The Impact of the Department of Health, England, Code of Practice on International Recruitment

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June 2007
Executive Summary

The main objectives of this evaluation, as set out in the terms of reference, were to assess the impact of the Department of Health Code of Practice (CoP) on developing countries, to identify issues for further study of the impact of the CoP in the UK, and to assess whether the CoP is meeting the objectives originally set out for it.

Active international recruitment of health professionals was an explicit policy intervention of the Department of Health in England as one key element of achieving rapid staffing growth between 2000 and 2005.

The level of international recruitment has dropped significantly since early 2006 as work permits were required for International Medical Graduates who are not UK or EEA nationals after April 2006 and similar changes were made for junior physiotherapists and nurses between 2005 and 2006.

The Code of Practice was first drafted in 2001, a list of ‘developing countries’ to which it was intended to apply was specified in 2003, and extended to cover the activities of recruitment agencies, temporary staff and private sector employers providing NHS funded care in 2004. Earlier in 1999, the Department of Health had required NHS employers not to target South Africa and the West Indies.

In assessing the code, it has to be borne in mind that there is no single date to focus on, as there have been variations of the code in use since 1999.

The key points of the Code are:

► Developing countries should not be targeted for active recruitment by the NHS unless the government of that country formally agrees [a list of developing countries is provided]
► NHS employers should only use recruitment agencies that have agreed to comply with the Code
► NHS employers should consider regional collaboration in international recruitment activities
► Staff recruited from abroad have the same legal protection as other employees
► Staff recruited from abroad should have the same access to further training as other employees

Flows can be tracked from within the UK using registration data and work permit data. Both have limitations. Registration does not imply that the individual is practising in the UK, and work permit data only cover non-EU countries. Both sets of data suggest that fewer international health professionals are being absorbed by the UK health labour market, with new doctor and nurse registrations peaking in 2003.

There are no marked patterns in trends in migration of health professionals from countries included and not included in the Code’s list of ‘developing countries’. There has been an increasing trend in nurses newly registering who have been trained in the UK but fluctuating shares of migrants from ‘developing’ countries included in the list, ‘developing’ countries who have requested exemption from list countries and other ‘developed’ countries. This applies to registration and work permit data, and nurses and doctors.
Two case studies were conducted to explore the impact of the Code from the perspective of African countries.

In Kenya, although classed as in critical shortage of human resources for health by WHO, there is reported to be unemployment among nurses. In urban areas, there is considered to be over-staffing of both doctors and nurses. These two observations led many Kenyans to perceive that migration was not the critical issue affecting health workforce balance in the country. Nevertheless, there are unfilled vacancies in rural areas.

Data on migration of doctors is very limited in Kenya. For nurses, the best available source of information is the number seeking letters of verification of their qualifications, required for the registration process in overseas countries. These numbers peaked in 2003 for all destination countries, and in 2001 for migration to the UK. These estimates may be unreliable to the extent that nurses seeking letters of verification may not migrate.

Multiple explanations of the trends observed in relation to the UK were offered including better pay and conditions for doctors and to a lesser extent nurses in Kenya. However, the dominant explanations were those related to the greater difficulties of obtaining registration and work permits in the UK. The Code of Practice was not offered as an explanation of changes taking place.

There was said to be a growing rate of failure to achieve migration to the UK objectives after embarking on and investing in the process. Extensions to the Code are proposed that seek to reduce wasted investments.

Recruitment activity and aggressive active recruitment – such as the entering of workplaces to distribute information was perceived to have reduced significantly from the UK, but it is not clear whether the Code was influential in this, or whether a lack of vacancies in the UK explains it.

The Kenyan case study suggested that a dissemination effort was required to inform those affected of the provisions of the Code and avoid harmful misconceptions. An accompanying consultation process would be required to better tailor the provisions of the Code to the Kenyan situation. However, the major developments needed to achieve better health workforce balance in Kenya are probably under the control of the Kenyan government, in particular with respect to improving the internal distribution of the health workforce.

In Ghana, out-migration was almost universally viewed as a significant problem for the health system and the shortage situation is more clear cut. Data for nurses and pharmacists, based on verification of qualifications applications, indicate that migration has declined significantly from a peak in 2003.

There has been considerable progress in recent years in adapting Ghanaian human resource policy to the challenge of migration. Numbers in training have been increased, terms and conditions for all health professionals have been improved, post-graduate medical and surgical training opportunities in country have been instituted and the policy of ‘bonding’ nurses has been strengthened. These developments are likely to have played a considerable role in explaining trends in migration of health professionals.
As in Kenya, these explanations together with the greater difficulties and costs of achieving registration and work permits in the UK were offered as the explanation of the widely perceived reductions in migration in Ghana.

Recruitment activity was reported to be almost always covert in Ghana, and had been since the early days of migration, making it difficult to judge how recruiters had responded either to the Code or other developments in the international labour market.

**Recommendations**

1. It will only become clear whether the Code can have the intended impact on recruitment and migration when the UK labour market expands and needs international health professionals again. In preparation for this, the development of an information system to enable monitoring of international recruitment, such as the one used by NHS Scotland is recommended.

2. Better dissemination of the provisions and intent of the Code in African countries is recommended together with consultation on the appropriateness of its provisions in specific countries. DFID would be a suitable agent to promote this measure.

3. Extensions to the Code to target others involved in the recruitment process including regulatory agencies in the UK, training schools offering places to international professionals and private sector recruiters in African countries would respond to problems that are still occurring in international recruitment.

4. The MIDA project offers a promising model for interventions that would support those who having worked in the UK for a period would like to return on a short or long term basis.

5. Support to information system development in African countries to allow the monitoring of flows, stocks and policies in those countries is recommended.

6. Targeted and regionally or nationally negotiated investment in training institutions would be welcomed by African countries.

7. Constructive policy input is also needed in domestic human resource strategies to address the many reasons for poor availability of health professionals where needed that arise from causes other than international migration.
**Data and Policy Analysis**

1. Introduction

This report, commissioned by the Department for International Development (DFID), with support from the Department of Health in England, assesses the impact of the Department of Health Code for the international recruitment of health professionals.

