

A Global Skill Partnership in Nursing between Nigeria and the UK

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INTRODUCTION

The World Bank is partnering with the government of Nigeria to better understand how labor migration and skills partnerships can provide more and better jobs to Nigerian youth. One objective of this collaboration is to assess the feasibility of new bilateral labor agreements in chosen sectors, mirroring the Center for Global Development’s (CGD) Global Skill Partnership model.

A joint CGD-World Bank report—“Expanding Legal Migration Pathways from Nigeria to Europe: From Brain Drain to Brain Gain”¹—and a related brief ² present the results of this work. The report outlines both the opportunity inherent within the growing (yet unemployed) youth population in Nigeria and the declining working-age population in Europe that is leading to widespread skill shortages. It then describes the Global Skill Partnership model and applies it to case studies in three sectors: construction; information, communication, and technology (ICT); and this one, on nursing.

By 2030, the world will require an additional 15 million nurses if it is to reach universal health coverage (UHC). These shortages are felt globally, with both Nigeria and the UK suffering from a shortage of skilled personnel. Neither produce nor employ the number of nurses required within their public and private institutions, and both have specific needs. This case study outlines a Global Skill Partnership between Nigeria and the UK within nursing, including an overview of the training and migration landscape in both countries, the specific design of such a partnership, and risks and mitigation measures.

DEVELOPING A HEALTH CARE MIGRATION PARTNERSHIP

Globally, the world needs more health workers. A Global Burden of Disease Study in 2017 found that “only half of all countries had the health care workers required to deliver quality health care”, critical to achieving universal health coverage (UHC).³ These shortages are universal, but not universally distributed. For example, the World Health Organization (WHO) has shown that the African region experiences 24 percent of the disease burden but has only 3 percent of the world’s health workforce. Within countries, shortages are most acute within rural areas due to issues with worker recruitment and retention, as well as infrastructure deficits.⁴

Achieving UHC by 2030 will require 80 million health workers globally, double the number of health workers that existed in 2013. Currently, we are on track to produce 65 million health workers, leaving a shortage of 15 million.⁵ These shortages are likely to be highest among upper middle-income

¹ Samik Adhikari, Michael Clemens, Helen Dempster, and Nkechi Linda Ekeator. 2021. “Expanding Legal Migration Pathways from Nigeria to Europe: From Brain Drain to Brain Gain.” Washington, DC: Center for Global Development (CGD) and World Bank. <https://www.cgdev.org/publication/expanding-legal-migration-pathways-nigeria-europe-brain-drain-brain-gain>.

² Samik Adhikari, Michael Clemens, Helen Dempster, and Nkechi Linda Ekeator. 2021. “Why Europe Should Build Legal Migration Pathways with Nigeria.” Washington, DC: Center for Global Development (CGD) and World Bank. <https://www.cgdev.org/publication/why-europe-should-build-legal-migration-pathways-nigeria>.

³ The Lancet. 2018. “GBD 2017: a fragile world.” *The Lancet* 392(10159): 1683. November 10, 2018. <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2932858-7>

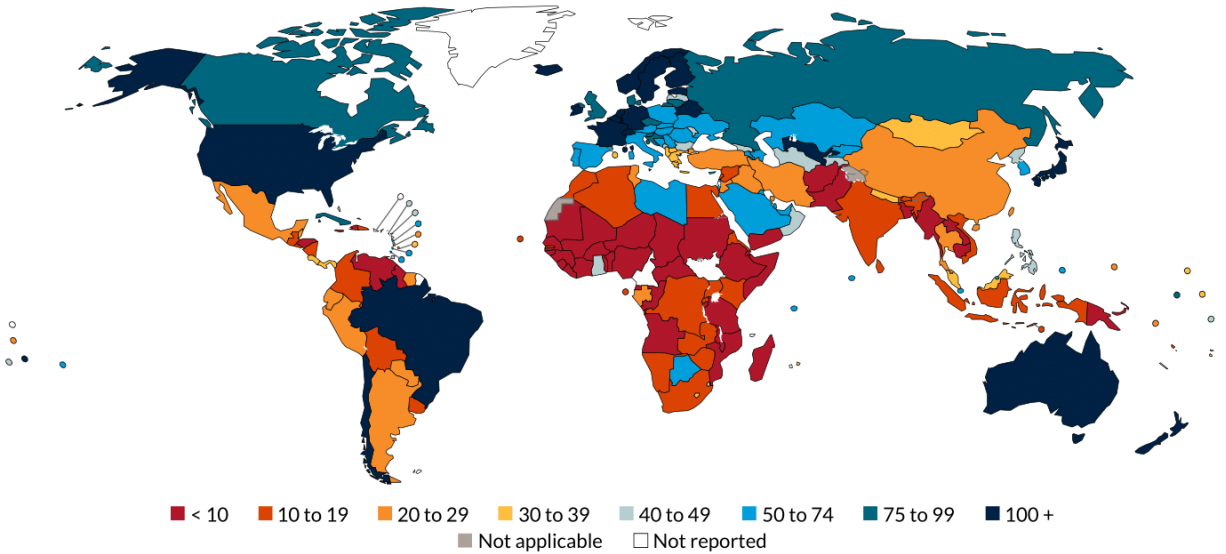
⁴ Onyema Ajuebor, Mathieu Boniol, Michelle McIsaac, Chukwuemeka Onyedike, and Elie A. Akl. 2020. “Increasing access to health workers in rural and remote areas: what do stakeholders’ value and find feasible and acceptable?” *Human Resources for Health* 18(77). <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-00519-2>

⁵ Jenny X. Liu, Yevgeniy Goryakin, Akiko Maeda, Tim Bruckner, and Richard Scheffler. 2017. “Global Health Workforce Labor Market Projections for 2030.” *Human Resources for Health* 15(11). <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0187-2>

countries, driven by economic and population growth, as well as aging demographics. Despite the need for increased health coverage in low-income countries, both the demand for and supply of health workers is projected to remain low. This could lead to a paradoxical situation whereby health workers are trained but unable to be employed within the current labor market.

The WHO defines “health workers” as all people who are engaged in actions whose primary intent is to enhance health. Therefore, it includes doctors, nurses, and midwives, along with hospital administrative and support staff. These professions all require different levels of qualifications and skills, and therefore different training architectures. In this report, we will primarily focus on nurses. Nursing is the largest occupational group in the health sector (59 percent); in 2018, there was a shortage of 5.9 million nurses worldwide, with 89 percent of the shortage in low- and middle-income countries (Figure 1).⁶

Figure 1. The density of nursing personnel in the world is highly uneven



Source: World Health Organization (WHO) 2020. “State of the World’s Nursing Report -2020.” Geneva: World Health Organization (WHO). <https://www.who.int/publications-detail-redirect/9789240003279>

⁶ World Health Organization (WHO) 2020. “State of the World’s Nursing Report—2020.” Geneva: World Health Organization (WHO). <https://www.who.int/publications-detail-redirect/9789240003279>

Health Worker Migration

The international migration of health workers is increasing, with a 60 percent rise in the number of migrant doctors and nurses working in OECD countries over the last decade.⁷ Today, for example, one in every eight nurses practice outside the country where they were born or trained, which translates into 3.7 million people.⁸ While most migration takes place from low- to high-income countries, there are emerging patterns of South-South migration as well. Such trends deplete low- and middle-income countries of their already meagre health workforces and contribute to a perception of brain drain.

Why do health workers move? Research has shown that while economic factors (e.g. higher potential earnings) are important, so too are institutional factors (e.g. declining health services, lack of equipment and support), professional factors (e.g. upgrading professional qualifications and skills), and political reasons (e.g. crime and political violence).⁹ For example, Awases et al (2004) find that many African health professionals are dissatisfied, suffering from delayed salaries and promotions, a lack of recognition, and an inability to afford the basic necessities of life.¹⁰ These issues are even more pronounced in rural areas. Governments find it difficult to translate public spending into effective services, even when such funding is available. Many countries (especially their public systems) are unable to employ newly qualified workers, even if such workers are required, creating emigration pressure and dissatisfaction. A range of potential policy options have been posited and these will be explored further in this section.¹¹

Despite these impacts, countries of destination have long encouraged health worker migration. From 2010 to 2015, the number of foreign-born doctors in 18 OECD countries rose by over 20 percent.¹² Many workers moved while young and obtained their qualifications in the country of destination, while others applied under increasingly less restrictive visa policies and targeted pilot programs. Today, the US has the largest number of foreign-trained doctors and nurses, followed by the UK. The Philippines is the largest global supplier of nurses, predominantly supplying markets in the US, UK, Saudi Arabia, the Netherlands, and Ireland.¹³

⁷ World Health Organization (WHO) “Health workforce—Migration.” <https://www.who.int/hrh/migration/en/>

⁸ World Health Organization (WHO). 2020. “State of the World’s Nursing Report—2020.” Geneva: World Health Organization (WHO). <https://www.who.int/publications-detail-redirect/9789240003279>

⁹ A good summary can be found in James Buchan, Tina Parkin, and Julie Sochalski. 2003. “International nurse mobility: Trends and policy implications.” Geneva: World Health Organization (WHO). https://apps.who.int/iris/bitstream/handle/10665/68061/WHO_EIP_OSD_2003.3.pdf

¹⁰ Magda Awases, Akpa R. Gbary, Jennifer Nyoni, and Rufaro Chatora. 2004. “Migration of Health Professionals in Six Countries: A Synthesis Report.” Johannesburg: World Health Organization (WHO) Regional Office for Africa. <https://www.afro.who.int/publications/migration-health-professionals-six-countries-synthesis-report>

¹¹ For example, raising wages and working conditions, providing fully or partially subsidized housing, providing pension plans and health insurance, ensuring good transport options, providing access to good schooling for health workers’ children, improving / providing infrastructure and equipment, and providing job security and career advancement opportunities. The best results, argue the World Health Organization (WHO), are those that bundle contextually relevant recommendations. For more information, please see Gloria Pallares. 2020. “Financial incentives for frontline health workers.” Devex. October 30, 2020. <https://www.devex.com/news/financial-incentives-for-frontline-health-workers-98447>; and World Health Organization (WHO) 2010. “Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations.” Geneva: World Health Organization (WHO). <https://www.who.int/hrh/retention/guidelines/en/>

¹² Organisation for Economic Cooperation and Development (OECD). 2019. “Recent Trends in International Migration of Doctors, Nurses and Medical Students.” Paris: OECD Publishing. <https://doi.org/10.1787/5571ef48-en>

¹³ For more information see Fely Marilyn E Lorenzo, Jaime Galvez-Tan, Kriselle Icamina, and Lara Javier. 2007. “Nurse Migration from a Source Country Perspective: Philippine Country Case Study.” *Health Services Research* 42(3 Pt 2): 1406-1418. June 2007. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955369>; and Barbara Brush and Julie Sochalski. 2007. “International Nurse Migration: Lessons From the Philippines.” *Policy, Politics, and Nursing Practice* 8(1): 37-46. March 2007. <https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1177%2F1527154407301393>

BOX 1. GERMANY'S TRIPLE WIN

Since 2013, Germany's Triple Win project has aimed to place qualified health professionals from third countries with German clinics, hospitals, and old people's homes. The project is being implemented by the International Placement Services (ZAV) of the Federal Employment Agency and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and is aimed at people from Serbia, Bosnia and Herzegovina, the Philippines, and Tunisia. These countries were selected as they have a surplus of well-trained nurses, thereby avoiding issues of brain drain.¹⁴

Jointly, ZAV and GIZ select applicants and pass on their details to the care facilities. Applicants must have already undertaken a three-year nursing training qualification. Before leaving, successful applicants are given German language training and cultural awareness and integration support. Nurses are initially granted a one-year residence permit which can be extended and translated into permanent residency in the long-run.¹⁵ By November 2019, more than 3,000 nurses had been placed of which 2,100 had already moved.¹⁶ Demand continues to grow, despite COVID-19, and the project is expected to expand to new countries of origin in 2021.

Source: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. 2021. "Sustainable recruitment of nurses (Triple Win)" Last updated January 2021. <https://www.giz.de/en/worldwide/41533.html>

Experts are split on the impact of health worker migration on patient outcomes. It is difficult to distinguish the impact of health worker migration on patient outcomes from broader structural factors. Clemens (2007) argues that Africa's generally low staffing levels and poor public health conditions, for example, are the result of factors entirely unrelated to the international movement of health professionals.¹⁷ On the contrary, he argues. The availability of health care migration pathways can actually incentivize people to undertake health worker training, thereby increasing the number of skilled professionals available. For example, a recent study in the Philippines found that for every nurse who moved abroad, approximately ten more individuals with nursing degrees graduated.¹⁸ Yet the study does not track the impact of this increase on the number of health workers working in the Philippines, nor on health outcomes. Other studies have found a perception that migration led to higher caseloads, which overextends, overburdens, and demotivates those who stay.¹⁹

Even if the specific impact on patient outcomes is difficult to identify, many argue that health worker migration has an adverse impact on health systems overall. This impact is the main concern of the WHO's Resolution 57.19: International migration of health personnel: a challenge for health systems

¹⁴ Juliana Ziegler. 2018. "A programme with three advantages." Deutschland.de. September 6, 2019. <https://www.deutschland.de/en/topic/life/society-and-integration/working-as-a-nurse-in-germany-the-gizs-triple-win-project>

¹⁵ Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. 2013. "Placement of qualified nurses from the Philippines in Germany." <https://poea.gov.ph/TWP/files/Triple%20Win%20Philippinen.pdf>

¹⁶ Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. 2021. "Sustainable recruitment of nurses (Triple Win)" Last updated January 2021. <https://www.giz.de/en/worldwide/41533.html>

¹⁷ Michael Clemens. 2007. "Do Visas Kill? Health Effects of African Health Professional Emigration." Center for Global Development (CGD) Working paper 114. Washington, DC: Center for Global Development (CGD). <https://www.cgdev.org/publication/do-visas-kill-health-effects-african-health-professional-emigration-working-paper-114>

¹⁸ Paolo Abarcar and Caroline Theoharides. 2020. "Medical Worker Migration and Origin-Country Human Capital: Evidence from U.S. Visa Policy." Amherst College Draft Working Paper July 2020. https://www.amherst.edu/system/files/Abarcar.Theoharides_2020_July_FINAL.pdf

¹⁹ Magda Awases, Akpa R. Gbary, Jennifer Nyoni, and Rufaro Chatora. 2004. "Migration of Health Professionals in Six Countries: A Synthesis Report." Johannesburg: World Health Organization (WHO) Regional Office for Africa. <https://www.afro.who.int/publications/migration-health-professionals-six-countries-synthesis-report>

in developing countries.²⁰ In situations of substantial health worker migration, countries of origin are effectively subsidizing the training of medical staff who benefit overseas markets and receive very little compensation in return. For example, Mills et al (2011) argue that “medical education is typically highly subsidized by the public sector in African countries, with more than half of the medical schools in Sub-Saharan Africa either offering free tuition or charging less than USD\$1,000 yearly.”²¹ Yet countries of origin cannot always recoup this investment. They estimate that for every Nigerian doctor that moves to the UK, Nigeria has lost \$71,757 in investment.

