far not been answered. The World Health Report 2006 adopted the terminology of ‘perverse subsidy’ (WHO, 2006a: 101) and the OECD-published report *The looming crisis of the health workforce*, briefly mentioned the issue of compensation, but dismissed it due to practical, conceptual and ethical difficulties (OECD, 2008: 71). Whilst the WHO Code acknowledges the need for HSS and destination countries’ responsibility in mitigating the negative effects of international migration, the calls for compensation from a number of source country member states during the early stages of negotiations were ignored in the final drafting of the WHO Code. This appears to stem from pragmatism with a sense that destination countries were likely to reject it, and a feeling that a limited Code was better than none. Some stakeholders however, anticipated a return to this issue and, as noted by the Brazilian delegate, planned to save the debate on compensation for the future (Dhillon and Taylor 2011: 11).

Box 3: Calculating the ‘perverse subsidy’

Mensah and colleagues proposed that one way to measure this benefit to destination countries is by calculating the cost of training health professionals. In the case of doctors and nurses migrating from Ghana to the UK, they estimated that the UK government had saved around £65 million from the employment of 293 Ghanaian doctors, and about £38 million from the employment of 1021 Ghanaian nurses in 2004 – figures that could rise to over £2.5 billion when considering the number of doctors and nurses originally trained in sub-Saharan Africa and registered in the UK in 2004 (estimates are based on the number of Ghanaian doctor and nurse registrations in the UK from 1998-99 and 2003-04 and on the assumption that it costs £220,000 to train a doctor in the UK and £12,500 to train a nurse) (Mensah *et al.*, 2005: 35). Other ways to estimate the perverse subsidy that are highlighted by the authors include putting a value on the benefits produced by the migrant health workers, by assessing the value they provide through their services or by looking at their respective salaries (Mensah *et al.*, 2005: 35; Mackintosh *et al.*, 2006: 761). According to their calculations, Ghanaian-trained health workers provided a value of approximately £39 million to UK health service users in 2004 – equivalent to 60% of the UK’s official development aid to Ghana for the same year (Mackintosh *et al.*, 2006).



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6. Conclusion

The Human Resources for Health (HRH) crisis remains one of the biggest threats to the delivery of essential health services in the Global South. The brain drain from these countries further exacerbates the problem and widens global health inequalities, while primarily benefitting wealthy countries in the Global North. Technological and demographic changes are expected to further increase the need for international health workers in wealthy countries over the next decade.

Still, current attempts to address the HRH crisis are likely to be insufficient, due to a lack of sustainable funding for health systems and binding international rules to adequately address the root causes of health worker migration.

Wealthier countries therefore must recognise their responsibility for the HRH crisis. In particular, together with other global health actors, destination countries must offer better technical and financial support to source countries to improve their workforce and take the calls to address the 'push' factors outlined in the WHO Code of Practice seriously. In the light of the

difficulties pertaining to the assessment of the impact of the Code on the global HRH crisis, this should also be reflected in the tools to assess the effectiveness of the Code. Health worker migration statistics seem to be an inappropriate marker for the effectiveness of the WHO Code. Instead, more attention should be paid to evaluating the efforts of countries in the Global North to address the 'push factors' of migration and support HRH and health system development in source countries.

The ongoing discussions surrounding the post-2015 development agenda and its focus on equity issues, offers an important opportunity to re-focus international attention on the HRH crisis and its contribution to rising global health inequalities. In addition, the renewed focus on Universal Health Coverage offers significant potential to highlight the importance of health workers in delivering health services. These developments also offer the opportunity to renew proposals that have called for a rethinking of the health aid framework to reflect the 'perverse subsidy' from poor to rich that results from international health worker migration.