The main objectives of this evaluation, as set out in the terms of reference, were to assess the impact of the Department of Health Code of Practice (CoP) on developing countries, to identify issues for further study of the impact of the CoP in the UK, and to assess whether the CoP is meeting the objectives originally set out for it.

The two main methods used in meeting these objectives were data and policy analysis and case studies. This chapter is in four further sections:

- Section 2 provides the contextual information necessary to conduct an assessment of the Code, and describes the Code itself and its main objectives
- Section 3 presents an analysis of relevant data on mobility patterns of health professionals
- Section 4 reports on the country case studies
- Section 5 highlights Lessons learned – for developing countries and for the UK including effectiveness of monitoring or ‘policing’ of the Code of Practice.

2. The Context for the Code: International recruitment to the NHS

Active international recruitment of health professionals was an explicit policy intervention by the Department of Health in England, as one key element in achieving rapid staffing growth, particularly in the period 2000 to 2005. The approaches used to international recruitment have varied for different occupations.

The recruitment of doctors to the NHS in England was centrally co-ordinated by the Department of Health but was individualised and targeted and has been supported by a range of initiatives. The Department of Health in England established a number of entry routes to support NHS Trusts to recruit consultants and other medical staff into the NHS, and contracted a specialist recruitment agency. Recruitment activity was focused on North America, “approved areas” of the Middle East, Australia, New Zealand and Europe (including Spain, Germany, Italy, Switzerland, Austria and Poland), as well as India.

In contrast to the ‘individualised’ structured approaches used to recruit doctors, the methods used by NHS employers to recruit nurses and other health professionals tend to be based on recruiting ‘batches’ of ten, twenty, fifty or more at a time from a specific country, often using recruitment agencies. The recruitment activity of individual NHS employers was supported by a regional network of international recruitment co-ordinators, who were based within the Strategic Health Authorities (SHA’s). The level of reliance on international nurse recruits was extremely high in some NHS Trusts, particularly in the South East of England (Buchan, 2003). In terms of active recruitment of nurses by the NHS employers in recent years, the Philippines, India and Australia had been the most common source countries.
With subsequent growth in the numbers of nurses and medical staff emerging from UK based education, and with financial difficulties hitting some trusts in England in 2006, the level of international recruitment has dropped significantly since early 2006. The Department of Health announced on 7 March 2006 that from 3 April 2006 International Medical Graduates (IMGs) - who are not UK or EEA nationals - wishing to work or train in the UK would need a work permit. This is a requirement. To obtain a work permit an employer must show that a genuine vacancy exists, which cannot be filled by a doctor who is a UK or EEA national. Similar changes were announced for junior physiotherapy posts in July 2005 and for general clinical nursing posts in July 2006. Removal from the Home Office list of “shortage” occupations makes it much more difficult for non EEA healthcare professionals to obtain a work permit to practice in the UK.

Other regulatory and education changes in recent months have also impacted to make entry to the UK more challenging. Since September 2005 all non EU international applicants who apply to the UK Nurses and Midwives Council (NMC) have been required to undertake all or part of a 20 day Overseas Nurses Programme (ONP), and from 1st February 2007, all non EU applicants (including those from English speaking countries) must have completed and provide evidence of a score of 7.0 or more on the British Council International English Language Test (IELTS)/IPD Australia before submitting their application to the NMC. These requirements have added cost and time to the application process.

**The Context for the Code**

| Rapid growth in NHS international recruitment activity 2000-2005 |
| Co-ordinated, targeted efforts with specific countries |

| Rapid downturn in active international recruitment from 2006 as a result of growth in availability of new home trained staff, NHS financial difficulties and regulatory and educational changes |

**The Department of Health Code of Practice**

The Department of Health in England first attempted to limit the potential negative impact of international recruitment of health professionals in 1999. It established guidelines which required NHS employers not to target recruit activities in South Africa and the West Indies (Department of Health 1999). It then introduced a Code of Practice for international recruitment for NHS employers in 2001 (Department of Health 2001). The Code issued in 2001 required NHS employers not to actively recruit from developing countries, unless there was government-to-government agreement. A full list of these countries was made available to NHS employers in early 2003. The Code was strengthened in 2004, and extended to cover recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector organisations providing services to the NHS (Department of Health 2004).

Any assessment of the impact of DH intervention on international recruitment activity must take account of these four points in the timeline:

**The 2004 Code: What is it?**

The key points of the Code, issued by the Department of Health in England, are:
Developing countries should not be targeted for active recruitment by the NHS unless the government of that country formally agrees. The list of developing countries is provided.

NHS employers should only use recruitment agencies that have agreed to comply with the Code.

NHS employers should consider regional collaboration in international recruitment activities.

Staff recruited from abroad have the same legal protection as other employees.

Staff recruited from abroad should have the same access to further training as other employees.

The Code “promotes high standards of practice in the ethical international recruitment of healthcare professionals. All employers are strongly commended to adhere to this code of practice” (Department of Health 2004). The foreword to the Code notes that “The international mobility of healthcare professionals is a well established practice that has been going on for many years. More recent times have seen an increasingly large-scale, targeted international recruitment approach by many developed countries to address domestic shortages. This can benefit the healthcare professional in terms of enriching experience and a chance to increase their quality of life. However, concerns related to the impact this may have upon the healthcare systems of developing countries also need to be addressed” (Department of Health 2004).