Promoting a Genuine Development Benefit

To address this imbalance, the same WHO Resolution calls on states to develop mechanisms whereby countries of destination can support the training of health personnel and the development of health systems within countries of origin. Such an approach has been codified in the WHO Global Code of Practice on the International Recruitment of Health Personnel. The Code of Practice discourages private recruitment from a list of countries that exhibit health worker shortage in a bid to avoid brain drain. Yet it supports health worker migration from these countries as long as it is conducted within a comprehensive government to government (G2G) agreement which ensures a genuine development benefit for the country of origin.²²

BOX 2. THE WHO INTERNATIONAL PLATFORM ON HEALTH WORKER MOBILITY

The WHO Global Strategy on Human Resources for Health, published in 2016, called on WHO to work with ILO, OECD, and other actors, to establish an international platform on health worker mobility.²³ The vision of the platform, launched in September 2019, is to maximize the benefits and mitigate the adverse effects from health worker mobility through elevated dialogue, knowledge, and cooperation.²⁴ To do this, members and other relevant stakeholders pledge to work together to refine partnership mechanisms, enhance national reporting on progress against the Code of Practice, support countries with gathering data and developing agreements, and publish research.²⁵

Source: World Health Organization (WHO). “International Platform on Health Worker Mobility.” <https://www.who.int/hrh/migration/int-platform-hw-mobility/en/>

²⁰ World Health Organization (WHO). “WHA57.19 International migration of health personnel: a challenge for health systems in developing countries.” Resolutions and Decisions of the 57th World Health Assembly. https://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf

²¹ Edward J. Mills, Steve Kanters, Amy Hagopian, Nick Bansback, Jean Nachege, Mark Alberton, Christopher G Au-Yeung, Andy Mtambo, Ivy L. Bourgeault, Samuel Luboga, Robert S. Hogg, and Nathan Ford. 2011. “The financial cost of doctors emigrating from Sub-Saharan Africa: human capital analysis.” *BMJ* 343. <https://doi.org/10.1136/bmj.d7031>

²² Michael Clemens and Helen Dempster. 2021. “Ethical Recruitment of Health Workers: Using Bilateral Cooperation to Fulfil the World Health Organization’s Global Code of Practice.” CGD Policy Paper 212. Washington, DC: Center for Global Development (CGD). <https://www.cgdev.org/publication/ethical-recruitment-health-workers-using-bilateral-cooperation-fulfill-world-health>

²³ World Health Organization (WHO). 2016. “Global strategy on human resources for health: Workforce 2030.” Geneva: World Health Organization (WHO). <https://www.who.int/hrh/resources/globstrathrh-2030/en/>

²⁴ World Health Organization (WHO). “International Platform on Health Worker Mobility.” <https://www.who.int/hrh/migration/int-platform-hw-mobility/en/>

²⁵ International Labour Organization (ILO), Organisation for Economic Cooperation and Development (OECD), and World Health Organization (WHO). “The International Platform on Health Worker Mobility: Elevating dialogue, knowledge and international cooperation.” <https://www.who.int/hrh/migration/International-platform-HW-mobility.pdf?ua=1>

There are many ways in which countries of destination can ensure a meaningful development benefit from any health care migration partnership. As discussed above, health systems in countries of origin suffer from a range of issues which constrain the system's ability to recruit and retain workers. Here, it is crucial to go beyond merely increasing supply. If countries of origin are unable to employ newly qualified workers, especially within the public system, this will merely create more emigration pressure and dissatisfaction. Instead, countries of destination should interrogate the reasons why more qualified workers are not trained and employed, and tackle these. As the WHO has mentioned, "the policy prescription should therefore focus on treating the underlying causes (in terms of improving the work environment, support systems and remuneration), rather than attempting to address in isolation the migratory phenomenon."²⁶

BOX 3. THE US NURSING EDUCATION PARTNERSHIP INITIATIVE (NEPI)

In 2003, the US enacted the President's Emergency Plan for AIDS Relief (PEPFAR) which sought to address the global HIV/AIDS epidemic through tackling a number of factors, including the lack of quality nursing and midwifery education in Sub-Saharan Africa. As a result, in 2011, PEPFAR's Nursing Education Partnership Initiative (NEPI) was launched.²⁷ Between 2011 and 2017, it supported 22 nursing education institutions across six African countries: Ethiopia, Democratic Republic of Congo, Lesotho, Malawi, and Zambia. NEPI's findings provide a useful framework for thinking about the challenges that face nursing education within Africa, and ways in which to improve it through updated curricula, training the trainers, and the establishment of nursing councils.²⁸

Source: Lyn Middleton, Andrea A Howard, Jennifer Dohrn, Deborah Von Zinkernagel, Deborah Parham Hopson, Barbara Aranda-Naranjo, Carolyn Hall, Address Malata, Thokozani Bvumbwe, Adeline Chabela, Nthabiseng Molise, and Wafaa M El-Sadr. 2014. "The Nursing Education Partnership Initiative (NEPI): innovations in nursing and midwifery education." *Academic Medicine* 89(8) S24-S28. August 2014. https://journals.lww.com/academicmedicine/Fulltext/2014/08001/The_Nursing_Education_Partnership_Initiative.9.aspx

²⁶ World Health Organization (WHO) 2020. "State of the World's Nursing Report—2020." Geneva: World Health Organization (WHO). <https://www.who.int/publications-detail-redirect/9789240003279>

²⁷ Lyn Middleton, Andrea A Howard, Jennifer Dohrn, Deborah Von Zinkernagel, Deborah Parham Hopson, Barbara Aranda-Naranjo, Carolyn Hall, Address Malata, Thokozani Bvumbwe, Adeline Chabela, Nthabiseng Molise, and Wafaa M El-Sadr. 2014. "The Nursing Education Partnership Initiative (NEPI): innovations in nursing and midwifery education." *Academic Medicine* 89(8) S24-S28. August 2014. https://journals.lww.com/academicmedicine/Fulltext/2014/08001/The_Nursing_Education_Partnership_Initiative.9.aspx

²⁸ Susan Michaels-Strasser, Janel Smith, Judy Khanyola, Roberta Sutton, Tashtiana Price, and Wafaa M. El Sadr. 2018. "Strengthening the Quality and Quantity of the Nursing and Midwifery Workforce: Report on Eight Years of the NEPI Project." *Annals of Global Health* 84(1): 31-35. <http://doi.org/10.29024/aogh.6>

While there are myriad potential investments, expanding the training infrastructure is likely to be a requirement of any health care Global Skill Partnership. The amount of donor funding that has been directed toward human resources for health has increased from \$34 million in 1990 to \$1.5 billion in 2016. This funding supports training, education, infrastructure, and the provision of equipment. Yet despite these grand figures, such funding only equates to 4 percent of development assistance for health.²⁹ Much of this support has gone towards Sub-Saharan African countries (Figure 2) and yet it remains insufficient. WHO estimates that funding for nursing education alone needs to increase by \$10 per capita in low- and middle-income countries.³⁰ Countries of destination could support such infrastructure by supporting and sustaining the human resource development plans of countries of origin thereby contributing to sustainable and equitable health systems.³¹

BOX 41. CORVUS HEALTH

Corvus Health was formed to provide services throughout the health worker life cycle, with a goal of reducing the global shortage and maldistribution of health workers around the world. In addition to broader efforts advising health care providers and training institutions, Corvus Health also has a model of sustainable health worker recruitment that increases the number of health workers trained in origin countries. It works in partnership with private health training institutions in countries of origin including Tunisia, Kenya, Ethiopia, Sudan, and Ghana. It helps to expand the quality of these schools, improving curricula, business and operational plans, and sharing best practices. Corvus Health then uses these schools as recruiters to place workers in health care facilities in countries of destination such as Canada. Corvus Health was one of 20 finalists in the Global Forum for Migration and Development's 2021 Migration Challenge and it is interested in including European countries of destination in the future.

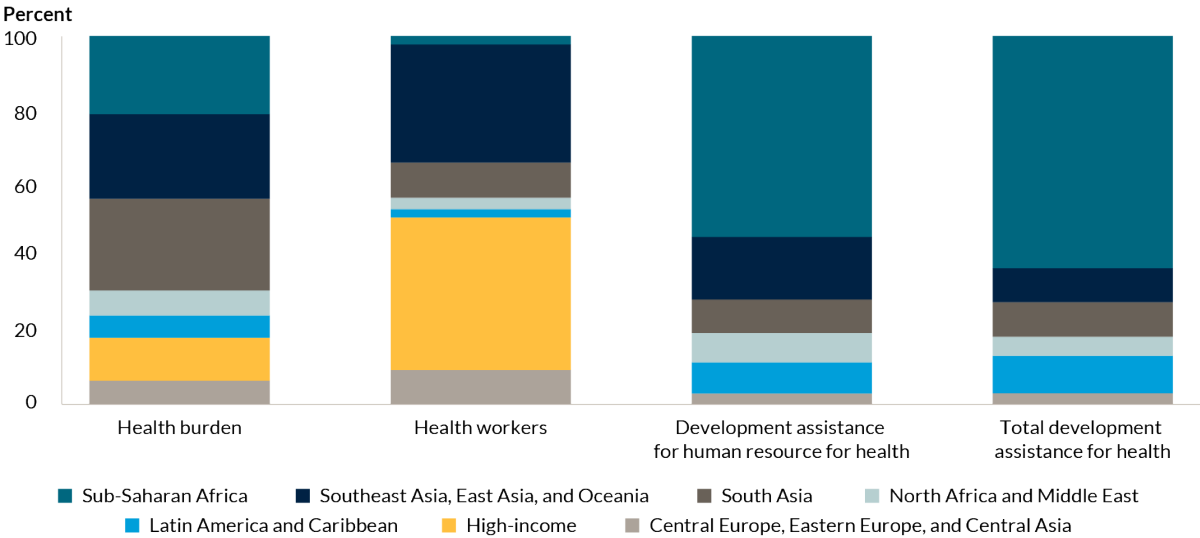
Source: <https://corvushealth.com/services/>

²⁹ Angela E. Micah, Bianca S. Zlavog, Catherine S. Chen, and Abigail Chapin. 2018. "Donor financing of human resources for health, 1990-2016: An examination of trends, sources of funds, and recipients." *Globalization and Health* 14(1). October 2018. <https://www.researchgate.net/deref/https%3A%2F%2Fglobalizationandhealth.biomedcentral.com%2Farticles%2F10.1186%2Fs12992-018-0416-z>

³⁰ World Health Organization (WHO). 2020. "State of the World's Nursing Report—2020." Geneva: World Health Organization (WHO). <https://www.who.int/publications-detail-redirect/9789240003279>

³¹ Remco van de Pas and Linda Mans. 2018. "Global Skill Partnerships & Health Workforce Mobility: Pursing a Race to the Bottom?" Discussion paper for the Stakeholder's Dialogue on International Health Worker Migration and the Global Skill Partnerships, 9 December, Marrakesh, Morocco. Ferney-Voltaire: Public Services International (PSI). http://world-psi.org/sites/default/files/attachment/news/web_2018_mig_report_marrakesh.pdf

Figure 2. Most development assistance for human resources for health goes to Sub-Saharan Africa

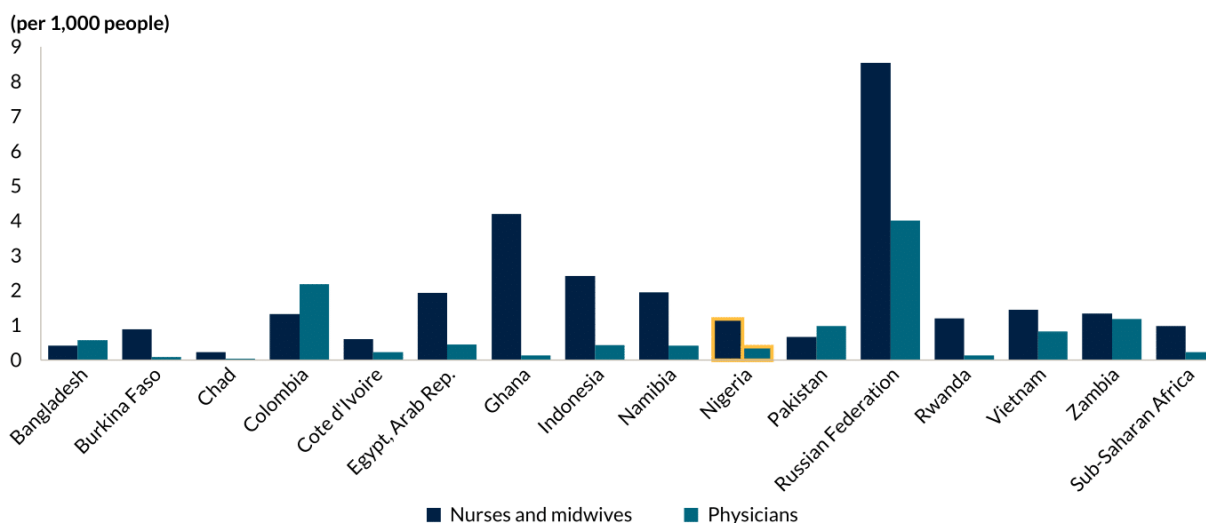


Source: Angela E. Micah, Bianca S. Zlavog, Catherine S. Chen, and Abigail Chapin. 2018. “Donor financing of human resources for health, 1990-2016: An examination of trends, sources of funds, and recipients.” *Globalization and Health* 14(1). October 2018. <https://www.researchgate.net/deref/https%3A%2F%2Fglobalizationandhealth.biomedcentral.com%2Farticles%2F10.1186%2Fs12992-018-0416-z>

HEALTH CARE IN NIGERIA

Nigeria needs more health care workers to serve its rapidly expanding population. In 2020, Nigeria had 1.2 nurses and midwives and 0.4 physicians for every 1,000 inhabitants, slightly higher than the Sub-Saharan African average but worse than many of its regional peers such as Ghana, Namibia, and Zambia as well as structural and aspirational peer countries such as Indonesia and Vietnam (Figure 3).