Bibliography

- Arnand S. and Bärnighausen T., 2004. Human resources and health outcomes: cross-country econometric study. *The Lancet* 2004 Oct 30-Nov 5;364(9445):1603-9.
- Arnand S. and Bärnighausen T., 2007. Health workers and vaccination coverage in developing countries: an econometric analysis. *The Lancet* 2007 Apr 14;369(9569):1277-85.
- BBC, 2012. *Malawian doctors - are there more in Manchester than Malawi?* [online] BBC. Available at <http://www.bbc.co.uk/news/magazine-16545526> [accessed March 15 2013]
- Blacklock C., Heneghan C., Mant D., Ward A.M., 2012. Effect of UK policy on medical migration: a time series analysis of physician registration data. *Human Resources for Health*. 2012 Sep 25;10(1):35
- Buchan J., Jobanputra R., Gough P. and Hutt R., 2005. Internationally Recruited Nurses in London. Profile and implications for policy [online] The King's Fund. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/internationally-recruited-nurses-london-profile-implications-policy-working-paper-jim-buchan-kings-fund-22-september-2005.pdf [accessed March 18 2013]
- Buchan J., McPake B., Mensah K., Rae G., 2009. Does a code make a difference? Assessing the English code of practice on international recruitment. *Human Resources for Health* 7:33. Available online at <http://www.human-resources-health.com/content/7/1/33> [accessed May 12 2013]
- Buchan J. and Seccombe I., 2010. Sustaining the long view – The UK nursing labour market review 2010 [online] RCN. Available at http://www.rcn.org.uk/__data/assets/pdf_file/0004/347953/003862.pdf [accessed March 22 2013]
- Buchan J. and Seccombe I., 2012. Overstretched. Under-resourced. The UK nursing labour market review 2012 [online] RCN. Available at http://www.rcn.org.uk/__data/assets/pdf_file/0016/482200/004332.pdf [accessed August 16 2013]
- Buchan J., 2010. Can the WHO code on international recruitment succeed? *BMJ*. 2010 Vol. 340 Issue 7750, p.791
- Bueno de Mesquita J. and Gordon M., 2005. The International Migration of Health Workers: A Human Rights Analysis [online] Medact. Available at http://www.medact.org/hpd_health_policy.php [accessed March 18 2013]
- Cangiano A., Shutes I, Spencer S., Leeson G, 2009. Migrant Care Workers In Ageing Societies. Report on Research Findings in the UK [online] Compass. Available at http://www.compas.ox.ac.uk/fileadmin/files/Publications/Research_projects/Labour_markets/Migrant_care_workers/MCW%20report%20-%20final%20-%20website%20version.pdf [accessed March 28 2013]
- Chakrabarty D., 1992. Postcoloniality and the artifice of history: who speaks for “Indian” pasts? *Representations*, 37, 1–26.
- Chant S and McIlwaine C., 2009. *Geographies of Development in the 21st Century: An Introduction to the Global South*. Edward Elgar: London
- Chen L., Evans T., Anand S., Boufford J.I., Brown H., Chowdhury M., Cueto M., Dare L., Dussault G., Elzinga G., Fee E., Habte D., Hanvoravongchai P., Jacobs M., Kurowski C., Michael S., Pablos-Mendez A., Sewankambo N., Solimano G., Stilwell B., de Waal A., Wibulpolprasert S., 2004. Human resources for health: overcoming the crisis. *The Lancet* 2004 Nov 27-Dec 3;364(9449):1984-90
- Cheng M.H., 2009. The Philippines' health worker exodus. *The Lancet* 2009 Jan 10;373(9658):111-2.
- CIA Factbook ,2013. Uganda [online] CIA. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html> [accessed March 18 2013]
- Connell J. and Buchan J., 2011. The Impossible Dream? Codes of Practice and the International Migration of Skilled Health Workers. *World Medical & Health Policy* 2011, Vol. 3 Issue 3, pp. 1–17
- Crisp N., 2007. Global Health Partnerships. The UK contribution to health in developing countries [online] UK DoH. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065359.pdf [accessed March 24 2013]
- Department of Health, 2001. Code of Practice for NHS Employers Involved in International Recruitment of Healthcare Professionals [online] DoH. Available at http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006781 [accessed March 13 2013]
- Department of Health, 2004. Code of practice for the international recruitment of healthcare professionals [online] DoH. Available at http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730 [accessed March 13 2013]
- Dhillon, I.S, Taylor, A.L, 2011, Georgetown Public Law and Legal Theory Research Paper No. 11-140 Georgetown Business, Economics and Regulatory Law Research Paper No. 11-31 Available at <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1733&context=facpub> [accessed June 10 2013]