The list of countries was developed by the Department of Health in discussion with DFID. The list is based on the OECD Development Assistance Committee list of aid recipients. It also includes countries from which the UK has agreed not to recruit. “The rationale for the list is based on the economic status of the countries and how many health professionals are available”. At the time of writing the list includes 154 countries. Three countries on the list have been exempted on the basis of bilateral agreements:

**China** (“The Chinese government have asked that China be removed from this list but requested no recruitment should take place in rural areas”)

**India** (“After discussions with DFID and High Commission in India, we can confirm that agencies can recruit healthcare professionals from India. However there are four states that receive DFID aid and should not be targeted for recruitment. These are Andhra Pradesh, Madhya Pradesh, Orissa, and West Bengal”)

**Philippines** (There is a Memorandum of Understanding between the UK and Philippine governments to enable the UK to recruit registered nurses and other healthcare professionals. Other healthcare professionals refers to physiotherapists, radiographers, occupational therapists, biomedical scientists and other allied health professionals that are regulated by appropriate professionals bodies in both countries)

There are therefore currently 151 countries on the list that are “no go” for NHS England active recruitment, and three where active recruitment is acceptable, within defined constraints. The list has been periodically reviewed. At the time of writing it was last updated on 7th March 2005, and last reviewed on 27th June 2006.
The focus of the Code is on channeling and directing NHS related recruitment activity away from defined countries, as well as to specified countries. It aims to prevent “active” recruitment initiated by the NHS, in the countries specified in the list which is maintained on the website of the Department of Health (and, more recently, on the website of NHS Employers, the organisation that has taken on responsibility for day to day aspects of recruitment practice in the NHS in England). It is directed at NHS employers in England, recruitment agencies commissioned to recruit staff on behalf of NHS employers, temporary staffing agencies providing staff to NHS employers, and private sector employers in England if they are providing NHS funded care.

The NHS in Scotland has issued its own Code on international recruitment, and has begun active monitoring of NHS international recruitment activity (Scottish Executive, 2006). The NHS in England has not conducted standard or systematic central monitoring of the numbers of nurses being recruited by the NHS. The House of Commons International Development Committee in a report on migration and development recommended that data on the number of overseas nurses should be collected by the NHS, stating that the absence of this information “is a gaping hole in the evidence base for policies relating to migration and development” (House of Commons International Development Committee, 2004).

As well as active recruitment, there are four types of “passive” recruitment which have contributed to increasing the number of international health workers coming to the NHS in England, but have not cut across the Department of Health Code:

- some international staff are employed after they take the initiative to apply for employment, whilst located abroad;
- some “international” workers will already be resident in the UK, but not yet in employment such as refugees;
- some health workers will move jobs relatively quickly once they have arrived in the UK. In some cases they have been recruited initially by independent sector employers (outside of coverage of the Code) who have charged a fee, and offered them an adaptation course, but they have then moved onto NHS employment (see e.g Buchan et al, 2005);
- increased access to employment opportunities have been facilitated by access to the Internet, and web based advertising. In this situation, the employer may not be directly “active” in beginning the recruitment process.

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<tr>
<th>The 2004 Code covers:</th>
<th>The 2004 Code does not cover</th>
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<tr>
<td>NHS employers in England, recruitment agencies working on behalf of the NHS, temporary staff working in the NHS, private sector health care organisations providing care to the NHS</td>
<td>Other private sector health care organisations in England</td>
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<td>Prevents active direct recruitment of health professionals from 151 countries specified on the list</td>
<td>The NHS in Northern Ireland, Scotland and Wales</td>
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<td></td>
<td>Active recruitment from non list countries and from the 3 countries (China, India, Philippines) currently exempted</td>
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<td>Employee led recruitment/ “passive” recruitment</td>
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Health professionals coming to NHS England for education/training

It is important to note, therefore, that The Code does not cover private sector employers (unless they are involved in providing services to the NHS) and does not prevent health professionals from countries on the list taking the initiative to apply for employment in England, or to come for training purposes.

The limitations in the Code, set out above, relate to the limits of its application and coverage. There is another limitation which relates to external perceptions of the Code. There is an assumption made by some commentators, both in the UK and elsewhere, that the Code sets out to "prevent" all international recruitment from developing countries, but in reality it does no such thing.

Employer level information
The DH in England records the number of international doctors it employs, but does not do so for other health professional occupations. Whilst some individual NHS employers can give a precise figure for the number of international nurses and other health professionals in their employment, others cannot estimate. As there is no central requirement for standard data on nationality or country of training of nurses, each Trust can record this information in whatever form it wishes.

NHS recruitment managers in the seven NHS Trusts interviewed in 2002 reported generally that the 2001 Code was helpful in setting out the steps in an effective approach to international recruitment (‘very good…clear and balanced’, ‘fairly straightforward…supports good practice’) (Buchan, 2003). The main limitation identified by these NHS respondents was the absence of a detailed list of specified countries (as noted above the full list of ‘proscribed’ countries was not available on the relevant website until 2003). All the managers interviewed were in favour of detailed guidelines setting out which source countries were, or were not ‘ethical’ sources.

3. Data analysis: Tracking NHS international recruitment activity
Against this backdrop of rapid growth, and then decline in international recruitment activity to the NHS, what data sources can enable an assessment of flows of health professionals into the UK? And how useful is this data in evaluating the impact of the Code?

Two main sources of data are examined in this report to examine trends in inflow of health professionals from other countries.

Firstly, registration data from the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) are examined. All doctors and nurses who wish to practice in the UK must be registered with the relevant UK body. As such, the registration data give information on the annual number of “new” registrants from other countries. This enables trends to be assessed. The GMC records country of qualification, the NMC the country of application. However there are limitations with the data – the main constraint is that the data only show the individual has been registered- they do not necessarily mean they have actually come to the UK and are practising in the UK.

The second source of information is the inflow data on applications for work permits.
Most non-UK applicants for employment from countries outside the European Union/
European Economic Area (EU/EEA) who wish to take up employment in the UK are required to obtain a work permit. Work permit data can therefore be used as another source of information on trends in inflow from non-EU/EEA countries. Work permits are issued for a specified period of time.

Data from both data sources are best analysed over time, as year on year fluctuations may be the result of data collection delays, backlog in registration activity etc.

The data analysed in this section is presented in graphical form for ease of assessment, and is normally categorised in four types of “source” country:
- UK (where the individual was trained in a UK institution);
- other “developed” countries;
- “developing” countries that have requested exemption from list coverage of the Code (India, Philippines, China);
- and the “list” countries- those that are on the list of countries proscribed for active NHS recruitment activity.