Figure 3. Nigeria has fewer nurses/midwives and physicians per 1,000 people than many of their its peer countries



Source: World Bank, World Development Indicators. Nigeria’s peers are selected based on the groupings provided in the World Bank Systematic Country Diagnostic (2019) report.

Nigeria’s health-related indicators highlight the extent of health care needs in the country and show great variation between income groups and regions in access to health care services. For example, Nigeria has the highest under-five mortality rate in the world with 117 deaths per 1,000 live births. More starkly, the under-five mortality rate of 158 deaths per 1,000 live births among the poorest quintile is eight times worse than in the richest quintile.³² In the Northern region of the country, stunting rates among children under-five are three times higher than in the South.³³ There is a high degree of heterogeneity in the availability of health care services across different regions in Nigeria with an urgent need to increase the number of high-quality health workers and improve their distribution.

Health care in Nigeria is delivered through a three-tier system consisting of the Federal Ministry of Health (FMH), the respective States’ Ministries of Health, and the National Primary Healthcare Development Agency. Tertiary health care delivery is provided through teaching hospitals which are managed by Colleges of Medicine in either Federal- or State-owned universities; secondary health care delivery is provided through Federal Medical Centers and General Hospitals, while Health Centers provide primary health care at the community level.³⁴ Seventy-three percent of hospitals and clinics are publicly funded whereas 27 percent are privately-owned. Around 85 percent of hospitals and

³² World Bank. 2018. “Investing in Human Capital for Nigeria’s Future.” Nigeria Biannual Economic Update Fall 2018. Washington, DC: World Bank. <http://documents1.worldbank.org/curated/en/346771542864299850/pdf/132316-21-11-2018-17-31-9-NigeriaBEUAMF.pdf>

³³ National Bureau of Statistics (NBS) and United Nations Children’s Fund (UNICEF). 2017 Multiple Indicator Cluster Survey 2016-17, Survey Findings Report. Abuja, Nigeria. Available at: <https://www.unicef.org/nigeria/sites/unicef.org/nigeria/files/2018-09/Nigeria-MICS-2016-17.pdf>

³⁴ Francis Koce, Gurch Randhawa, and Bertha Ochieng. 2019. ‘Understanding Healthcare Self-referral in Nigeria from the Service Users’ Perspective: a Qualitative Study of Niger State.’ *BMC Health Services Research* 19(1) 209. April 2019. <https://doi.org/10.1186/s12913-019-4046-9>

clinics offer primary care facilities with 14.5 percent offering secondary care and 0.4 percent offering tertiary care.³⁵

The public health care system is funded through annual budgets including the National Health Insurance Scheme which covers certain eligible Nigerians who contribute to the scheme.³⁶ In 2020, the health care budget was a total of N46 billion, which was N4.15 billion less than the allocation for 2019.³⁷ Nigeria's 2018 domestic general government health expenditure of \$12.45 per capita and 0.58 percent as a percentage of GDP is lower than the Sub-Saharan African average of \$30.25 and 1.87 percent, respectively, and also lower than its regional peers Ghana (\$30.3 and 1.38 percent) and Kenya (\$37.24 and 2.18 percent) respectively.³⁸ Private health care providers are funded by the users.

The Workforce

According to the 2018-19 National Living Standard Survey (NLSS), around 3 percent of the active working-age population between the ages of 15 and 64 in Nigeria were employed in the health care sector. Of those working in the health sector, 57 percent were employed in urban areas and 43 percent were employed in rural areas; over 60 percent have completed tertiary education and an additional 26 percent have completed secondary education; 94 percent were between the ages of 25 and 64; and 54 percent were women.

The health workforce in Nigeria is made up of medical professionals including doctors, dentists, nurses, pharmacists, medical laboratory scientists, community health practitioners, and other clinical support workers. Table 1, which is based on the Nigeria Health Workforce Country Profile of 2018 and is not exhaustive of the categories of health care professionals in Nigeria, shows that nurses make up the highest number of health workforce when compared to other professionals during a given period. Note that while Nigeria has one of the highest health workforce densities in Africa, it is still below the recommended standard.³⁹ The WHO's indicative minimum density to achieve the SDG Target 3.8 regarding UHC is 4.45 doctors, nurses, and midwives per 1,000 population; Nigeria has below 2.1.

³⁵ Nigeria Health Facility Registry, retrieved from <https://hfr.health.gov.ng/>

³⁶ Nigeria National Health Insurance Scheme. See more at <https://www.nhis.gov.ng/>

³⁷ For more information, please see Paul Adepoju. 2020. "A breakdown of Nigeria's 2020 budget for health." *Healthnews*. <http://www.healthnews.ng/a-breakdown-of-nigerias-2020-budget-for-health/>

³⁸ World Bank. "World Health Organization Global Health Expenditure database." Available at: https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=ZG-NG&most_recent_value_desc=true

³⁹ World Health Organization (WHO). 2016. "Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals." Background paper No. 1 to the Global Strategy on Human Resources for Health. Geneva: World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf>

Table 1. Profile of health care professionals in Nigeria as of 2018

Profession	Number Registered	Number per 100,000	Ratio to Population
Doctors	74,543	36.3	1:2,753
Dentists	4,358	2.12	1:49,075
Nurses	180,709	88.1	1:1,135
Midwives	120,870	58.9	1:1,697
Pharmacists	24,668	12	1:8,317
Community Health Officers	8,533	4	1:24,044
Community Health Extension Workers	61,668	30	1:3,327

Source: Federal Ministry of Health, Nigeria. 2018. Nigeria Health Workforce Country Profile. Available upon request.

As of 2018, Nigeria had 180,709 nurses and 120,870 midwives registered with the Nursing and Midwifery Council of Nigeria (NMCN). Eighty-seven percent of nurses and midwives are females and 72 percent are between the ages of 30 and 60 years. Nigeria’s ratio of 1 nurse for every 1,135 in the population and 1 midwife for every 1,697 in the population is among the lowest in the world and similar to the Sub-Saharan African average.

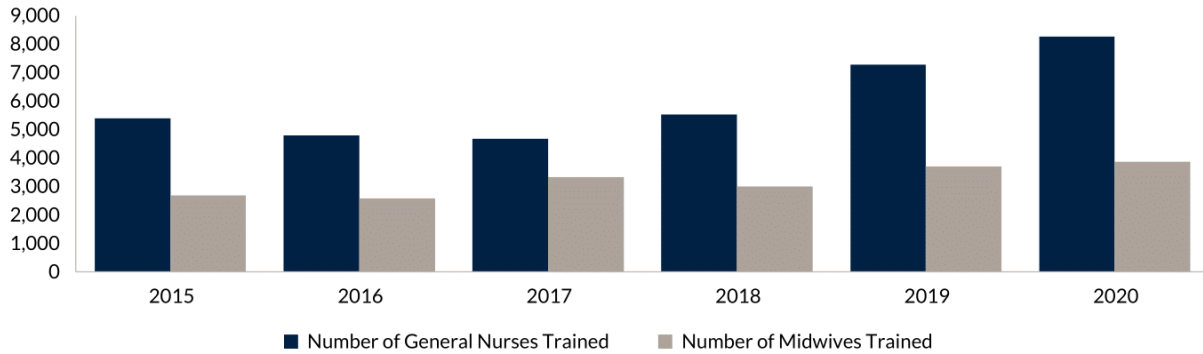
Based on data from NMCN, critical nursing shortages in Nigeria are primarily found in the areas of Cardiothoracic, Anesthesia, Burns and Plastic, Occupational Health, Nephrology, and Otorhinolaryngology. In terms of nursing related technology and equipment, Nigeria primarily faces shortages in Automated Infusion Pump, Portable Cardiac Monitor, Antishock Garment, Glucometer, Doppler Fetal Monitor, Standard Delivery and Smart Beds, and Electronic Health Records (ERS) and Computer Systems.

Health Care Management and Training

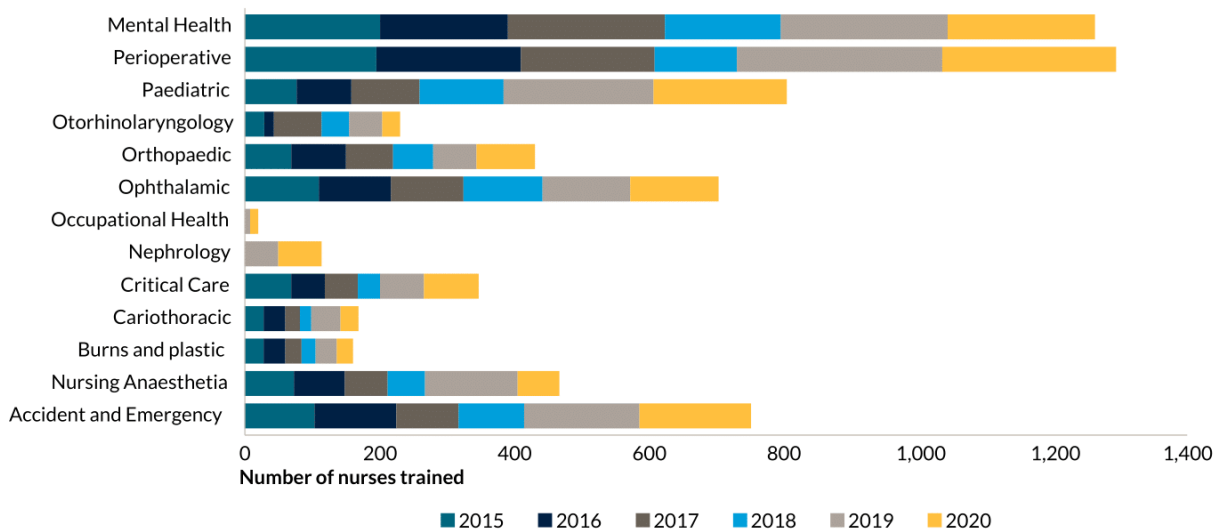
The NMCN trained more than 35,000 general nurses and more than 19,000 midwives between 2015 and 2020. Figure 4 (Panel A) shows that the number of general nurses trained by NMCN has increased from 5,392 in 2015 to 8,261 in 2020. Similarly, the number of midwives trained by the council increased from 2,690 in 2015 to 3,704 in 2020. Figure 4 (Panel B) shows the number of nurses trained between 2015 and 2020 by specialties. The three categories of nurses most frequently trained by the council were in the areas of Perioperative, Mental Health, and Pediatric whereas the lowest numbers of nurses trained were in areas of Cardiothoracic, Burns and Plastic, Nephrology, and Occupational Health. These have been highlighted by the NMCN as areas with critical shortages of nurses and areas that can benefit from further investments in training, infrastructure, and equipment.