- Dussault G., Fronteira I., and Cabral J., 2009. Migration of health personnel in the WHO European Region [online] WHO Regional Office for Europe. Available at http://www.euro.who.int/__data/assets/pdf_file/0010/95689/E93039.pdf [accessed March 14 2013]
- Dussault G., Perfilieva G., Pethick J., 2012. Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel in the European Region [online] WHO Regional Office for Europe. Available at <http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/health-workforce/publications2/2012/implementing-the-who-global-code-of-practice-on-international-recruitment-of-health-personnel-in-the-european-region-draft> [accessed March 14 2013]
- Eckenwiler L., 2009. Care worker migration and transnational justice. *Public Health Ethics* 2009;2: 171–83.
- European Commission, 2012. Commission Staff Working Document On An Action Plan For The EU Health Workforce [online] Available at http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf [accessed March 14 2013]
- European Observatory on Health Systems and Policies, 2013. PROMeTHEUS – Health Professional Mobility in The European Union Study [online] Available at <http://www.euro.who.int/en/who-we-are/partners/observatory/activities/research-studies-and-projects/prometheus> [accessed March 14 2013]
- Financial Times, 2005. Blair agrees help for African countries. [online] FT. Available at <http://www.ft.com/cms/s/0/b02a3b74-104d-11d4-bd5c-00000e2511c8.html#axzz2OXutFc7k> [accessed March 24 2013]
- GMC, 2012. The state of medical education and practice in the UK [online] UK GMC. Available at <http://www.gmc-uk.org/publications/somep2012.asp> [accessed March 15 2013]
- GMC, 2013. List of Registered Medical Practitioners – statistics [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [accessed March 15 2013]
- Hardill I. and Macdonald S., 2000. Skilled international migration: The experience of nurses in the UK. *Regional Studies* Vol. 34 No. 7, pp 681–692.
- IDMC, 2011. Internal Displacement: Global Overview of Trends and Developments in 2010 [online] Internal Displacement Monitoring Centre. Available at <http://www.internal-displacement.org/publications/global-overview-2010> [accessed May 10 2013]
- IHME, 2012. The Global Burden of Disease: Generating Evidence, Guiding Policy [online] IHME. Available at <http://www.healthmetricsandevaluation.org/gbd/publications/policy-report/global-burden-disease-generating-evidence-guiding-policy> [accessed March 24 2013]
- IHME, 2012b. GBD Profile: Ethiopia [online] IHME. Available at <http://www.healthmetricsandevaluation.org/sites/default/files/country-profiles/GBD%20Country%20Report%20-%20Ethiopia.pdf> [accessed March 26 2013]
- ILO, 2008. ISCO-08 Structure and preliminary correspondence with ISCO-88 [online] ILO. Available at <http://www.ilo.org/public/english/bureau/stat/isco/isco08/index.htm> [accessed March 22 2013]
- Kampala Declaration, 2008. Health Workers for All and All for Health Workers – The Kampala Declaration and Agenda for Global Action [online] WHO. Available at http://www.who.int/workforcealliance/forum/2_declaration_final.pdf [accessed March 14 2013]
- Kaplan A.D., Dominis S., Palen J.G., Quain E.E., 2013. Human resource governance: what does governance mean for the health workforce in low- and middle-income countries? *Hum Retour Health*. 2013 Feb 15;11(1):6.
- Labette R., Packer C., Lassen N., 2006. Managing health professional migration from sub-Saharan Africa to Canada: a stakeholder inquiry into policy options. *Hum Resources for Health*. 2006 Aug 14;4:22
- Labonte R. and Marriott A., 2010. IHP+: little progress in accountability or just little progress? *The Lancet* 2010 May 1;375(9725):1505–7
- Lorenzo F.M., Galvez-Tan J., Icamina K., Javier L., 2007. Nurse migration from a source country perspective: Philippine country case study. *Health Services Research*. 2007 Jun;42(3 Pt 2):1406–18.
- Lozano R., Naghavi M., Foreman K., Lim S., Shibuya K., Aboyans V. et al., 2012. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet* 2012 Dec 15;380(9859):2095–128
- Mackey T.K., Liang B.A., 2013. Restructuring brain drain: strengthening governance and financing for health worker migration. *Glob Health Action*. 2013 Jan 15;6(0):1–7
- Mackintosh M., Mensah K., Henry L., and Rowson M., 2006. Aid, restitution and international fiscal redistribution in health care: implications of health professionals' migration. *Journal of International Development* 18(6), pp. 757–770.
- Marchal B., Cavalli A., Kegels G., 2009. Global health actors claim to support health system strengthening: is this reality or rhetoric? *PLoS Med*. 2009 Apr 28;6(4):e1000059
- Marshall S.J., 2004. Developing countries face double burden of disease. *Bull World Health Organ*. 2004 Jul;82(7):556.