In assessing the impact of the Code, it has to be borne in mind that there is no single date to focus on, as there have been variations of the Code in use since 1999. Four milestone dates to consider are:

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<th>Year</th>
<th>Event</th>
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<td>1999</td>
<td>DH requires NHS employers not to target South Africa and the West Indies</td>
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<tr>
<td>2001</td>
<td>DH issues Code- requires NHS employers not to actively recruit from developing countries unless a bilateral agreement exists</td>
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<tr>
<td>2003</td>
<td>DH/DFID list of “developing countries” made available to NHS employers</td>
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<tr>
<td>2004</td>
<td>DH issues revised Code – now also covers recruitment agencies, temporary staff and private sector employers providing NHS funded care</td>
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As the main area of interest for this report is to examine any evidence of impact of the Code on recruitment patterns from developing countries, the primary focus is on the trend in flow of health professionals from countries covered by the list, both in terms of actual numbers, year on year, and as a % of overall flow. In assessing these trends, it is also important to highlight any other factors which will have had an impact on these trends.

Registration data
Figure 1 presents the registration data for doctors. The “spike” in registration in 2003 is reportedly a result of changes to the Medical Act (Statutory Instrument 2002/3135) which was to come into effect at the end of 2003 and accelerated applications from university graduates of certain universities in specified countries- Australia, New Zealand, South Africa, Singapore, West Indies, Malaysia and Hong Kong. Overall, the trends in registration data show that most fluctuation in recent years has been in the “other developed” country category. There has been little change in the annual number of registrants from the “list” countries- which has varied between 1,800 and 2,200 in recent years. Figure 2 below presents the same data in % format.
Figure 3 below, presents the registration data for nurses (in practice very few midwives have been registered from “list” countries). The peak year for nurse registrants from overseas sources was 2001/2. In the period between 2001/2 and 2005/6 the annual number of nurses registering from “list” countries has declined by more than half, the annual number from list exempt countries by more than one third, whilst the annual number registering from UK sources has increased by more than 40%.

Work permit data

Work permit data are not directly comparable with registration data. They cover calendar years (registration data for nurses cover the period April to March); they exclude individuals from EU countries, and they only provide data on non UK sources, so cannot be used to assess the relative contribution of “new” UK sources in overall numbers of new registrants. They are also more narrowly focused on employment as a reason for entry to the UK, rather than the broader range of reasons why an individual may wish registration (as precursor to training for example). This narrower focus on entry reasons which require a UK employer sponsor may mean that work permit data are a more helpful source than registration data, in relation to assessing the impact of the Code. [Note: data were supplied by Work Permits UK, who requested that the following be noted: “figures quoted are not provided under National Statistics protocols. They have been derived from local management information and are therefore provisional and subject to change”]

The number of work permits/first time approvals issued to doctors increased rapidly from 1999 (547) to 2004 (2645) and then declined to 1931 in 2006. Figure 4 presents the data on work permits, shown in % terms by category of source country. The data on the allocation of work permits to doctors which are illustrated in the Figure show some fluctuation between “list” and list exempt countries over the period 2001 to 2006, but no overall trend of change. They show little % change in the relatively low level of doctors from other developed countries that are being issued with permits – less than one in ten per annum (EU countries are not covered by work permit requirements). The overall number of permits being approved for doctors increased and peaked in 2004, and then declined, but there has been no sign of a relative decrease in the % of approvals for applicants from “list” countries in recent years.

The overall annual number of work permit/first permission approvals issued to nurses increased rapidly from 1,918 in 1999, to 15,246 in 2002, and then declined to 10,730 in 2005, with a further marked decline in 2006, to 4,931. The annual % distribution across different types of source country is shown in Figure 5.

As with the data on permits for doctors, there is little sign of any marked trend of change in % of nurses from list countries and from list exempt countries being issued with work permits over the period 2001-2006. The overall annual number of permits has decreased rapidly since 2002, but the list countries do not appear to have experienced a decline relative to the “exempt” countries on the list.

Aggregate data on work permits may conceal significant changes in trends in specific countries. More detail on work permits issued to nurses from three countries is shown in Figure 6.

South Africa has been one of the four main source countries for nurses being registered in the UK in recent years (India, the Philippines and Australia being the others). The data on permits/first permission approvals highlights that the number of approvals for South African nurses peaked in 2002, and has then declined rapidly. The numbers issued for nurses from Ghana and Kenya have been smaller; peak
years were 2002 or 2003, and there has then been some decline in more recent years.

There are only limited data available from source countries to assess if outflow to the UK has changed in recent years. Data from South Africa are shown in Fig 7.

The data shows the number of verifications issued to South African nurses. A verification of qualifications is required if the nurse applies to enter the register of another country, so verification data gives some indication of numbers considering leaving a country, and also the preferred destination country. The data show that there has been a reduction in the number of verifications issued since 2003, and those applying for the UK. However there is no sign of a “displacement” of applications away from the UK towards other countries- there has been no increase in applications to other countries such as Australia or USA.

What do these data tell us about the impact of the Code? Firstly the main limitations in interpretation must be noted. These relate to three factors:

- The coverage of the Code
- The impact of other factors
- The constraints on attributing causality

Coverage: As noted above, the Code is targeted only at active recruitment; it was not intended to stop inflow. The data available do not give any information of type of inflow or reason for inflow, and do not differentiate between NHS and non NHS destinations- so it is not possible to identify only those doctors or nurses who have been recruited by the NHS.

Impact of other factors: There have been other factors which will have impacted significantly on trends in inflow- either affecting supply or demand. For example, UK based demand for international recruits will have declined as a result of the rapid reduction in NHS active recruitment since 2005, because of the increased English language requirements for nurses since September 2005 and because of the removal of nurses and doctors from work permit “shortage” categories.

Causality: The data show trends across time. They do not identify reasons for changes in trends. They may pinpoint dates when a change in trend has occurred, but attributing this change trend to one or more causes has to be undertaken with caution.