Figure 4. The number of nurses and midwives trained by the NMCN has increased from 2015 to 2020

Panel A: It has not kept pace with the need of the growing needs or population growth in Nigeria



Panel B: Most of Nigeria’s nurses are not being trained in categories where shortages exist



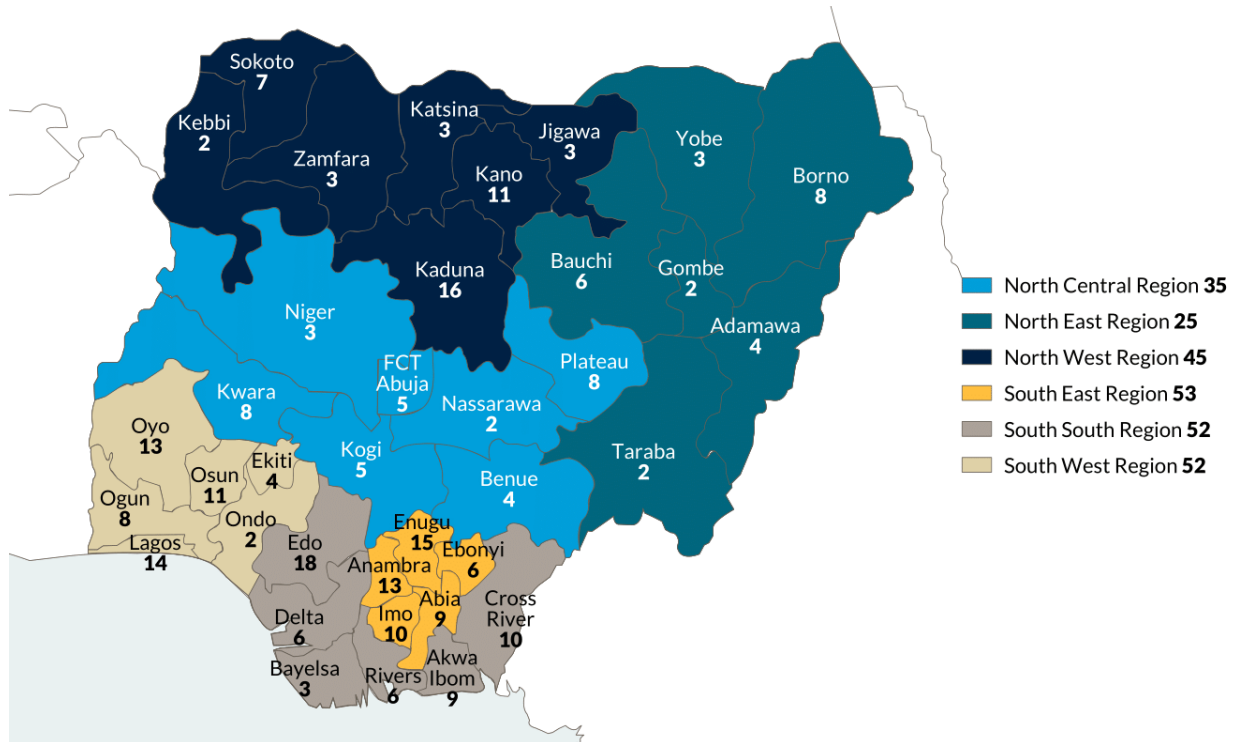
Source: Administrative Data provided by the Nursing and Midwifery Council of Nigeria (NMCN)

In addition to 34 departments of nursing in Nigerian universities, as of 2018, there were 262 health care training institutions nationwide—171 basic nursing schools, 83 basic or post-basic midwifery schools, and 8 community midwifery schools. Out of the 262 training institutions, 99 were fully accredited, 147 had provisional accreditation, and 16 had accreditation denied or withdrawn. As Figure 5 shows, nursing training institutes are located in different states of the Federation, with 50 percent located in 10 states, 6 of which are located in the South and only 2 in the North, pointing to acute shortages of training institutions in the Northern regions of the country.⁴⁰ In 2018, the

⁴⁰ Edo (18), Kaduna (16), Enugu (15), Lagos (14), Anambra (13), Oyo (13), Kano (11), Osun (11), Cross River (10), and Imo (10).

profession of nursing, midwifery and community midwifery added 8,154 graduates to its numbers; 3,561 of existing practitioners (43 percent of the number added) migrated the same year.⁴¹

Figure 5. Nursing institutions are concentrated in the Southern regions of Nigeria



Source: Ezra Gayawan, Ekundayo D Arogundade, and Samson B Adebayo. 2014. "Possible determinants and spatial patterns of anaemia among young children in Nigeria: a Bayesian semi-parametric modelling." *International Health* 6(1): 35-45. March 2014. <https://doi.org/10.1093/inthealth/iht034>, modified to show number of nursing training institutions in each State and the Federal Capital Territory

A prospective trainee must present a minimum of five O Level credit passes at not more than two sittings from any of the following: West African Examination Council (WAEC), National Examination Council (NECO) or National Business and Technical Examinations Board (NABTEB).⁴² The minimum entry age for a trainee is 16 years.⁴³ Candidates may undertake a 3-year basic nursing training in a School of Nursing followed by a 1-year Midwifery training; or they can enroll for the 5-year nursing program in a Department of Nursing at the universities.

Both routes consist of classroom and practical training. However, while the former entails more of hospital placement, the latter entails more of classroom training. The 3-year trainees receive a Certificate in General Nursing while the 5-year graduates receive multiple certificates including the Certificate in General Nursing, General Midwifery Certificate, Certificate in Public Health, and

⁴¹ Africa Health Workforce Observatory. 2008. "Human Resources for Health: Country Profile Nigeria." Abuja: Africa Health Workforce Observatory. https://www.who.int/workforcealliance/knowledge/resources/hrh_profile_nigeria/en/

⁴² The credit passes must be in Mathematics, English Language, Physics, Chemistry, and Biology.

⁴³ Nursing and Midwifery Council of Nigeria. "Programs and Requirements." <https://www.nmcn.gov.ng/requirement.html>

Bachelor of Nursing Science (B. N. Sc.).⁴⁴ Nurses can pursue specialist trainings in different fields.⁴⁵ Each training takes 18 months to complete.⁴⁶

Over 600,000 nurses are needed in Nigeria between 2016 and 2030.⁴⁷ As of 2018, Nigeria had less than 200,000 nurses which means a shortage of over 400,000 nurses.⁴⁸ The top five states and territory with the highest number of practicing nurses per 100,000 members of the population are the Federal Capital Territory (186.4), Edo (118.4), Lagos (113.7), Enugu (105.1), and Kwara (103.2); while the bottom 5 are Jigawa (17.7), Kano (20.8), Katsina (21.2), Kebbi (22.5), and Yobe (25.9).⁴⁹ This means that Nigeria could benefit from more nursing training and employment, especially in the North-West and North-East where the lowest densities were recorded. Some unemployed nurses could be absorbed to shore up the number of health workers especially in states with the lowest densities and to limit the numbers migrating to work abroad. Nurses from the Southern states could be attracted to work in the North if the Northern states government would employ them on equal terms as their indigenous nurses rather than employ them on contract basis.

Migration

The draft National Policy on Health Workforce Migration for Nigeria does not prohibit migration. Rather, the policy recommends better and more ethical health worker migration which allows countries to work together in finding mutually beneficial solutions to their respective health workforce problems, balancing the migration rights of individual health workers with the health care needs of the population they are meant to serve.⁵⁰

Migration of nurses has been recognized as one of the critical issues facing the Human Resources for Health (HRH) policy, planning, and management in Nigeria. The goal is to provide appropriate and adequate human resources for health care at all levels of the health care system. There are no official legal pathways for Nurses to migrate for employment. However, the NMCN which regulates the Nursing and Midwifery sector and registers qualified nurses and oversees the accreditation of Schools of Nursing and Midwifery, also issues the Letter of Good Standing, a document that verifies certificates and confirms registration status of those who wish to migrate.⁵¹

⁴⁴ Nursing—University of Lagos. “Welcome to the Department of Nursing.” https://unilag.edu.ng/?page_id=2836

⁴⁵ Psychiatrist, Accident and Emergency, Public Health, Pediatric, Dialysis/Renal, Peri-operative, Occupational Health, Anesthetics, Ophthalmic, Ear, Nose & Throat (ENT), Burns and Scald/Disaster, Oncology, Orthopedic, Neonatal, Intensive/Critical Care, Nurse Tutor/ Educator, and Cardiothoracic nursing. For more information please see Damilola Bode-Benson, 2016. “Nursing Specialties: Availability, Choices and Reason. *NursingWorld*. August 3, 2016. <https://www.nursingworldnigeria.com/2016/08/nursing-specialties-availability-choices-and-reason-by-damilola-bode-benson>. Radiography, Urology, Respiratory, Rehabilitation, Otorhinolaryngology, Ophthalmic, Nephrology, and Hospice/Palliative Care nursing. For more information please see National Association of Nigeria Nurses and Midwives. “Some Classification of Nurses.” <https://www.nannm.com.ng/some-classification-of-nurses/>

⁴⁶ Ahmadu Bello University Teaching Hospital (AbUTH) Zaria. “Postbasic Nursing.” <https://abuth.gov.ng/index.php/schools/postbasic-nursing>

⁴⁷ Oladimeji Adebayo, Adetunji Labiran, Franklin Emerenini, and Leslie Omoruyi. 2016. “Health Workforce for 2016-2030: Will Nigeria have enough?” *International Journal of Innovation Research and Growth* 4(1): 9-16. https://www.researchgate.net/publication/309399635_Health_Workforce_for_2016-2030_Will_Nigeria_have_enough

⁴⁸ Africa Health Workforce Observatory. 2008. “Human Resources for Health: Country Profile Nigeria.” Abuja: Africa Health Workforce Observatory. https://www.who.int/workforcealliance/knowledge/resources/hrh_profile_nigeria/en/

⁴⁹ Ibid.

⁵⁰ Draft National Policy on Human Resources for Health Migration.

⁵¹ Nursing and Midwifery Council of Nigeria. “Verification of Certificate.” <https://www.nmcn.gov.ng/verify.html>

Thirteen percent of the nurses and midwives who were registered in 2016 requested Letters of Good Standing from the NMCN and their destination countries were the US, Canada, the UK, United Arab Emirates (UAE), Australia, and Ghana.⁵² Between 2017 and 2020, the number of nurses and midwives requesting for Letters of Good Standing from NMCN progressively increased—from 2,689 in 2017 to 7,360 in 2020, which as a proportion of general nurses trained is a rise from 57 percent of nurses requesting the Letter of Good Standing in 2017 to 89 percent in 2020.⁵³ In 2018, Nigeria was one of the top five countries whose candidates successfully took the US nurse licensure examinations.⁵⁴

HEALTH CARE IN THE UK

The majority of health care in the UK is delivered through the country’s free, publicly-funded, health care system—the National Health Service (NHS). While there is a smaller private health care sector, the majority of employers (and employees) reside in the public sector. Policy for health in the UK is devolved to the Administrations in each of the four nations. NHS England and NHS Improvement lead the NHS in England and the Department of Health and Social Care (DHSC) provides the overarching policy and strategy. NHS England and Ireland is responsible for overseeing the commissioning, the planning, and the buying, of NHS services. The service is funded through direct taxation: in 2018, the UK spent £214.4 billion on health care, which equals 10 percent of gross domestic product. Health expenditure has been growing over recent years, with spending on long-term care growing at an even faster rate due to the UK’s shifting and aging demographics.⁵⁵

The Workforce

NHS staff are employed throughout the four countries that make up the UK, though the NHS is the largest employer in England with nearly 1.2 million full-time equivalent (FTE) staff.⁵⁶ Around half of all employees are professional qualified clinical staff working in hospital, community, and primary care settings. These workers are direct employees of various NHS trusts which manage facilities around the country. Today, there are around 150,000 doctors and 330,000 nurses and midwives working for the NHS, in addition to clinical support staff, scientists, technical staff, infrastructure support, and ambulance workers, to name a few (Figure 6).

⁵² World Health Organization (WHO) and European Union. 2017. “A Dynamic Understanding of Health Worker Migration.” https://www.who.int/hrh/HWF17002_Brochure.pdf

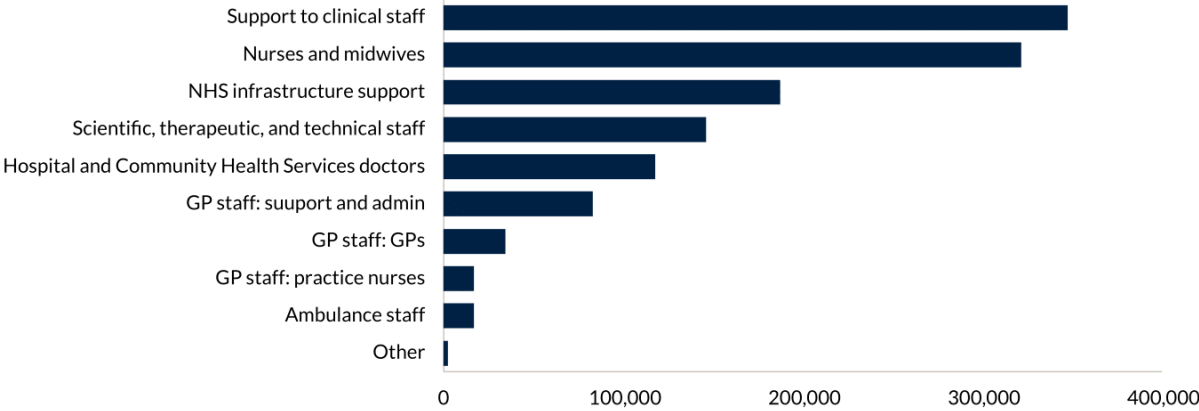
⁵³ Administrative Data provided by the Nursing and Midwifery Council of Nigeria (NMCN)

⁵⁴ National Council of State Boards of Nursing. 2018. “The 2018 NCLEX Examination.” <https://yearinreview.ncsbn.org/2018/nclex.htm>

⁵⁵ Office for National Statistics. 2018. “Healthcare expenditure, UK Health Accounts: 2018.” <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2018>

⁵⁶ 1.2 million in England, 162,000 in Scotland, 89,000 in Wales, and 64,000 in Northern Ireland. Please see Full Fact. 2017. “How many NHS employees are there?” June 1, 2017. <https://fullfact.org/health/how-many-nhs-employees-are-there/> and The King’s Fund. 2021. “NHS workforce: our position.” Last updated February 26, 2021. <https://www.kingsfund.org.uk/projects/positions/nhs-workforce>