- Mensah K., Mackintosh M., Henry L., 2005. The 'Skills Drain' of Health Professionals from the Developing World: a Framework for Policy Formulation [online] Medact. Available at <http://www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf> [accessed March 15 2013]
- Mills E.J., Kanters S., Hagopian A., Bansback N., Nachega J., Alberton M., Au-Yeung C.G., Mtambo A., Bourgeault I.L., Luboga S., Hogg R.S., Ford N., 2011. The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis. *BMJ*. 2011 Nov 23;343:d7031
- OECD, 2007. Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration. [online] OECD. Available at <http://www.oecd.org/els/mig/41515701.pdf> [accessed March 25 2013]
- OECD, 2008. The Looming Crisis in the Health Workforce [online] OECD. Available at http://www.who.int/hrh/migration/looming_crisis_health_workforce.pdf [accessed March 18 2013]
- OECD, 2010. Policy Brief: International Migration of Health Workers [online] OECD. Available at <http://www.oecd.org/migration/mig/44783473.pdf> [accessed March 15 2013]
- OECD, 2012. Paris Declaration and Accra Agenda for Action. [online] OECD. Available at http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html [Accessed March 21 2013]
- Pang T., Lansang M.A. and Haines A., 2002. Brain Drain and Health Professionals. *British Medical Journal* Vol. 324 pp. 499-500.
- Save the Children, 2011. No child out of reach. Time to end the health worker crisis <http://resourcecentre.savethechildren.se/library/no-child-out-reach-time-end-health-worker-crisis>
- Somaliland Ministry of Planning and National Development and UNICEF
- Taylor A.L., Hwenda L., Larsen B.I., Daulaire N., 2011. Stemming the brain drain--a WHO global code of practice on international recruitment of health personnel. *N Engl J Med*. 2011 Dec 22;365(25):2348-51
- The Aspen Institute, 2012. HWMI Innovation Award [online] The Aspen Institute. Available at <http://www.aspeninstitute.org/policy-work/global-health-development/news/hwmi-innovation-award> [accessed March 20 2013]
- The Commonwealth, 2003. Commonwealth Code Of Practice For The International Recruitment Of Health Workers [online] The Commonwealth. Available at http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf [accessed March 19 2013]
- The Economist, 2004. Doctors' dilemma [online] The Economist. Available at <http://www.economist.com/node/3423186> [accessed March 15 2013]
- The Guardian, 2005. Assessing the cause and effect of health worker migration [online] Guardian. Available at <http://www.guardian.co.uk/global-health-workers/health-workers-move-from-area-of-origin> [accessed March 15 2013]
- The Guardian, 2011. Nursing dream fades for Filipinos as UK jobs dry up [online] The Guardian. Available at <http://www.guardian.co.uk/world/2011/feb/23/nursing-dream-filipinos-uk-jobs> [accessed March 19 2013]
- The Kaiser Family Foundation, 2013. Country data [online] KFF. Available at <http://www.globalhealthfacts.org/data/topic/map.aspx?ind=74&by=Location&order=a&fmt=76#notes> [accessed March 28 2013]
- Uganda Ministry of Health, 2011. Uganda Health System Assessment 2011 [online] Uganda MoH. Available at http://health.go.ug/mohweb/?page_id=176 [accessed March 19 2013]
- Uganda Ministry of Health, 2011/2012. Annual Health Sector Performance Report – Financial Year 2011/2012 [online] Uganda MoH. Available at http://health.go.ug/mohweb/?page_id=176 [accessed March 19 2013]
- UNDP, 2012. Somalia Human Development Report 2012 [online] United Nations Development Programme. Available at <http://hdr.undp.org/en/reports/national/africa/somalia/name,25684,en.html> [accessed May 10 2013]
- UNICEF, 2013. Somalia Child and Maternal Health. [online] Unicef. Available at <http://www.unicef.org/somalia/health.html> [accessed May 10 2013]
- University of the Philippines, 2012. Reviewing the Exodus of Health Workers [online] UP. Available at <http://www.up.edu.ph/index.php/more-on-up/22-forum/557-reviewing-the-exodus-health-workers> [accessed March 21 2013]
- VSO, 2010. Brain Gain – Making Health Worker Migration Work For Rich And Poor Countries [online] VSO. Available at <http://www.vso.org.uk/sites/vso/files/documents/Campaigns/brain-gain-report.pdf> [accessed March 9 2013]
- VSO, 2012. Our side of the story – Ugandan health workers speak up [online] VSO. Available at <http://www.vso.org.uk/about/where-we-work/uganda> [accessed March 18 2013]
- Vujicic M., Zurn P., Daillo K., Adams O. and Dal Poz M., 2004. The role of wages in the migration of health care professionals from developing countries. *Human Resources for Health* 2004 Apr 28;2(1):3.
- WHO, 2004. Resolutions and Decisions: WHA57.19 [online] WHO. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf [accessed March 9 2013]
- WHO, 2006a. World Health Report 2006 – Working Together for Health [online] WHO. Available at <http://www.who.int/whr/2006/en/> [accessed March 6 2013]