The data on registrations of doctors and nurses highlight the rapid growth in inflow over the period up to 2001/2 (for nurses), and 2003/4 (for doctors), and subsequent decline. However, because no data are available that pertain only to numbers actively recruited by the NHS in England, it is not possible to assess the extent to which the Code has directly impacted on the level of active recruitment in target countries. It is clear that there has been a reduction in inflow in the last two years, but it cannot be stated with any certainty how much that decline can be attributed to the impact of the Code – in any case the Code was functioning in its major elements since late 2001. What can be stated with certainty is that other factors – notably the reduction in active international recruitment as a result of increases in home based training, reduced vacancies and financial difficulties in some NHS trusts- will also have had an effect on reduced inflow.
Case studies

1. Introduction

The terms of reference for the case studies were to:

1. Identify and report on data on flows (direction and quantity) of health professionals
2. Identify what factors are most likely to change the flows of health professionals from developing countries – including the Code of Practice
3. Discuss the international policy context of health workers recruitment and migration and identify current knowledge gaps for future research
4. Assess as far as possible whether and how the inclusion of the private/independent sector has made a difference

In the course of the case studies it became apparent that the context of the four questions was complex and that a number of broader factors frame adequate responses to the terms of reference. The reports that follow are not structured according to the questions, but the questions are returned to explicitly in the concluding section.
Kenya case study

Barbara McPake and George Rae

1. Kenyan context

1.1 Stock and flows of health workers within Kenya
There appears to be no central data base compiling the numbers of nurses being trained each year. We were given estimates of 500 per year graduating with diplomas and 150/year graduating with BSN degrees. The number of doctors produced each year is approximately 350.

Clemens and Pettersson (2006) estimate the number of Kenyan doctors and nurses within the country as 3,855 and 26,267 respectively. These estimates are based on census data, and this was said to be the most reliable estimate by the USAID funded Capacity Project representative that we spoke to. Numbers estimated for the World Health Report (2006) are rather higher at 4,506 and 37,113 respectively.

Although a project located at the Nursing Council of Kenya and supported by CDC and Emory University aims to establish a data base of the stocks and flows of nurses, and there are proposals to extend this data base to cover doctors, at this date the data are only partially compiled and to date include only about 12,500 nurses working in the public sector (not necessarily the total public sector employment). This data base will eventually be able to break down the numbers of doctors and nurses by employment status, demographic variables and year of training.

We were unable to obtain data on the numbers of unemployed nurses or doctors, although it is considered that there is considerable unemployment among nurses and the figure 7,000 unemployed nurses was cited by some. There may be no unemployed doctors, however some may be undertaking their internships on a voluntary basis because of the absence of approved posts, matched with budgeted salaries in the Government. The Capacity Project’s recruitment exercise received applications from 2,064 unemployed but qualified health workers of various professions. In contrast, it is thought that there are not unemployed doctors and said that when it came to the government’s attention that there were 300 unemployed doctors, recurrent budget was increased to allow their absorption into the public service.

There is an apparent contradiction in the position that Kenya is a country that suffers from an acute shortage of nurses and the reported unemployment rate. This arises because the Kenyan economy does not employ sufficient nurses to meet the WHO standard of the minimum appropriate level. Economic definition of shortage (demand greater than supply) and medical definition of shortage (sufficient human resource to achieve public health targets) diverge.

However, there is an expanding public sector employment of both doctors and nurses with the public sector reported to have increased its recruitment of doctors and nurses last year by 300 and 3000 respectively. (This latter figure emphasises the importance of an up to date estimate of nurse employment.)
1.2 Internal distribution of the labour force.

There is unequal distribution of the labour force between urban and rural and especially 'hard-to-reach' parts of the country.

Within the public sector, deployment procedures appear to be the source of the problem. Health workers appear able to renegotiate their posting using various strategies, something that results in over-staffing in most urban Hospitals particularly those in Nairobi and Mombassa and under-staffing nearly everywhere else.

The situation has deteriorated further as a result of changing relative reimbursement packages between the faith based organisation (FBO) sector and the public sector, with the latter paying significantly higher wages. The FBO sector dominates provision in the most hard-to-reach parts of the county.

According to one source, the FBO sector’s total reimbursement package (worth approximately K.Sh. 12,000) is now worth only about one half of that in the public sector (worth approximately K.Sh. 27,000). Such comparisons are complex, and we were not able to verify these estimates. It was also stated that nurses in the FBO sector could fail to receive their wages if receipts at the relevant health facility were insufficient.

Lax supervision in the public sector, especially in over-staffed Nairobi facilities is claimed to make these differences more acute. It is claimed to be possible, by being scheduled to work night duties, to be largely absent from post and manage a second job or a course of study.

Nurses have tended to leave the FBO sector for the public sector rather than migrate directly from FBO employment outside Kenya. The main impact is felt as the loss of trained nurses and the ability to recruit only trainees.

It has become very difficult for the FBO sector to recruit nurses under these terms, even from the pool of unemployed nurses. A representative of Christian Health Association of Kenya (CHAK) mentioned a hospital that had advertised extensively and failed to recruit, and was currently trying (but apparently failing) to negotiate with the Nursing Council of Kenya (NCK), the entry of a Tanzanian nurse.

An emergency hire programme supported by the Presidential Emergency Plan for AIDS Relief (PEPFAR), the Clinton Foundation, and the Global Fund for AIDS, TB and malaria (GFATM) and the Government of Kenya recruited an estimate of 3000 nurses, mostly to serve in rural areas in both the Government and FBO health facilities, in 2006.

The PEPFAR emergency hire programme was implemented by the Capacity Project and recruited 830 nurses and other health professionals to work in 193 sites, 26 of which were able to open as a result of this gesture. It received approximately 7000 applications for these posts, funded only at allowable public sector rates (albeit with maximum allowances). This suggests that it is possible to staff hard to reach areas at reasonable reimbursement rates. The contracts offered were fixed term (3 year) with no possibilities of redeployment. 60 of the recruits were received by FBOs. The Ministry of Health plans to integrate the emergency hired nurses into the public health workforce at the end of the contracts, although this was not advertised.