Figure 6. The Workforce in the UK’s National Health Service



Source: Lucina Rolewicz and Billy Palmer. 2019. “The NHS workforce in numbers.” Nuffield Trust. Last updated February 29, 2020. <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

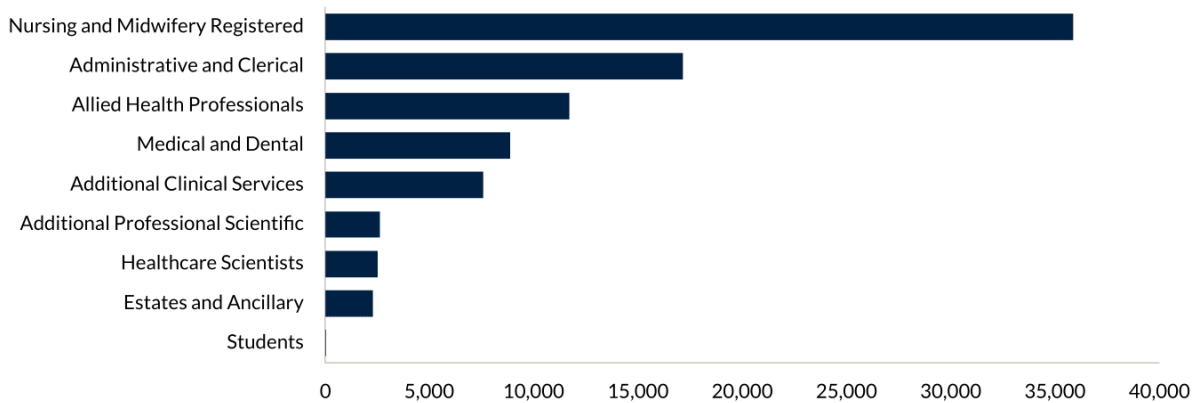
There is no single, robust data source on the level of vacancies within the NHS, but estimates show that there are large and widespread staff shortages. Between October and December 2019 alone, 100,000 FTE vacancies were advertised, a shortfall of 8.1 percent.⁵⁷ While these vacancies also reflect standard turnover, many are due to widespread and persistent shortages. In June 2020, NHS hospitals, mental health services, and community providers reported a shortage of nearly 84,000 staff, as well as 2,500 FTE GPs.⁵⁸ These shortages are not felt evenly, with the highest percentage of vacancies in London (10.7 percent) and lowest in the North East and Yorkshire (5.5 percent).⁵⁹ The majority of vacancies are for registered nurses and midwives, with administrative and clerical support, and allied health professions, coming in second and third (Figure 7). Many of these nurses are needed within critical, community, mental, and social care, while there is an increasing need for aged care nursing assistants as well.

⁵⁷ Lucina Rolewicz and Billy Palmer. 2019. “The NHS workforce in numbers.” Nuffield Trust. Last updated February 29, 2020. <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

⁵⁸ NHS Digital. 2020. “NHS Workforce Statistics—June 2020.” September 24, 2020. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2020>

⁵⁹ NHS Digital. 2020 “NHS Vacancy Statistics (and previous NHS Vacancies Survey.” <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey>

Figure 7. Staff shortages in the UK’s National Health Service



Source: Lucina Rolewicz and Billy Palmer. 2019. “The NHS workforce in numbers.” Nuffield Trust. Last updated February 29, 2020. <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

Note: FTE number of vacancies, October-December 2019.

The Health Foundation, King’s Fund, and Nuffield Trust have estimated that without policy action and investment, shortages could grow to 200,000 by 2023-24 and at least 250,000 by 2030. Nursing remains the key area of shortage and requires over 100,000 new workers by 2028-29.⁶⁰ These unfilled vacancies are putting pressure on remaining staff, leading to high levels of stress, absenteeism, and turnover. They have also led to an over-reliance on temporary staff, which strains already tight budgets.⁶¹ Such pressures have been exacerbated by a lack of new staff coming through the system. Between 2010 and 2018, the amount of care provided by the health service increased by a third, yet the number of nurses barely shifted.⁶² In 2021, it was found that 28 percent of nurses and health professionals leave the NHS within the first three years of service.⁶³

Health Care Management and Training

Given the large nursing staff shortages within the NHS, the following section will focus on the process by which UK nationals become a nurse in the UK and the main actors involved. There are four main fields of nursing in the UK: adult, children’s, learning disability, and mental health nursing.⁶⁴ Some degrees allow trainees to specialize in two of these fields. To become an adult nurse, trainees will need to have five GCSE’s and two A levels at secondary education level, and then apply for a nursing undergraduate degree at a number of universities throughout the UK. The Bachelor of Nursing degree generally takes three years and involves both theoretical study and a clinical placement. If trainees

⁶⁰ Ben Gerschlick and Anita Charlesworth. 2019. “Health and social care workforce: Priorities for the new government.” *The Health Foundation*. November 27, 2019. <https://www.health.org.uk/publications/long-reads/health-and-social-care-workforce>

⁶¹ Lucina Rolewicz and Billy Palmer. 2019. “The NHS workforce in numbers.” *Nuffield Trust*. Last updated February 29, 2020. <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

⁶² Anita Charlesworth. 2021. “Staff shortages left the NHS vulnerable to the COVID-19 storm.” *The Health Foundation*. January 12, 2021. <https://www.health.org.uk/news-and-comment/blogs/staff-shortages-left-the-nhs-vulnerable-to-the-covid-19-storm>

⁶³ The King’s Fund. 2021. “NHS workforce: our position.” Last updated February 26, 2021. <https://www.kingsfund.org.uk/projects/positions/nhs-workforce>

⁶⁴ NHS. “How to become a nurse.” <https://www.healthcareers.nhs.uk/explore-roles/nursing/studying-nursing>

already have a degree in a relevant subject, they can undertake a postgraduate degree which only takes two years.

These courses must be approved by the Nursing and Midwifery Council (NMC)—the professional regulator for the nursing and midwifery sector.⁶⁵ They have four main roles:

1. Maintaining a register of nurses and midwives who meet the requirements for UK registration;
2. Setting requirements for professional education;
3. Promoting and developing standards, promoting lifelong learning; and
4. Investigating issues with nurse and midwife conduct.

As described above, nurses who have completed their qualification and registered with the NMC are then employed by UK Trusts around the country. If they wish, they can then apply to join a union. There are three nursing unions: the Royal College of Nursing (RCN), UNISON, and Unite. The RCN is the world's largest nursing union and professional body. They represent more than 450,000 nurses, student nurses, midwives, and nursing support workers, offering “free and confidential advice and support on employment matters, career development, immigration, welfare and more.”⁶⁶ UNISON acts for members in public services, including health care,⁶⁷ and Unite has over 100,000 members within the health care sector.⁶⁸ There are also a number of smaller unions.⁶⁹

Many have attributed these staffing shortages to a failure to invest in training. OECD data shows that the number of people with a nursing qualification per head of population in the UK is below the OECD and the EU-14 average (Figure 8). In 2011, the number of training places for nurses was reduced by 10 percent. Nurses were able to access bursaries to help support their training and living costs, yet this scheme was capped due to limited funds. In a bid to increase take-up, this scheme was dropped in 2017 but it did not lead to an increase in people taking up training places. Attrition remains high—one in four nursing students does not graduate.⁷⁰ Thankfully, things may be slowly shifting. The number of FTE nurses and health visitors rose by 4.8 percent in the year to June 2020.⁷¹ COVID-19 has led to record numbers of students enrolling in nursing programs, up 32 percent in the last year.⁷² Yet advocates warn that this is still not meeting the scale of the shortages, with many pushing for a robust, long-term approach to measuring demand and potential supply of nurses.⁷³

⁶⁵ Nursing and Midwifery Council. “Who we are and what we do.” <https://www.nmc.org.uk/about-us/our-role/>

⁶⁶ Royal College of Nursing. “What the RCN does.” <https://www.rcn.org.uk/about-us/what-the-rcn-does>

⁶⁷ UNISON. See <https://www.unison.org.uk/>

⁶⁸ UNICTE. See <https://unitetheunion.org/>

⁶⁹ Polly Adgey. “What is a nursing Union and Why Should I Consider Joining One?” *SureCert*. September 6, 2018. <https://www.surecert.com/blog/what-is-nursing-union-why-should-consider-joining-one/>

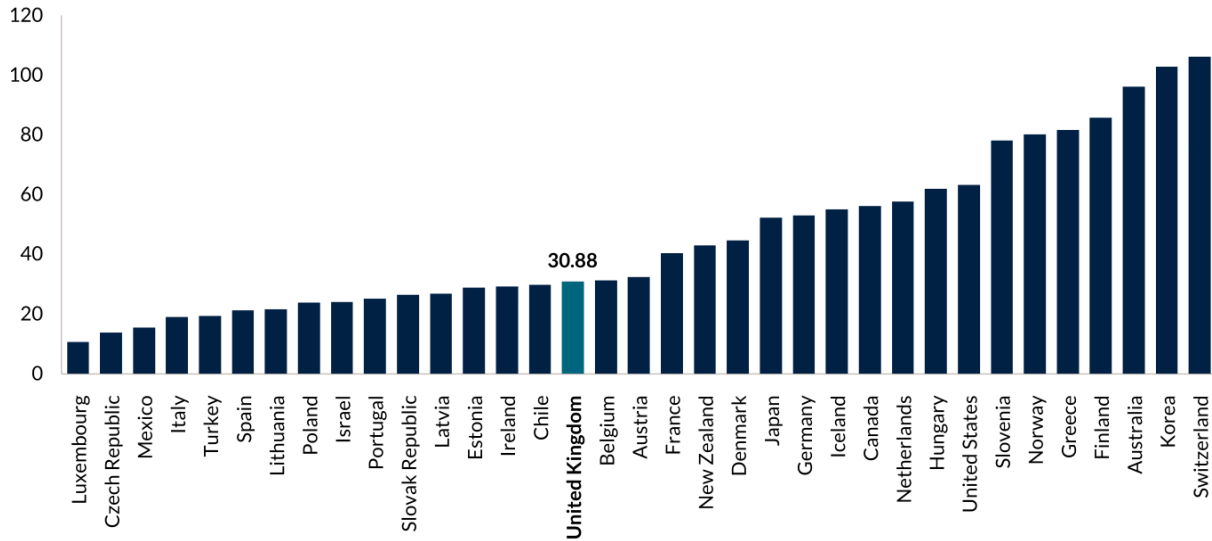
⁷⁰ Ben Gerschlick and Anita Charlesworth. 2019. “Health and social care workforce: Priorities for the new government.” *The Health Foundation*. November 27, 2019. <https://www.health.org.uk/publications/long-reads/health-and-social-care-workforce>

⁷¹ James Buchan, Jane Ball, Nihar Shembavnekar, and Anita Charlesworth. 2020. “Building the NHS nursing workforce in England: Workforce pressure points.” London: The Health Foundation. <https://www.health.org.uk/publications/reports/building-the-nhs-nursing-workforce-in-england>

⁷² BBC. 2021. “Covid-19: Record number of students apply for nursing.” February 18, 2021. <https://www.bbc.com/news/uk-56111379>

⁷³ For example, the Health Foundation's REAL Centre produced a model that can be used to develop supply projections of the nursing workforce with a time horizon of 10 to 20 years. See Siôn Cave, Emma Woodham, Dave Exelby, Keith

Figure 8. The number of people in the UK with a nursing qualification per head of population is one of the lowest rates in Europe



Source: Organisation for Economic Cooperation and Development (OECD) “Nursing graduates.” Retrieved March 19, 2021. <https://data.oecd.org/healthres/nursing-graduates.htm>
 Note: Data from 2019 or latest available.

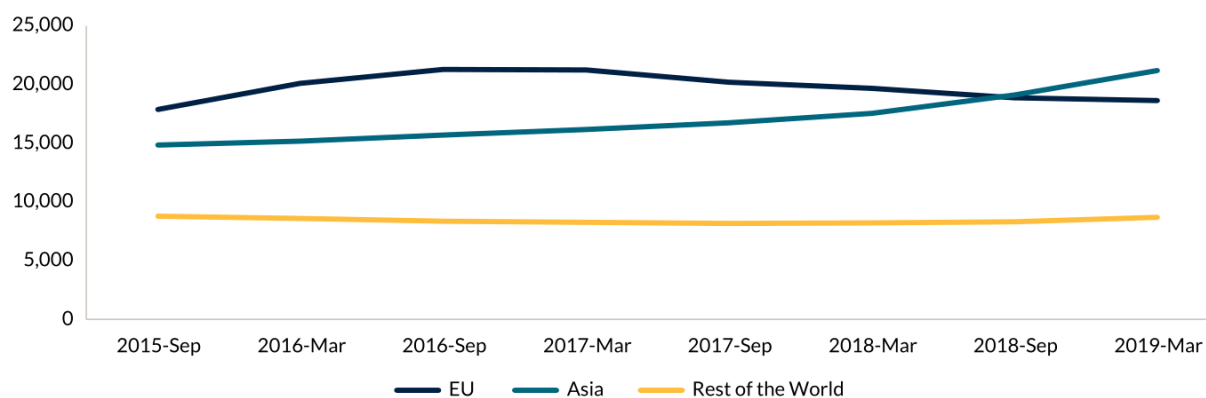
These staff shortages have long been front of mind for the UK’s successive governments. In 2020, the new Conservative government pledged to increase nurse numbers by 50,000 over the next five years, and offered additional cost of living support of £5,000.⁷⁴ A new “We are the NHS, We are Nurses” campaign is attempting to recruit teenagers and those switching careers.⁷⁵ The NHS’ Long Term Plan acknowledges the shifting needs of the sector, and is supported by a workforce development strategy in the form of the NHS People Plan.⁷⁶ Such interventions, coupled with long-term investment, will needed to reduce the impact of these broader shifts. Recognizing the limited nature of these investments, the government has also turned to international recruitment, a key part of the government’s commitment to deliver 50,000 additional nurses by 2024.

