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The current status of migration into the UK's National Health Service.

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Introduction

The international movement of workers in the health sector is not a new phenomenon. Concerns over the 'brain drain' of health workers were expressed at the Edinburgh Commonwealth Medical Conference in 1965. In the 1970s the World Health Organization was prompted to examine the global stocks and flows of doctors and nurses in what is the only study of its kind [1]. This report made little impact and the migration of health professionals has gradually increased over the years. There have been regular articles in leading medical journals pointing out the impact that migration has on poorer countries, but little has been done to solve the problem. [2-5].

During the early days of the NHS there was considerable mistrust of the new system and many British trained doctors left to work in North America and other more affluent ex colonial countries. This large-scale emigration created shortages in the NHS and overseas recruitment of both doctors and nurses began. These individuals came from many economically poorer Commonwealth countries and over the years successive “waves” of migration have brought staff to the NHS from different parts of the world[2]. In the 1960’s and early 1970’s large numbers of doctors from the Asian sub-continent came to work in the UK, most stayed and have become the backbone of primary care in many inner-city areas. This group are rapidly nearing retirement and with shortages of “home grown” staff, large numbers of doctors from Sub-Saharan Africa have arrived in the UK. These individuals are drawn to the UK by the economic benefits of work in a developed country and the chance to train as a specialist. The UK has thus developed a culture that accepts the migration of doctors to and from the country as being the norm.

As the large scale movement of health professionals from developing countries is now impacting on the health systems of those countries questions are being asked about the feasibility of continuing these migratory policies. There is also an element of self-interest beginning to appear. With the rapid expansion of the intake into medical schools pressure on the availability of posts is being felt in the middle grades of postgraduate training. These posts have traditionally been the entry point of International Medical Graduates (IMG’s) into the NHS. However more and more of these posts are being earmarked for locally trained staff. Matters came to a head in July 2005 when substantial numbers of pre-registration house officers had no posts to

go to when they finished their intern year. A survey carried out by the BMA showed that of 276 doctors surveyed 104 (37.7%) had not been able to find a post starting in August [6]. True to the British tradition 58% of the respondents stated that they would consider moving abroad to continue their training if they were unable to find an accredited training post in the UK.

What is the current status in the supply of doctors in the NHS?

The general view is that the NHS is better placed in 2005 than it was 5 years ago. However there is still a net shortage of consultants and an excess of non-British trained juniors chasing too few jobs in the NHS. There is a general feeling that the international recruitment of senior staff into the NHS has not been successful.

The expansion of medical education over the last few years has increased numbers into medial school but these newly trained doctors are still working their way through the training grades. There are critical vacancies in some specialties. It was estimated in 2003 that 500 of the 3,222 consultant Psychiatrist posts in the UK were unfilled. By the year 2009 the Department of Health has estimated that the NHS will need over 4,000 Psychiatrists to provide an adequate service. The NHS will need to find 1,300 psychiatrists in the next 4 years to get the staffing levels to the prescribed standard [7]. In the late 1990's the U.K trained too many obstetricians and over 350 migrated or have been retrained in other fields [8]. The longer-term outcome of this has been a decline in the number of British trained male physicians entering postgraduate training in obstetrics.

The College of General Practice's Workforce Committee in its first report in 2004 suggested that by 2011 an additional 4,473 whole time equivalent GP's would be required, this equates to a 6,574 increase in the actual numbers of GP's in practice [9]. This highlights another issue that planners have to face up to – the feminization of the Medical profession. General Practice has become the career choice for many women and in order to get an acceptable work/life balance many are choosing to work part-time [10]. This puts additional pressure on training at all levels.

Government Policy over the last 7 years has been to move the NHS from a Consultant "led" service to a Consultant "delivered" service. The implications for this, in terms

of the numbers of consultants, are enormous. Rob Webster and his colleagues have shown in their paper that there has been a rapid expansion of the medical workforce in the UK in the last 10 years [11]. This has been achieved in two ways. There has been a 66% rise in the intake into British medical schools. Secondly there has also been an increase in the numbers of graduates from foreign medical schools entering the NHS with over 26,000 in post in 2004. This is an increase of 6,000 since 1994, however the proportion of doctors from overseas has remained constant at 25% over this time period. The UK is unlikely to be able to meet its needs for all its doctors from locally qualified graduates for a number of years.

Expanding undergraduate medical education.