Two large Kenya Ecumenical Council (KEC) hospitals have closed in the last year. While difficulties of recruitment are mentioned, the main cause of closure was explained to be financial difficulties. This will further worsen human resource
distribution in the country and remove services from some large areas of the country. One of the KEC hospitals (Kilgoris in Transmara) has been an important training facility. As a training school, it remains open only to attain the completion of training of the current cohort of nursing students.

A Ministry of Health subvention paid to FBOs, estimated to have subsidised to the extent of 25% was removed in the late 1990s. After a period of no support, the Ministry of Health now seconds some staff to FBOs, but it is often difficult to retain these secondeeis who are able to negotiate redeployment.

In KEC, morale difficulties arising from the terms and condition differences between differently hired staff members were acknowledged. The CHAK representative did not consider that problem had emerged.

1.3 External migration of doctors and nurses.
The only internal source of data on doctor migration is the numbers seeking ‘Certificates of Good Standing’ from the Kenya Medical and Dental Association. These are required for doctors who are planning to practice outside the country or go abroad for postgraduate medical training. A register of these has only recently been started to be compiled, and shows that 28 doctors had sought these letters since 6th February 2007, with an additional 3 said to be in process. This equates to approximately one doctor every 4 days. These certificates expire after six months but this should not affect the data for the 4 month period reviewed.

While this number is relatively small, so is the total number of doctors. Clemens and Pettersson (2006) estimate the total number of Kenyan doctors practising outside Kenya as 3,975, 56% of the total stock of doctors estimated. 2,733 of these are estimated to be practising in the UK. These are probably over-estimates of Kenyan trained doctors practising outside because they include all those of Kenyan birth, including those who migrated as children or before basic training.

Training is the usual vehicle by which doctors migrate – it was said to be relatively rare for a doctor to migrate directly to an overseas post other than a training post, or to set up an overseas private practice.

Table 1 presents data compiled by the Nursing Council of Kenya on number of nurses whose qualifications were verified between January 1993 and December 2006. Nurses require qualification verification as part of the registration process in a second country.

The table shows that verification numbers peaked in 2003 at 940, having first dipped from the 2001 level in 2002. This reflects a peak in the numbers seeking verification for exit to the UK in 2001, and a peak in the numbers seeking verification for exit to the USA in 2003. In both countries, numbers have fallen sharply since their peaks. The evidence that sharp falls have occurred in both the UK and the USA is not supportive of an explanation based on UK policy alone.

Clemens and Pettersson’s (2006) data indicate that there are 26,267 nurses in Kenya, 1,336 Kenyan nurses in the UK and 2,372 nurses, or 8% of the total stock practising outside Kenya altogether. This suggests that fewer nurses than doctors have left Kenya, suggesting a contrasting picture to the data we were able to collect in country. Our data relate to flows and Clemens and Pettersson’s to stocks and it is possible in principle that the difference relates to the period earlier than our flow data. However, the views of those interviewed do not support that explanation.
Table 1: Total number of nurses verified to apply for foreign registration from January 1993 to December 2006

<table>
<thead>
<tr>
<th>Country</th>
<th>1993</th>
<th>94</th>
<th>95</th>
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<th>04</th>
<th>05</th>
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<tr>
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<td>10</td>
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<td>6</td>
<td>9</td>
<td>8</td>
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<td>1</td>
</tr>
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<td>2</td>
<td>1</td>
<td>0</td>
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<td>6</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
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<td>50</td>
<td>56</td>
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<td>10</td>
<td>15</td>
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<td>59</td>
<td>94</td>
<td>64</td>
<td>41</td>
<td>39</td>
<td>4769</td>
</tr>
</tbody>
</table>

NB. Totals have been adjusted to add correctly. The table provided cites the total number of nurses verified over the period as 4783.

We were offered multiple explanations of the trends observed in relation to the UK, few of which appeared to make a connection to the Code of Practice.

Better pay and conditions for doctors and to a lesser extent nurses were argued to provide some of the explanation. However, a paper published in 2006, based on analysis of the preliminary data available from the NCK/Emory/CDC data base indicates that 50% of nurses want to migrate.

Greater difficulties in achieving access to the UK labour market dominated explanations. These include:

- Greater difficulties in obtaining visas. The categories of general nurse and general doctor have been removed from the list of occupations in short supply by the Home Office in the last two years. This implies that work permits and working visas will only be issued if the entrant has identified an employer and that employer is willing to support the entrant’s application for a work permit. Many people interpreted these greater difficulties as being the effect of the Code of Practice.

- More stringent ‘adaptation’ requirements and difficulties in securing placements. Until 2005, registration with the NMC required, apart from verified Kenyan qualifications, a period of UK based ‘supervised practice’. Since September 2005 this process of adaptation requires successful completion of a 20 day Overseas Nurses Programme (ONP) which includes class based course and completion of an adaptation placement, and an increased pass requirement in English language proficiency (since increased further in February 2007). The ONP is perceived as expensive and placements are perceived as virtually impossible to identify, perhaps because of the change to migration rules.

- Increased total costs of the process. In part because of the difficulties addressed in the previous two paragraphs, total costs of emigrating have
increased. These were estimated by the Silver Ray recruitment agency to total as follows: K.Sh. 5,000 to NCK for verification (some nurses have to pay K.Sh. 10,000 for verification of 2 qualifications); £140 to register with the NMC in the UK; K.Sh 15,000 for the IELTS English language test; K.Sh 1-3,000 for copy of transcript from training school; Air ticket at least K.Sh 50,000 and adaptation course £2-4,000. At K.Sh. 100 = £1, these costs amount to approximately £3-5,000 – the lower estimate roughly equal to the annual income of a public sector nurse.

These costs are non-refundable in the case that the test is failed (visa, IELTS) or in the case that the nurse is unable to complete the whole package of transactions required to achieve the move.