Derbyshire, Rosemary Wildblood, and Nihar Shembavnekar. 2020. “Nurse supply model: progress so far.” London: The Health Foundation. <https://www.health.org.uk/publications/nurse-supply-model-progress-so-far>
⁷⁴ Department of Health and Social Care (DHSC) 2019. “Nursing students to receive £5,000 payment a year.” Published December 18, 2019. <https://www.gov.uk/government/news/nursing-students-to-receive-5-000-payment-a-year>
⁷⁵ NHS. “We are Nurses. We are the NHS.” <https://www.healthcareers.nhs.uk/we-are-the-nhs/nursing-careers>
⁷⁶ NHS. “NHS Long Term Plan.” <https://www.longtermplan.nhs.uk/>; and NHS. “We are the NHS: People Plan for 2020/21—action for us all.” <https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/>

Migration

In 2018, non-British nationals made up 12 percent of the NHS workforce—6 percent EU nationals and 6 percent non-EU nationals.⁷⁷ Of those doctors who were non-EU nationals, the greatest proportion came from Asia, South Asia, and Sub-Saharan Africa. Out of those from Sub-Saharan Africa, the greatest proportion came from Nigeria: 1,391 doctors. Similar trends can be seen within the nursing profession, with Asian nurses outstripping those from EU countries (Figure 9). The proportion of foreign-born workers varies throughout the country, with the greatest proportions in London.

Figure 9. UK National Health Service workers of non-British origin



Source: Office for National Statistics (ONS) “International migration and the healthcare workforce.” Last updated August 15, 2019. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/articles/internationalmigrationandthehealthcareworkforce/2019-08-15>

Note: NHS HCHS nursing workforce in Trusts and CCGs by nationality, England, 2015-2019

There are two ways in which nurses can be recruited from overseas: directly by Trusts, or through an intermediary. To be offered a job, nurses must acquire both a UK work permit and a Nursing and Midwifery Council registration. They must have a valid nursing qualification from their home country which is verified by the Council. They must pass an English language test (IELTS or OET) and pass a two-part Council application process: a computer based multiple-choice examination (which nurses can access in their home countries) and a practical test which is held in the UK (the objective structured clinical examination, or the OSCE). Employers often sponsor foreign nurses to come to the UK where they are able to work as health care assistants until they pass their OSCE. Completing all of the above is difficult without the support of an agency, hence a large overseas recruitment industry exists.

⁷⁷ Office for National Statistics (ONS) “International migration and the healthcare workforce.” Last updated August 15, 2019. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/articles/internationalmigrationandthehealthcareworkforce/2019-08-15>

The UK has become a “net importer” of health care professionals. Every year, the NHS needs to recruit 5,000 nurses from overseas.⁷⁸ The OECD has found that the UK imports more foreign-trained nurses than all other countries bar New Zealand, Switzerland, and Australia.⁷⁹ As described above, European-trained nurses have long been a source of talent for the NHS. Yet Brexit, and the extension of language requirements, has led to a fall in the number of European professionals seeking employment in the UK. As the King’s Fund notes, “the number of nurses and midwives from Europe leaving the Nursing and Midwifery Council’s register has risen from 1,981 in 2015/16 to 2,838 in 2019/20, while the number joining fell by 90 per cent over the same timeframe.”⁸⁰

Therefore, the NHS is having to look elsewhere. Over the same time period, there has been some increase in the number of nurses arriving from countries outside the EU, especially India and the Philippines.⁸¹ The UK maintains its own Code of Practice for the international recruitment of health and social care personnel which precludes active recruitment of health care professionals from developing countries, unless there exists a government-to-government agreement to support recruitment activities.⁸² Under this Code, the UK has negotiated agreements which allow recruitment from the Philippines⁸³ and all Indian states barring Andhra Pradesh, Madhya Pradesh, Orissa, and West Bengal (those that receive ODA).⁸⁴

The updated Code, published in late February 2021, reduces the number of countries which require such agreements, in line with new guidance from the WHO. The UK no longer holds its own list of countries, but uses the WHO Support and Safeguards List of 47 countries with the most pressing health workforce to population ratios, including Nigeria.⁸⁵ Neither India nor the Philippines are on this list, reflecting their fast-growing economies and therefore declining potential for nurse emigration. The DHSC and NHS are exploring other markets, in two ways. The first is exploring potential markets with which to develop government-to-government agreements. Promoting mobility in line with the UK’s Code will require in-depth consultation with the Ministries of Health in these countries and for robust agreements to be signed which promises mutually beneficial migration.

⁷⁸ The King’s Fund. 2021. “NHS workforce: our position.” Last updated February 26, 2021. <https://www.kingsfund.org.uk/projects/positions/nhs-workforce>

⁷⁹ Ben Gerschlick and Anita Charlesworth. 2019. “Health and social care workforce: Priorities for the new government.” *The Health Foundation*. November 27, 2019. <https://www.health.org.uk/publications/long-reads/health-and-social-care-workforce>

⁸⁰ The King’s Fund. 2021. “NHS workforce: our position.” Last updated February 26, 2021. <https://www.kingsfund.org.uk/projects/positions/nhs-workforce>.

⁸¹ Ben Gerschlick and Anita Charlesworth. 2019. “Health and social care workforce: Priorities for the new government.” *The Health Foundation*. November 27, 2019. <https://www.health.org.uk/publications/long-reads/health-and-social-care-workforce>

⁸² Department of Health and Social Care (DHSC) 2021. “Code of practice for the international recruitment of health and social care personnel.” <https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel>

⁸³ NHS Employers. “Memorandum of Understanding between the Government of the Republic of the Philippines and the Government of the United Kingdom of Great Britain and Northern Ireland in Healthcare Cooperation.” <https://www.nhsemployers.org/~media/Employers/Documents/Recruit/UK%20Philippines%20MOU.pdf>

⁸⁴ NHS Employers. 2021. “Developing countries—recruitment.” Published February 25, 2021. <https://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/list-of-developing-countries>

⁸⁵ World Health Organization (WHO) 2021. “Health Workforce Support and Safeguards List, 2020.” Published February 25, 2021. https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5

BOX 5. HEALTH EDUCATION ENGLAND'S GLOBAL LEARNERS PROGRAMME

Health Education England (HEE) essentially oversees the training and development of the health workforce in England. It is a nondepartmental body sponsored by the Department of Health and Social Care (DHSC). According to its website, HEE is responsible for ensuring that the NHS' future workforce is "available in the right numbers and has the necessary skills, values and behaviours to meet patients' needs and deliver high quality care."⁸⁶

One way it does this is by working globally: supporting NHS staff and organizations in their engagement overseas, bringing overseas staff to work on placements, and by aligning objectives through different government departments including the Foreign, Commonwealth, and Development Office.

HEE's Global Learners Programme offers the ability for foreign-trained nurses to work in the NHS.⁸⁷ Applicants must be registered nurses who have practiced for at least six months after qualifying and have practiced within the last two years. They must have a minimum grade of B in reading, speaking, and listening English and a C+ in writing. Nurses are able to apply for roles from their home countries, pass an initial CBT test, and then apply for a UK visa. Once their visa is approved, and they have paid the requisite fee, they prepare to move to the UK. Applicants are provided with flights to the UK and three months of accommodation by their employer Trust, along with pastoral care and integration support. Once they arrive, they start work for their new employer before taking the Objective Structured Clinical Examination (OSCE) which leads to full qualification. Successful trainees are allowed to bring their dependents, and all can stay for the full length of the visa (three years) before transferring onto a Tier 2 (General) Visa and eventual permanent residency and citizenship.

The program operates through agreements that the UK has with several low- and middle-income countries including focusing on at-scale recruitment from states in India and supporting labor ministries to ensure candidates reach a level at which they are able meet the NMC requirements (for example, through support with English language programs). A pilot called "Earn, Learn, Return" was launched in 2017/18 yet the Tropical Health Education Trust (THET) noted that few nurses were likely to return home to their countries of origin, and more clarity around the circular mobility nature of this scheme was required.⁸⁸ As a result, the program shifted to focusing on skills development with no requirement to return. As of the start of 2021, over 2,000 nurses are working in NHS through the scheme, and approximately 1,500 due to start during 2021/22.

The program is winding down over 2021/22 with HEE's successor programs focusing on managed educational partnerships with low- and middle-income countries. These small bilateral programs, such as the partnership with Saint Vincent and the Grenadines, will focus on staff exchange and capacity building.

Source: NHS Health Education England. "Global Learners Programme." <https://glp.hee.nhs.uk/>; and interviews with Health Education England staff.

⁸⁶ NHS Health Education England. "Global engagement." <https://www.hee.nhs.uk/our-work/global-engagement>

⁸⁷ NHS Health Education England. "Global Learners Programme." <https://glp.hee.nhs.uk/>

⁸⁸ Graeme Chisholm. 2019. "Forthcoming Tropical Health and Education Trust (THET) Report: Migration and Mobility." Submitted to the 2nd Review of Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Draft Evidence Brief No. 3. June 14, 2019. https://www.who.int/docs/default-source/health-workforce/eag2/2nd-review-of-code-relevance-and-effectiveness-evidence-brief-3-thet.pdf?sfvrsn=541bdee3_2

The second way is by augmenting the formal immigration system. Due to Brexit, the UK has had to develop a new Points Based Immigration System which came into force in January 2021. Within the context of this system, the UK has introduced a new Health and Care Visa.⁸⁹ To be eligible, an applicant must have a job offer from a relevant employer within the health and care sector, be undertaking a specific job role within the visa rules (e.g. doctor, nurse, adult social care professional), be paid over £20,480, and speak English up to level B1. This standard is likely to be one of the biggest barriers to take-up as it is one of the highest English language requirements in the world. The fees are substantially lower than normal immigration fees, there are no annual caps or quotas, no requirement for employers to advertise locally, and the ability to transition an initial five-year visa into permanent residence and eventually citizenship.

The Health and Care Visa is remarkably open. Given the high level of skill shortages within the NHS, and the government requirement to recruit more staff within a short period of time, it is likely that employers will seek to take advantage of this new openness. Many foreign-trained health professionals have been educated at British-designed institutions, which will have provided them with relatively transferable skills and a high level of interest. It also opens up opportunities for health care assistants to enter the UK and work within the system. If nurses are not able to pass their OSCE exam within eight months, they are able to downgrade to the position of health care assistant and continue to work, rather than losing their immigration status (as was the case before). The visa is new, and take-up is yet to be seen (due to COVID-19) and extensively evaluated.

Yet there are three main barriers to relying on the new Health and Care Visa to meet the overall shortage of health workers in the UK. The first is the promotion of the Health and Care Visa abroad—if countries (and individual potential migrants) are unaware of the new visa, it is unlikely that they will know to apply or to augment their education and skill investment decisions to take advantage of this new pathway. The second is the potential sending countries. If the UK wants to actively facilitate migration from countries on the WHO Support and Safeguards List (including Nigeria), it will need to do so through a comprehensive bilateral migration agreement. And the third is rising concerns that the UK should be “compensating” countries who are sending large numbers of health workers to the UK. For example, in late 2020, Conservative MP Andrew Mitchell introduced the Doctors and Nurses (Developing Countries) Bill.⁹⁰ The Bill recognizes the impact that increased labor migration can have on the health workforce of countries of origin, and requires “the Secretary of State to report on the merits of a scheme for the United Kingdom to pay to train two doctors or nurses in developing countries for each doctor or nurse recruited to the National Health Service from those countries.” The Global Skill Partnership model mirrors this approach, while also overcoming the other two barriers mentioned above.

⁸⁹ Gov.UK. “Health and Care Worker visa.” <https://www.gov.uk/health-care-worker-visa/your-job>

⁹⁰ Doctors and Nurses (Developing Countries) Bill. Last updated January 14, 2021. <https://bills.parliament.uk/bills/2804>

BOX 6. TROPICAL HEALTH EDUCATION TRUST (THET)

The Tropical Health Education Trust (THET) was formed in 1988 as a UK charity. It trains and educates health workers in Africa and Asia, by partnering UK-based NHS Trusts, Royal Colleges, and academic institutions with those in the region. These partnerships deliver health worker training programs based on the needs of the partner institutions. Much of this is delivered by UK volunteers and almost 100,000 have volunteered their time over the past 30 years.

THET has long advocated for greater investment by the UK in the training and education of overseas health care professionals, as well as health systems strengthening. Its flagship UK Partnerships for Health Systems (UKPHS) program aimed to help low- and lower middle-income countries build stronger, more resilient health systems, with the ultimate aim of achieving universal health coverage and better servicing poor and vulnerable populations.⁹¹ Unfortunately, this project was recently cut due to the reduction in UK aid spending.

In 2019, THET submitted a brief to the 2nd review of the WHO Code of Conduct in which it recommended the UK establish a “unified health workforce strategy at the national level which maximizes the synergies between UK Official Development Assistance (ODA) funding and NHS investments in workforce allowing for the meaningful circulation of health workers.” This brief was then translated into a more comprehensive policy paper.⁹² In this policy paper, THET called on ODA to be used for health systems strengthening in low- and middle-income countries, and for the NHS to focus on foreign-trained health worker integration in the UK.⁹³ In addition, this report also calls on the UK government to “scale-up publicly funded Skills Mobility Partnerships.” It reviews a number of different forms of skill partnerships, noting that circularity should be encouraged and built into the structure of the program. It also calls for any partnerships to adhere to both THET’s “principles of partnership” and the WHO’s Twinning Partnerships for Improvement.