The expansion of places in medical school has been achieved in a number of ways. Firstly four new medical schools have been opened in areas of the country where previously there had been no undergraduate medical education. Secondly, new approaches to medical education have been developed. Courses, which rely on student centred, learning using a problem-based approach, have been introduced. The newer medical schools are much less reliant on the traditional teaching hospital for clinical teaching. Students are attached to community and primary care services and use local District Hospitals for their clinical learning. Thirdly the intake into the traditional 5-year post-school courses has been expanded by 40%. To do this Admission Sub-Deans have targeted local school leavers, often from inner city schools. Many of these individuals are from families from the ethnic minorities and these students are often the first university-entrant in the family. Finally half of the medical schools have started new graduate entry courses. Students on these courses have a primary degree in a science subject, most with some biology or psychology and they graduate after 4 years.

What has the UK done to curb the inflow of IMG's?

When examining recruitment policies it is important to distinguish between active recruitment at Government to Government level and the ad hoc migration of individual health workers from developing to developed countries. British Government policy is quite strait forward on this issue: The stated Government Policy is that the NHS does not actively recruit from any country that does not wish to be recruited from [12]. This includes all countries in Sub-Saharan Africa. The UK was

the first developed country to implement and review policies that explicitly prevent the targeting of developing countries in the international recruitment of health care professionals. However, the NHS has shortages of doctors and in order to meet the targets set by Government the recruitment of IMG's is an important method of filling the gaps. As Rob Webster has stated in his paper, "It is also clear that international recruitment will continue to be an important short-term solution to England's medical workforce shortages. Increased demand across the developed world and competition for staff means that international migration of healthcare professionals is a global phenomenon" [11].

Over the last 6 years the UK Government has developed Codes of Practice aimed at a more ethical approach to recruitment of heath workers from poorer countries [13, 14, 15]. The most recent version, published in December 2004, gives explicit guidance on best practice in the recruitment of International Health Workers [15]. The approach adopted by the UK Government is that recommended by the World Health Assembly Resolution 57.19 to manage healthcare migration. These Codes of Practice govern the Health Service's recruitment of International Healthcare Professionals. The Code is underpinned by the principle that developing countries, that are experiencing shortages of healthcare staff themselves, should not be targeted for recruitment. In addition, the Department of Health has negotiated an agreement for this Code to apply to the independent healthcare sector. A number of countries have indicated that they have a surplus of healthcare professionals and are content for the UK to recruit their workers using the ethical code of practice. The following agreements are in place [16]:

Philippines: The UK has a Memorandum of Understanding with Philippines, which offers individual nurses the opportunity to work in England

Spain: The UK Government is working with the Spanish Ministry of Health to give Spanish nurses, doctors and pharmacists the opportunity to work in England. Spain trains more healthcare professionals than there are jobs in the Spanish health service and the government is happy for recruitment to take place. All doctors and nurses within the EU whose qualifications meet minimum training standards set by the EU have the right of free movement within the European Economic Area.

India: The UK has a recruitment agreement with India, which offers individual nurses the opportunity to work in England. However, four states receive aid and should not be targeted for recruitment. These are Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal.

South Africa: A Memorandum of Understanding now exists between the UK Department of Health and the South African Department of Health. This has focussed on creating opportunities for healthcare professionals, from both countries, to undertake time limited placements that will give opportunities for exchange of knowledge and skills and develop collaborative approaches to health between the two countries.

China: Some discussions have taken place between UK and the Chinese Government about the future of recruitment from China.

Indonesia: The UK has a Memorandum of Understanding with Indonesia, which offers individual nurses the opportunity to work in England.

The NHS is strongly encouraged to use these channels for all its international recruitment activity outside the European Economic Area. However there are concerns that some UK hospitals are not sticking to the codes of practice or are targeting health workers from other Sub-Saharan countries not covered by the code. In Lilongwe Central Hospital in the capital of Malawi, only 169 of the 520 established nursing posts were filled in 2004, following a mass exodus of nurses to the United Kingdom [17].

The picture from Malawi highlights a major ethical problem facing UK Government. No matter how many Memoranda of Agreement are in place each of us has a human right to seek employment in another country if the laws of that country allow us to work there. Despite the agreement with South Africa large numbers of South African nurses continue to arrive in the UK to work. Examination of the pay and conditions of service in South Africa partly explains why many of these individuals come to the UK.

Differences in earnings of South African Nurse in South Africa and UK

In South Africa a senior nurse would be paid in the region of R70,000 per annum, this equates to £ 6,500. In the UK the equivalent salary scale would put the nurse on a salary of £25,000 or R275, 000 per annum. The package includes the usual NHS pension. For a nurse earning £25,000 in her final year of a 5 year contract the pension would be equivalent to R17, 000 pa. This represents a substantial increase in the pension the nurse would receive after 30 years in the South African state health service.