It was said that the UK NMC does not warn those registering that the chances of obtaining visa and adaptation placements are slim when accepting payments for registration. An NMC news page attached to documentation provided by the Hope Institute (see below) states ‘We won’t hide the fact that this is a difficult process, and not every applicant succeeds. We send out several thousand initial overseas application packs every year but because it could take up to two and half years from point of application to getting on the Register, it is impossible to say just how many are unsuccessful because their level of skill didn’t meet our standards’. The tone of the news page is otherwise very encouraging. While this could be argued to provide warning, it implies that the only constraint applicants will meet is that of demonstrating adequate skill levels.

Data do not allow analysis of the characteristics of nurses migrating. Several informants considered that the first wave of nurses who migrated were retirees, generating income to provide for a pension. In the public system the retirement age is 55. It is said that more recent emigrants are younger – new graduates who are not absorbed into the public system. It was said that BSN graduates have found it difficult to be absorbed in a public system that has not adjusted to accommodate this higher qualification that was available to nurses when it was designed. Some argue that the emigrants are the 'best' nurses – variously, because these are the ones with qualifications sought in the UK and elsewhere or because they are the more entrepreneurial 'risk takers'. One nurse described the perception that she was viewed by others as a failure because she had stayed.

### 1.4 Developments in availability of evidence

The NCK/Emory/CDC data base will make an important contribution to the ability to monitor the human resource situation in country.

The Institute of Migration is commissioning a series of studies to improve the evidence base for understanding the health workforce and migration situation.

The first study is a policy review involving the analysis of legislative context in health, labour and migration for the management of migration of health workers. This study is ongoing, has been contracted to an independent consultant and a preliminary report is under review by IoM before release.

The second is an analysis of trends, magnitudes, dynamics, data collection and management. It is likely to be contracted as an adjunct to the NCK/Emory/CDC exercise and will focus on an identification of who collects and retains what elements of data relevant to the issue, and what gaps exist. This has not yet been commissioned.
The third is an analysis of the impacts on health service delivery of migration. This has yet to be commissioned and will be co-funded by Equinet.

1.5 Developments in human resource policy
The policy direction indicated by the current Health Sector Strategic Plan (HSSP) is to emphasise strengthening the lowest levels ('level 1' and 'level 2') of the system which are the community and most basic facility levels. These levels require increased numbers of community health workers and nurses and clinical officers with the most basic qualifications. It is recognised that this conflicts with the professional aspirations of health workers, and that emphasising this direction in personnel management may provide further impetus to migration.

1.6 Relevance of context for review
It can be concluded from these contextual characteristics that migration is not the major factor driving health worker shortages that arise only in remoter, rural parts of Kenya. While some argue that public training resources are squandered in the process, it is not clear that they would not be equally squandered by the failure to absorb trained nurses who have migrated, into the labour force. There appears to be a greater willingness on the part of the Ministry of Health to ensure all available doctors are absorbed into the labour force, but it is not clear that this would be feasible if all Kenyan trained doctors were available in Kenya, nor that this would be consistent with the direction advanced by the HSSP.

The Code of Practice may not best be judged by its impact on a migration that is not viewed as a problem by most informants. In section 2, we consider its impact in terms of the extent to which it may be associated with a reduction in the inappropriate recruitment activities it seeks to curb.

2. Code of practice: evaluation of impact

2.1 Evidence on extent of active recruitment and trend
Many respondents commented on a history in the country of very active recruitment on behalf (direct or indirect) of the UK NHS. They remembered seminars in hotels, visiting agents, and newspaper advertisements.

Two private hospitals in Nairobi, managed by ex-patriate British hospital directors, were reputed to have in the past encouraged staff of those hospitals – doctors and nurses – to pursue opportunities in the UK. There was no knowledge of the rationale for that encouragement among those who talked about it.

These activities were mostly believed not to be occurring still on behalf of the UK. Although some respondents thought they had recently seen job or hotel seminar advertisements, they tended not to be sure on what country’s behalf those advertisements had been placed.

One respondent had been collecting information about migration to the UK on behalf of a rural nurse colleague on the day we spoke to her. The information collected related to a course offered by the Hope Institute in Leeds which promises to enable nurses to overcome the barriers enumerated in 1.3 to entry to the UK. It supports students to improve their IELTS scores, obtain places on adaptation courses and work experience in the UK, open bank accounts and obtain National Insurance numbers.

We spoke to a recruitment agency, the Silver Ray, which used to support many nurses who wanted to migrate to the UK. The manager of the agency stated that she
would no longer advise nurses to consider the UK but would point them in the
direction of the USA or Australia instead. She cited many of the difficulties listed in
section 1.3 as reasons for this advice.

Some nursing specialties, such as mental health nursing are still on the list of
professions in short supply but there are very few of these in Kenya.

She used to work through agencies in the UK on some occasions. She believes one,
In-touch care, is the only one still actively recruiting, but will only deal directly with
nurses. It seems that its interpretation of the code of practice is that it should not deal
with Kenyan based agencies.

2.2 Evidence of unscrupulous agent activity
We heard very few accounts of unscrupulous agent activity. This was thought
probably not extensive in relation to professional migration but largely to be a
problem associated with the unskilled labour force. It was agreed however, that those
who felt ‘duped’ would probably prefer to conceal the fact.

However, it was perceived as unethical to recruit qualified professional nurses for
relatively unskilled jobs in nursing homes and similar. A number of respondents were
conscious that Kenyan nurses had found themselves working in such jobs and this
was considered demeaning and exploitative. While it is not clear that any of these
nurses have been deliberately misled, the tone of invitation from the NMC, and the
advertising of the Hope Institute certainly give no warning that this is a possible
outcome of entry into the UK labour market. Whether or not this is unscrupulous
depends on the likelihood that those to whom they are appealing are likely to end up
in this situation.