Source: NHS Health Education England. “Global Learners Programme.” <https://glp.hee.nhs.uk/>; and interviews with THET staff

IMPLEMENTING A GLOBAL SKILL PARTNERSHIP

As described above, the UK is experiencing large and persistent skill shortages, particularly within the nursing profession. Its NHS has long relied on migrant staff, and local Trusts (particularly those in urban and peri-urban areas) have much experience with recruiting and integrating foreign-trained workers. Yet the countries of origin that the NHS has long relied upon, including India and the Philippines, are rapidly developing, creating concern that they may not be viable sending markets in the long-term. As a result, the UK is turning to new potential partner countries, particularly former British colonies in South East Asia and Sub-Saharan Africa. Many of these countries are on the WHO’s

⁹¹ Tropical Health and Education Trust (THET) “UK Partnerships for Health Systems (UKPHS).” <https://www.thet.org/ukphs/>

⁹² Graeme Chisholm. 2019. “From Competition to Collaboration: Ethical leadership in an era of health worker mobility.” London: Tropical Health Education Trust (THET). <https://www.thet.org/our-work/policy-work/from-competition-to-collaboration/>

⁹³ Graeme Chisholm. 2019. “Forthcoming Tropical Health and Education Trust (THET) Report: Migration and Mobility.” Submitted to the 2nd Review of Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Draft Evidence Brief No. 3. June 14, 2019. https://www.who.int/docs/default-source/health-workforce/eag2/2nd-review-of-code-relevance-and-effectiveness-evidence-brief-3-thet.pdf?sfvrsn=541bdee3_2

Support and Safeguards List, requiring the development of meaningful bilateral agreements that promote development on both sides.

As mentioned earlier, Nigeria suffers from a lack of qualified health workers, particularly nurses, and particularly within the Northern areas of the country. It also lacks substantial local and international investment in the development of its training and health management infrastructure; a gap that targeted overseas development assistance could fill. A health partnership between the UK and Nigeria could therefore deliver benefits to both countries, increasing the stock of skilled health professionals and improving health systems for all.

One way to do this is through the Global Skill Partnership model. A Global Skill Partnership is a bilateral labor migration agreement between a country of origin and a country of destination. The country of origin agrees to train people in skills specifically and immediately needed in both the country of origin and destination. Some of those trainees choose to stay and increase human capital in the country of origin (the “home” track); others migrate to the country of destination (the “away” track). The country of destination provides technology and finance for the training and receives migrants with the skills to contribute to the maximum extent and integrate quickly.

The following sections outline how such a Global Skill Partnership in nursing could be developed between the UK and Nigeria, including aspects of its design, risks and mitigation measures, and potential funding sources. The points listed below are not exhaustive. Undoubtedly, further points will be raised through the required extensive consultations between parties on both sides, and opportunities for testing new approaches should be pursued.

Design

Below we have outlined the various stages required when designing a Global Skill Partnership, namely:

1. Signing government-to-government agreement;
2. Consulting relevant stakeholders;
3. Signing on interested employers;
4. Developing curricula and training materials;
5. Designing contributions to broader systems;
6. Facilitating mobility; and
7. Evaluating the scheme (and potentially scaling).

Signing a government-to-government agreement

The first stage required within the formulation of a health care Global Skill Partnership is the signing of an MoU or a BLA. Nigeria is on the WHO’s Support and Safeguards List, and therefore is governed by both the WHO and the UK’s Code of Conduct. As a result, the UK is barred from recruiting Nigerian health professionals through direct recruitment and must facilitate any mobility through formal government-to-government agreements. These agreements should be negotiated directly by the

Ministry of Health in Nigeria and DHSC in the UK and take into account the needs of the labor force on both sides. The WHO has developed a sample MoU which could be developed for this case.⁹⁴ The document could borrow elements from the MoU between the UK and the Philippines as a model (see Box 7) while including more specific language about increasing the supply of workers in Nigeria and facilitating health systems strengthening.

BOX 7. MEMORANDUM OF UNDERSTANDING BETWEEN THE UK AND THE PHILIPPINES

In the early 2000s, the UK signed two agreements with the Philippines. The first, a recruitment agreement, was signed in 2002 and was to be valid for three years. It detailed the organization of the recruitment process and included elements of ethical recruitment and protection. The second, MoU, was signed in 2003 and ratified in 2004. This document was more encompassing and included three main aims: to facilitate the recruitment of Filipino health care professionals by the UK; to intensify bilateral exchanges of policy thinking with regard to nursing workforce development and best practice; and to involve professional staff and health care managers with a view to developing mutual recognition agreements.⁹⁵

The MoU was never implemented, and the recruitment agreement was terminated in 2006. Ostensibly, this was because the NHS had fewer vacancies and as such a reduced demand for foreign workers. In total, between 2002 and 2006, 175 nurses were recruited within the government-to-government agreement while many thousands more migrated outside this agreement. Makulec (2014) notes that the limited significance of the MoU could be due to the limited scope of the agreement as well as bureaucracy and costs linked to its implementation.⁹⁶

Despite these setbacks, health worker migration between the Philippines and the UK is still active. Between March 2016 and March 2019, 4,000 Filipinos came to work in the NHS, becoming the second largest migrant group after Indians.⁹⁷ There are three unions that exist to support Filipino nurses with their personal and professional development while providing a support and advocacy network: the (official) Philippine Nurses Association⁹⁸ (which serves Filipino nurses worldwide) and two that serve UK-based nurses, the Filipino Nurses Association⁹⁹ and Filipino UK Nurses Community.¹⁰⁰

Source: Agnieszka Makulec. 2014. Philippines' Bilateral Labour Arrangements on Health-care Professional Migration: In Search of Meaning. Report prepared for the EU-ILO project on "Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers". Makati City: International Labour Organization (ILO). https://www.ilo.org/wcmsp5/groups/public/---asia/--ro-bangkok/---ilo-manila/documents/publication/wcms_320609.pdf

⁹⁴ Ibadat S. Dhillon, Margaret E. Clark, and Robert H. Kapp. 2010. "Innovations in Cooperation: A Guidebook on Bilateral Agreements to Address Health Worker Migration." Washington, DC: The Aspen Institute. <https://www.who.int/workforcealliance/bilateral01.pdf?ua=1>

⁹⁵ James Buchan, Susanna Baldwin, and Miranda Munro. 2008. "Migration of Health Workers: The UK Perspective to 2006." OECD Health Working Papers No. 38. Paris: OECD Publishing. <https://doi.org/10.1787/228550573624>

⁹⁶ Agnieszka Makulec. 2014. *Philippines' Bilateral Labour Arrangements on Health-care Professional Migration: In Search of Meaning*. Report prepared for the EU-ILO project on "Decent Work Across Borders: A Pilot Project for Migrant Health Professionals and Skilled Workers". Makati City: International Labour Organization (ILO). https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-manila/documents/publication/wcms_320609.pdf

⁹⁷ Rivkah Brown. 2020. "More Filipino Healthcare Workers Have Died of Covid-19 in the UK Than the Philippines. Why?" *Novara Media*. December 16, 2020. <https://novaramedia.com/2020/12/16/more-filipino-healthcare-workers-have-died-of-covid-19-in-the-uk-than-the-philippines-why/>

⁹⁸ Philippine Nurses Association, Inc. <http://www.pna-ph.org/>

⁹⁹ Filipino Nurses Association United Kingdom. <https://fnauk.org.uk/>

¹⁰⁰ Filipino UK Nurses Community. <https://www.filipinoukurse.com/new-about-us>

Consulting relevant stakeholders

The second phase will be to ensure that all relevant stakeholders have been consulted and had the opportunity to engage with the design of the Global Skill Partnership—the relevant stakeholders are listed in Table 2. While not all of these stakeholders need to be formally engaged in the implementation of the project, it is crucial that all are regularly consulted throughout the length of the project and given the opportunity to provide feedback on required course corrections. This will ensure that all stakeholders provide a positive rhetoric about the impact of the project which will be necessary given inevitable criticism from both within and outside government.

Table 2. Required stakeholders for a UK-Nigeria nursing Global Skill Partnership

	Nigeria	Role	UK	Role
Government	Federal Ministry of Health, Nursing and Midwifery Council (NMCN), Federal Ministry of Labor and Employment	Sign MOU, manage project	Department of Health and Social Care (DHSC)	Sign MOU, manage project
	Nigerian in Diaspora Commission	Ensure protection of “away” track nurses when they move abroad and liaise with all parties to harness the project for national development	Foreign, Commonwealth, and Development Office (FCDO)	Provide ODA, ensure development impact of project
Nongovernmental bodies	Nursing World Nigeria	Help with pre-selection processes and orientation using their existing platform; support Migrants Resource Center (MRC) with pre-departure counselling and orientation leveraging experience working with nurses	NHS Professionals, NHS Trusts, and other registered recruitment agents	Help design pre- and post-departure training (soft skills, language), support integration and further training of health workers once they arrive in the UK
	Nigerian Labor Congress	Ensure that both local and international labor standards are maintained for the protection of trainees and employees under the project	Tropical Health Education Trust (THET)	Design curriculum, bring qualified NHS trainers to support trainers in Nigeria, provide recommendations on origin country health systems strengthening

	Nigeria	Role	UK	Role
International bodies	World Health Organization (WHO), Nigeria	Support Federal Ministry of health to ensure that project design is compliant with WHO code for human resources recruitment.	World Health Organization (WHO), Global	Ensure design is WHO Code compliant, share best practice
	International Organization for Migration (IOM), Nigeria	Support Migrants Resource Center (MRC) with pre-departure counselling and training	International Organization for Migration (IOM), Global	Support implementation of pre- and post-departure training, share best practice, (possibly) provide funding
	International Labour Organization (ILO), Nigeria	Support Nigerian Labour Congress to ensure that labor standards are maintained in accordance with ILO Conventions relating to the protection of migrants' rights	International Labour Organization (ILO), Global	Provide oversight of labor standards, protect migrant rights
Professional bodies	Nursing and Midwifery Council of Nigeria (NMCN)	Verify that nurses are accredited and provide Letters of Good Standing where necessary, supporting the integration and qualification recognition of returnees	Nursing and Midwifery Council (NMC)	Provide accreditation to curriculum, register Nigerian nurses
Employers	Federal Ministry of Health, State Ministries of Health, National Primary Healthcare Development Agency, Private Hospital owners	Recruit "home" track trainees post training, supporting the integration and qualification recognition of returnees	NHS Employers, NHS England and Ireland, and NHS Trusts willing to engage with the project	Recruit nurses in "away" track, facilitate OSCE completion, integration and further skills training
Trade unions	National Association of Nigerian Nurses and Midwives, Nigeria Labor Congress	Collaborate with relevant bodies to ensure protection of the labor rights of nurses selected for the project	Royal College of Nursing (RCN), UNISON, and Unite	Provide oversight of labor standards, protect migrant rights, ensure program is not used as a substitute for improvements in wages and working conditions
Diaspora organizations	Nigerians in Diaspora Commission	Support integration of Nigerians in "away" track through collaboration with UK diaspora groups, support reintegration of GSP returnees	AFFORD, Nigerian Nurses Charitable Association UK	Support integration of Nigerians in "away" track, facilitate remittance and skill transfer

Signing on interested employers

The third phase is to select employers to partner with in both Nigeria and the UK. In the former, employers of nurses and midwives are the ministries of health at both the federal and state levels, the National Primary Health Care Development Agency (NPHCDA) and operators of private hospitals. The NPHCDA oversees the training of health workers at the community level and is rightly placed to know where shortages exist and what specialties are most required to target those going through the “home” track. And while states with good existing training institutions could be useful, it will also make sense to work with states with a shortage of health workers so that trainees can be easily absorbed. It would be practical to cultivate partnerships that produce trainees for the North of Nigeria, as well as for rural areas. In the UK, it makes sense to pick NHS Trusts which are suffering from significant skill shortages but which are also situated in cities with large African diaspora. As described above, London is suffering from the most acute worker shortages. Within London, the borough of Southwark has the greatest number of citizens identifying as having an African heritage, followed by Lambeth and Lewisham. Hence potential partners could be the three main NHS Trusts in these boroughs: Guys and St Thomas’s NHS Foundation Trust, King’s College Hospital NHS Foundation Trust, and Lewisham and Greenwich NHS Trust (respectively).

Developing curricula and training materials

The fourth phase is to consult with the NHS Trusts willing to engage with the project and the Ministry of Health in Nigeria to design the curriculum for the training of Nigerian nurses. The most difficult part of the design will be ensuring that the training course delivers in both the “home” and “away” track and conforms to the needs of the labor markets on both sides. Ideally, the program would deliver one curriculum that serves the needs of both countries. To create this, it will be necessary to conduct in-depth reviews of labor needs (both now and in the future) in both countries by conducting desk research and engaging with senior federations, chambers of commerce, employment agencies, and investment agencies. Such skills needs should be developed in line with national employment strategies and contribute to the economic development goals of both countries. These analyses will also be useful far beyond the health sector, helping to identify skill needs across a range of sectors to support a range of potential partnerships.