Other data also indicate the disparity between salaries in the developing and developed world. This table shows the monthly salary of a junior doctor in a number of Sub-Saharan countries in 1999 [18]. The UK salary for a doctor 4 years post qualification with additional salary enhancement for long working hours is shown for comparison.

Average monthly salary levels for junior doctors in 1999

Sierra Leone	Ghana	Zambia	Lesotho	Namibia	South Africa	United Kingdom
£31.25	£120.6	£125	£661	£726	£776	£3000

A similar situation is occurring in some of the former eastern block countries that are now members of the European Union. In 2004 almost 500 Polish doctors registered to work in the UK alone. In Poland a middle grade hospital doctor earns about £206 per month, which is insufficient for them to live on. So many doctors have now left Poland that the health care system is under pressure [19].
Whilst there is such a discrepancy in earnings it is almost impossible to stop health worker migrants coming to UK to fill the gaps in the NHS.

Many young doctors come to UK from Sub-Saharan Africa and the Asian sub-continent looking for work. In order to practice in the UK, IMG's needed to pass the PLAB test. This test is the main route by which they demonstrate that they have the necessary skills and knowledge to practice medicine in the UK. It has been estimated that there are currently 9,000 doctors who have passed the test who are seeking employment in UK [20]. A local hospital recently advertised for 4 junior doctors to work in the Accident and Emergency Department and received over 900 applications for these posts. This is a very wasteful system. Many of these individuals will never

be able to find work in the NHS. As Buchan et al have said in a paper describing nurses in a similar predicament, “this is the worse-case scenario for all involved – one country has lost a nurse, the UK has not yet gained a nurse and the nurse herself is prevented from making use of her skills” [21]. From a medical perspective the real losers are often the patients in a rural area in Africa who are without a physician providing them with the most basic of health care [22].

The second reason why many of these doctors come to the UK is to try to obtain post-graduate training, which often is not available in their home country. With the expansion of UK medical school intake there is now considerable pressure on many of these training places from home applicants. If developing countries are to embrace modern medical practice it is vital that appropriate training of their graduates takes place.

UK policy on the training of overseas doctors.

The UK does not currently have a policy on the short term training of IMG’s so that they can return to their own country after an appropriate period of postgraduate training. In recent years many IMG’s have not required a work permit to remain in the UK. This “permit-free” situation is about to change so that in future there will be much tighter control of IMG’s immigration status.

There are a number of small scale programs which have been developed to train individuals in specific clinical areas. One University is currently training two Clinical Geneticists for a Gulf State. The nature of the training contract ensures that these individuals will return home on completion of their contract. Another initiative has developed Fixed Term Training Appointments (FTTA’s). These are currently being developed and could be adapted to meet the specific training needs of doctors from low income countries. The Royal College of Obstertrician and Gynecologists have developed a program of International Training Fellowships. On completion of the Fellowship the doctor is not licensed to practice in UK and has to return to their own country [20].

As the NHS’s reliance on IMG’s diminishes new approaches are being sort to ensure that the UK continues to train postgraduates from other countries. There are always

going to be times when there are either shortages or excesses of locally trained graduates. The use of IMG's in these circumstances is seen as a buffer for the failings in human resource planning.

Why action is needed to reduce the flow of health workers from developing countries. In 2000 the United Nations Millennium Summit stated that economic development in the world's poorest countries could only be achieved if the health of the population was improved [23]. The summit developed eight Millennium Goals:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV and AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Three of the goals directly relate to health, whilst the rest target economic growth and education. Without significant investment from developed countries none of the goals are achievable. Whilst we, as the most affluent of countries, continue to actively use health staff from these poorer countries to provide an inexpensive source of labour for own health systems there is little chance that the health and economy of these countries will ever improve.

Conclusions

Our health systems continue to attract health workers from the developed world. The factors which stimulate migration are complex but at their heart is the poor economic status of many of the countries providing these migratory workers. Poor salaries and lack of capital investment in health infrastructure makes the work environment unattractive.

The goals of the United Nations Millennium Summit are achievable. However if there is to be any improvement in the health of the populations of poorer countries, and thereby improvement in their economies, the developed world must not rely on migratory health workers to support their own health systems. There should also be an obligation to help to develop both undergraduate and postgraduate medical education in these countries [24]. Innovative and politically sensitive solutions to the shortage of postgraduate training posts, that take into account the differing health needs of these countries, are needed. If the developed world fails to become self-sufficient in the production of medical graduates it is unlikely that the desired improvement in health care in the developing world will ever occur.

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