- WHO, 2006b. Health System Profile Somalia [online] WHO. Available at <http://gis.emro.who.int/HealthSystemObservatory/PDF/Somalia/Full%20Profile.pdf> [accessed May 10 2013]
- WHO, 2006c. Opportunities For Global Health Initiatives In The Health System Action Agenda [online] WHO. Available at <http://www.who.int/management/mhswork/en/index.html> [Accessed March 21 2013]
- WHO, 2007. Counting health workers: definitions, data, methods and global results [online] WHO. Available at http://www.who.int/hrh/documents/counting_health_workers.pdf [accessed March 12 2013]
- WHO, 2007b. Pacific Code of Practice for Recruitment of Health Workers and Compendium [online] WHO. Available at <http://www.hrhresourcecenter.org/node/3448> [accessed March 19 2013]
- WHO, 2010. The WHO Global Code of Practice on the International Recruitment of Health Personnel [online] WHO. Available at http://www.who.int/hrh/migration/code/code_en.pdf [accessed March 9 2013]
- WHO, 2010b. Migration of health workers [online] WHO. Available at <http://www.who.int/mediacentre/factsheets/fs301/en/index.html> [accessed March 20 2013]
- WHO, 2010c. Scaling up education and training of human resources for health in Ethiopia. [online] WHO. Available at http://www.who.int/workforcealliance/knowledge/case_studies/ethiopia_case_study_2010.pdf [accessed March 25 2013]
- WHO, 2011. Noncommunicable diseases: Fact sheet. [online] WHO. Available at <http://www.who.int/mediacentre/factsheets/fs355/en/index.html> [accessed March 25 2013]
- WHO, 2012a. World Health Statistics 2012. [online] WHO. Available at http://apps.who.int/iris/bitstream/10665/44844/1/9789241564441_eng.pdf [accessed March 13 2013]
- WHO, 2012b. National Reporting Instrument [online] WHO. Available at http://www.who.int/hrh/migration/code/WHO_CODE_NationalReportingInstEn.pdf [accessed March 13 2013]
- WHO, 2013. Global Atlas of the Health Workforce [online] WHO. Available at <http://apps.who.int/globalatlas/default.asp> [accessed March 13 2013]
- WHO, 2013b. Draft guidelines on monitoring the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel [online] WHO. Available at <http://www.who.int/hrh/migration/code/information/en/index.html> [accessed March 22 2013]
- WHO, 2013c. The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs. Sixty Sixth World Health Assembly Provisional Item 17. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_25-en.pdf [accessed 1 July 2013]
- Wismar M., Maier C.B., Glinos I.A., Dussault G., Figueras J., 2011. Health Professional Mobility and Health Systems. Evidence from 17 European countries. [online] WHO Europe. Available at <http://www.euro.who.int/en/what-we-publish/abstracts/health-professional-mobility-and-health-systems.-evidence-from-17-european-countries> [accessed March 22 2013]
- Wismar M., Glinos I.A., Maier C.B., Dussault G., Palm W., Bremner J., Figueras J., 2011b. Euro Observer: Health Professional Mobility and Health Systems. Evidence from 17 European countries. [online] WHO Europe. Available at http://www.euro.who.int/__data/assets/pdf_file/0006/145158/EuroObserver-Summer-2011_web.pdf [accessed March 22 2013]
- World Bank, 2012. Remittances to developing countries will surpass \$400 billion in 2012. [online] The World Bank. Available at <http://siteresources.worldbank.org/INTPROSPECTS/Resources/334934-1288990760745/MigrationDevelopmentBrief19.pdf> [accessed March 21 2013]
- World Bank, 2013a. Country Profile: Mozambique [online] The World Bank. Available at <http://www.worldbank.org/en/country/mozambique> [accessed May 8 2013]
- World Bank, 2013b. Country Profile: Somalia [online] The World Bank. Available at <http://data.worldbank.org/country/somalia> [accessed May 10 2013]
- World Bank, 2013c. Country Profile: Uganda [online] The World Bank. Available at <http://data.worldbank.org/country/uganda> [accessed March 18 2013]
- World Bank, 2013d. Country Profile: Ethiopia [online] The World Bank. Available at <http://data.worldbank.org/country/ethiopia> [accessed March 18 2013]

The Health Worker Crisis: an analysis of the issues and main international responses

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

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The project is funded by the European Union.



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