In conducting research and analysis for this report, we suggest that the “home” track focuses on producing nurses who are specialized in the shortage occupations listed above. The “away” track should focus on preparing Nigerians to become primary care nurses in the UK. While existing consultations and desk research did not allow for the assessment of shortages in the categories of primary care nurses or community health workers in Nigeria, it did show significant degree of heterogeneity among the presence of training institutions by different regions. Design of both the “home” and “away” track should account for these regional variations in ensuring that those trained in the “home” track are equipped to fill shortages in lagging regions and those trained for the “away” track do not deplete much needed human resources away from lagging regions, particularly in the North.

Given the requirement within the NMC for both theoretical and practical training over a three-year period, the “away” track will need to facilitate both. The theoretical training should be developed with the NMC to ensure it adheres to the curriculum requirements of NMC’s professional standards. The practical training could be encouraged through regular periods of exchange or by delivering two years of theoretical training in Nigeria and the last year of practical training in the UK. Such an approach requires long-term embedded engagement and may not be possible within the timeframe dictated by

the UK government’s campaign pledges. Therefore, in the first stage of the pilot, training could be focused those who have already graduated as nurses, midwives, or community health workers within Nigeria, providing them with one year of “top up” training within Nigeria to prepare them for the UK market. Concurrently, the UK could invest in broader health systems strengthening for those trainees preparing to be nurses within the Nigerian market.

Whichever route is chosen, those on the “away” track will also need language training. Nigeria is not included on the list of “majority English-speaking countries” that the NHS holds, and therefore Nigerians need to pass the IELTS or OET and obtain B1 or 7.0 and above. This training should be delivered by professional English language trainers, whether in person within Nigeria or remotely from the UK or other locations. It must also include an integration component which should provide information about entry into the UK economy and society. This could be delivered by IOM or other nongovernmental organizations such as diaspora groups who, perhaps, facilitate the cultural integration of refugees and asylum-seekers now. Both tracks will need to include some form of soft skills training too, in transfer thinking, problem-solving, and independent learning.

Designing contributions to broader systems

The training and mobility aspects of the project should be accompanied by ODA investments to improve the health system of Nigeria as a whole. Nigeria, as a signatory to the Abuja Declaration should be spending 15 percent of its annual budget on health; in 2018, it was just 3.89 percent.¹⁰¹ As a result, the international community needs to support Nigeria to increase the amount of money it spends on health infrastructure and outcomes, while also directly supporting the improvement of both. There are two types of contributions that should be assessed as part of the project. The first contribution should support the Ministry of Health and its associated public health infrastructure to better train, recruit, and retain workers. A key challenge here is working with the Ministry of Health to support them in completing the WHO’s National Health Workforce Accounts¹⁰² and a health workforce migration management strategy. Second, the Ministry of Health needs to be supported to better spend and distribute the money it gets from the central treasury. This money should go into building and expanding educational facilities in areas with shortages, particularly for skills at either end of the spectrum: including increasing the stock of health care workers in lagging regions and those with advanced specialisms. Such moves will lead to the increased production of health workers within shortage occupations.

On recruitment and retention, there is much evidence that shows that the wages and working conditions of public health professionals need to be increased but that national budgets often do not allow for this. Instead, creative solutions could be found such as providing basic housing or a housing allowance, improving the quality of facilities, equipment, drugs, and medical supplies, and ensuring facilities are located where there is both demand but also access to good schools and other services. Such investments will also allow staff present within these facilities to add the value required (with ensuing benefits for patient outcomes). These latter interventions are especially needed for rural areas. Okoroafor et al (2018) have found a large shortage of workers in rural areas due to lower salaries, housing/living conditions, children’s education, and opportunities for career advancement.

¹⁰¹ World Bank. “Current health expenditure (% of GDP)—Nigeria.” <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=NG>

¹⁰² The National Health Workforce Accounts is a system by which countries progressively improve the availability, quality, and use of data on health workforce through monitoring of a set of indicators to support achievement of UHC, SDGs, and other health objectives. See <https://www.who.int/hrh/statistics/nhwa/en/>

Addressing these concerns should be done in line with the WHO's recommendations for rural retention, and bundles of interventions should be tested and evaluated.¹⁰³

Such interventions should reflect the Government of Nigeria's priorities for the development of its health system. A scoping exercise should identify where support should be provided, along with indicators of success for such efforts—for example the completion of certain documents such as a health workforce strategy, or the expansion of essential services to a larger number of vulnerable people by a certain date. Strengthening such health systems should have “important multiplier effects towards fostering inclusive societies, including through creation of decent and productive jobs.”¹⁰⁴

Facilitating mobility

The sixth phase is to design the mobility component of the “away” track. Given the substantial shortages within the UK, and the additional benefits that will flow through the BLA, a permanent pathway is recommended with no active facilitation of return. Trainees should be brought in under the new Health and Care Visa and granted a three-year visa which can be extended if both the employer and employee are satisfied. As a result of this visa category, no support for return and reintegration should be needed, though some financing should be set aside should participants choose to return for any reason. They should be able to bring their dependents who should also have access to work visas. IOM could support with pre- and post-departure training, while NMC should help facilitate registration and post-arrival training. Those in the “away” track should also be connected to diaspora groups such as AFFORD when they arrive, to help facilitate their integration. Labor standards must be upheld throughout; in particular governments should adhere to the Nursing Personnel Convention 1977 (No 149) and its recommendation 1977 (No 157) which outline key minimum standards.¹⁰⁵

Evaluating the scheme (and potentially scaling)

As described in Section 2, the potential benefits from Global Skill Partnerships are vast and must be evaluated. This evaluation should be conducted at the beginning, middle, and end of the project, as well as some time after to ascertain the long-term impacts of the program. It is not enough to facilitate the mobility of such workers and then assume, due to the design of the training, that integration will be automatic. Negative experiences are likely to create a negative feedback loop, deterring future participants in the scheme from choosing the “away” track. Hence close attention should be paid to the integration prospects of such trainees.

Such activities could be conducted in-house (perhaps by the Research and Evidence Division of the Foreign, Commonwealth, and Development Office (FCDO)) or contracted externally. Crucially, such evaluations should use control groups for both employees and employers to understand the impact of the program in all countries and for all sets of people. Reiterating the above, understanding the impact of the project to employers is vital to being able to prove the importance to other employers and other governments.

¹⁰³ Sunny Okoroafor, Daniel Salihu, Bello Innwa, Moses Ongom, Adam Akmat, Wondimagegnehu Alemu, Chukwuemeka Nwachukwu, and Joseph Bassey. 2018. “Retention of Frontline Health Workers in Remote and Rural Areas in Cross River State: A Discrete Choice Experiment.” Abuja: World Health Organization (WHO).

¹⁰⁴ World Health Organization (WHO). 2010. “Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations.” Geneva: World Health Organization (WHO). <https://www.who.int/hrh/retention/guidelines/en/>

¹⁰⁵ International Labour Organization (ILO). 2020. “Guidelines for skills modules in bilateral labour migration agreements.” Geneva: International Labour Organization (ILO). https://www.ilo.org/global/topics/labour-migration/publications/WCMS_748723/lang--en/index.htm

It is likely that the FCDO will be required to test the impact of the approach on irregular migration from Nigeria. As noted above, there is little evidence showing the impact of opening new legal pathways on irregular migration flows.¹⁰⁶ The evidence that does exist shows that only by coupling legal pathways (at all skill levels, for all types of migration) with robust border enforcement can irregular migration be reduced. It is therefore unlikely that a pilot of say, 100 nurses, will reduce irregular migration. That being said, the implementation of a Global Skill Partnership could be used to test this link, by measuring the emigration intentions and actual emigration rates of both the control group and those on the “home” track.

Based on the evidence gathered, the main actors will need to decide whether and how to scale the pilot scheme. The Global Skill Partnership model is best implemented at a small scale in the early phases—perhaps bringing over 100 nurses in the first cohort. In this way, the assumptions inherent in the design can be tested and adapted. In the long run, given strong demand, there is potential to scale the project to thousands of nurses per year, perhaps also expanding opportunities to countries such as Ghana and Kenya. Over time, the unit cost of the project should decrease. Close attention should be paid to the project, and multiple evaluations conducted, to ensure the project is still having the desired impact. If the needs of employers change or diminish, the project must be ready to adapt to this new reality.

Risks and Mitigation Measures

The full report which accompanies this case study outlines a number of risks and potential mitigation measures that are inherent in all Global Skill Partnerships.¹⁰⁷ In addition to this list, there are three specific risks which are likely to occur in the development of such a partnership in health care between the UK and Nigeria.

Those trained within the “home” track are not able to find meaningful work. Many countries of origin have sought out such partnerships as they are overproducing health workers that they are unable to recruit within the local public systems.¹⁰⁸ Such surpluses should not be taken advantage of by countries of destination. Instead, the UK should work with Nigeria to invest in health systems strengthening and improve the capacity of the health sector in Nigeria to absorb new recruits. Two other elements should help mitigate this risk: one, carefully design the curriculum so graduates within the “home” track have the precise skills needed by local institutions and two, involve local institutions early in the process so that they can ensure the skills and qualifications of those in the “home” track meet the needs of such employers.

Those trained for the “home” track could use the new Health and Care Visa route to access UK employers. As mentioned above, the design of the new Health and Care Visa allows appropriately qualified workers to apply for roles in the NHS. If the Global Skill Partnership facilitated a certain level of training for Nigerians within the “home” track, they could use this training to apply for roles in the UK, thereby undermining the purpose of the “home” track. To overcome this, it may be necessary to

¹⁰⁶ Rachel Cooper. 2019. “Legal Pathways’ Effects on Irregular Migration.” GSDRC Helpdesk Report. August 2019. <https://gsdrc.org/publications/legal-pathways-effects-on-irregular-migration/>

¹⁰⁷ Samik Adhikari, Michael Clemens, Helen Dempster, and Nkechi Linda Ekeator. 2021. “Expanding Legal Migration Pathways from Nigeria to Europe: From Brain Drain to Brain Gain.” Washington, DC: Center for Global Development (CGD) and World Bank. <https://www.cgdev.org/publication/expanding-legal-migration-pathways-nigeria-europe-brain-drain-brain-gain>

¹⁰⁸ Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. 2021. “Sustainable recruitment of nurses (Triple Win)” Last updated January 2021. <https://www.giz.de/en/worldwide/41533.html>

ensure that those who are trained in the “home” track graduate with skills that fit the immediate needs of Nigeria. This is opposed to those who go through the “away” track, and graduate with skills needed in the UK. For example, by training those in the “home” track in demonstrated nursing categories with shortages, it is unlikely that those who go through this training will be able to access the Health and Care Visa without further training. The other option would be to require the UK to only recruit nurses who have gone through the “away” track, as part of a condition of the BLA.

No-one will be interested in choosing the “home” track, given the attractiveness of the UK market. The percentage of the world who migrate has, and remains, small despite the large self-reported desire to move. Similarly, emigration from Nigeria remains extremely small. We can expect that not everyone wants to leave their home country due to family and other commitments, cultural preferences, and a desire to contribute to the societies and economies of their own country. These workers deserve the ability to do so, with increased skills and broader human capacity. Yet the earning potential within the “away” track is likely to be a strong lure, and the project should consider ways in which to even out the incentive structures. For example, the project could include a bonded scheme whereby those on the “away” track need to contribute to rural clinics for a year before they leave.

Funding

While Global Skill Partnerships can be financed in a number of ways, one of the guiding principles is that little to none of the financial burden should rest on the country of origin. This means that costs need to be borne by the country of destination itself, employers within the country of destination, and potentially also the trainees. Such a budget depends on the size of the Global Skill Partnership. As discussed above, it is generally recommended to start with a pilot, to test assumptions inherent within the model and address any misaligned incentive structures before scale. There is no firm guidance as to the size of such a pilot but an initial intake of approximately 100 nurses undergoing training would be a useful place to start.

The most obvious source of funding for a pilot program is the UK’s ODA budget. The UK’s Department for International Development (DFID) (now part of the new Foreign, Commonwealth, and Development Office (FCDO)) has long supported health systems strengthening in low- and middle-income countries.¹⁰⁹ The UK signed the IHP+ Global Compact, committing to improving the training and infrastructure for health workers. As described above, DFID has funded programs run by organizations like THET to train health workers and support linkages between health institutions in the UK and abroad. Today, the FCDO is collaborating closely with DHSC, the Home Office, and other relevant departments to explore joint partnerships. Hence there should be enough political support cross-government to invest in such partnerships.

In late 2020, the UK government announced that it would no longer be spending 0.7 percent of GNI on ODA, but instead reducing this contribution to 0.5 percent. This will undoubtedly make it difficult for UK departments to argue for ODA to be spent on a project such as a Global Skill Partnership. That being said, the UK’s aid strategy attempts to align development resources to the UK’s national interest—addressing the socio-economic development of people in low- and middle-income countries while also ensuring such investments benefit the UK. Here, the Global Skill Partnership is a clear

¹⁰⁹ Graeme Chisholm. 2019. “From Competition to Collaboration: Ethical leadership in an era of health worker mobility.” London: Tropical Health Education Trust (THET). <https://www.thet.org/our-work/policy-work/from-competition-to-collaboration/>

example of how ODA could be used to support socio-economic development in Nigeria (by increasing the number of health workers available and strengthening health systems) and support employers within the UK (by plugging skills gaps and thereby improving the productivity and effectiveness of the NHS).

It is important that any Global Skill Partnership adds to and complements the aid budget, rather than displacing other aid investments. As a result, it may be necessary to “top up” the UK’s ODA spend with other sources of financing. This financing could come from other UK” track could be required to pay for their own migration related costs (such as visa fees, airfare, and initial set-up) which would then be recouped from their NHS salary. This could be something facilitated by their new employers, the respective NHS Trusts. Finally, there may be other sources of financing, such as private philanthropy, to explore.



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