2.3 Explanation of falling migration to the UK
From all the foregoing, we judge it unlikely that the Code of Practice has played a
significant role in falling migration to the UK. The most powerful explanation of the
migration trend is the set of more binding constraints enumerated in section 1.3.
Additionally, the group of nurses we talked to spoke of being increasingly aware of
adverse conditions of work including racism, and the cost of living in the UK, and of
the improved conditions for nurses in Kenya.

2.4 Perceptions of the desirability of Code
It was not a unanimous view among stakeholders that it is better to be on the Code of
Practice list than not. Respondents spoke of the human rights of health
professionals to benefit from the international labour market and were generally not
sympathetic to limits to the circulation of information on that point.

Many pointed to the pool of unemployed nurses in defence of the view that there was
not a conflict between societal well being and individuals’ human rights. Others
mentioned the advantages of professional mobility that accrue to Kenya: remittances,
and educational benefits that returnees bring to the Kenyan health sector.

Others, who considered that migration was a problem on the grounds that it
constituted an exploitation of Government of Kenya public investment believed that
the Code was insufficient. A stronger agreement, such as was believed to be in place
between the UK and South Africa was mentioned, as was the need for the UK to
balance its own labour market through training and paying adequately.

Information about the Code was often absent or distorted. Some believed that the
Code was responsible for the various constraints listed in section 1.3. Viewed thus, it
was considered discriminatory or even racist by some, and by others presaged on the rationale that the UK was trying to exclude people it perceived as carrying HIV infection.

No respondent appeared to have been directly consulted concerning the Code or whether or not Kenya should be included in the list of developing countries attached to it. One respondent, thought some discussion had taken place in the Ministry of Labour. The view that it had not been designed with Kenya’s situation in mind was expressed by some respondents.

3. Lessons learned

3.1 Need for dissemination and flexibility
The limited knowledge of the code among respondents, and the misconceptions about its provisions and intentions by those who had heard of it, suggest that better communication was needed to avoid the damage to Britain’s reputation associated with perceptions of discriminatory intent.

A consultation process in country as to how the UK can best support Kenyan human resource policy would help to ensure that such misconception was reduced. Perhaps more importantly it would help to tailor the UK’s approach to the specific conditions in Kenya, rather than a generalised perception of conditions in Africa that may not match those of individual countries. While this process has no doubt already occurred in relation to the use of UK aid and the content of Kenyan government policy, it should also include discussion of measures that can be taken by the UK government and NHS in the UK. Such a consultation would most feasibly be initiated by DFID.

3.2 Potential alternative approaches
Many respondents considered that the most constructive intervention that the UK Government could make would be to develop government to government agreements over the exchange of health professionals. At present there are agreements between the Government of Kenya and those of Sudan and Namibia of this type. Any such developments would need to recognise immigration and visa and work permit rules, and that these could not be arbitrarily varied for health professionals in general or for the specific health professionals included in the scheme. Those who earned entitlements through normal routes could not have these removed for the purposes of the scheme. Hospital to hospital agreements may be slightly easier to manage because hospitals can stipulate the length of contract offered, but similar problems apply.

It was recognised that there may be differing comparative advantages in training of health professionals between Kenya and the UK that current patterns of migration reflect. Basic training in Kenya may be lower cost at comparable quality, making it cost-efficient for the NHS to recruit nurses trained in Kenya. Similarly, pursuit of post graduate training opportunities in the UK may suggest that the UK has comparative advantage at that stage of the process. Another type of constructive engagement possible from the UK would be investment in basic nursing and other health professional training in Kenya that would both recognise the benefits that the NHS gains from Kenyan public investment in training and directly benefit the NHS by adding further to the quality of training.

There were some suggestions about how the code might be extended to accommodate additional areas of activity and additional stakeholders.
The behaviour of a number of stakeholders in the migration process is not targeted by the code. This includes the behaviour of training schools offering courses like those of the Hope Institute, the Nursing and Midwifery Council and the General Medical Council whose responsibilities after accepting application for registration payments are not addressed, the Nursing Council of Kenya and the Kenyan Medical Association whose responsibilities in exchange for fees related to verification and letters of good standing are not addressed, and the Kenyan Association of Private Employment Agencies, who could potentially play a supportive role. Further definition of codes of good practice in relation to the operation of these bodies could ensure that migration that does take place is ‘informed migration’ and that lack of information about the likelihood of ultimate success in migration is not exploited when fees for different stages of the process are collected.

Some respondents argued for a ‘stronger’ code which they perceive to be in place in the agreement between South Africa and the UK. This is not supported by the more commonly held view that Kenya is not overall disadvantaged by health professional migration.

An effectively opposing view was that if interested recruiters are prevented from actively disseminating information about how to benefit from the global health labour market, a party perceived as disinterested should do so in its place. One suggestion was the British High Commission.

There are also measures that the Government of Kenya could take to support workforce balance. The code of regulation of civil servants explicitly rules out (we were told) the return of civil servants to the public system at any higher grade than the one they left. This prevents recognition of education and experience gained overseas and confronts potential returnees with the prospect of working at the same level of those who were their juniors when they left. Some potential returnees are likely to be dissuaded by these provisions.

While Kenya loses many health professionals to international migration, it gains few. This seems to be as much by policy design as by market forces. We were told that there are many doctors from the Indian sub-continent who would like to practice in Kenya but who are refused registration with regard to their competence levels. The rationale for this appears to be protectionism of the medical market for Kenyan practitioners, but this sits incompatibly with a concern for emigration.

4. Knowledge gaps

4.1 Data for monitoring purposes
The NMC/Emory/CDC data base will fill a number of knowledge gaps that will improve the capacity to monitor migration trends, especially if it is successfully extended to doctors. In particular, it will enable analysis of the characteristics of migrating Kenyan health professionals, and the extent to which losses of staff or difficulties of recruitment in those parts of the Kenyan health system in which health workers are scarce can credibly be linked to external migration. It will also enable estimation of the number of unemployed nurses and doctors, and should settle the large discrepancy in estimates from different sources of data about the extent of doctor migration and the relative importance of doctor and nurse migration. All these analyses are critical for the issue at the centre of the Kenyan case study – can migration be considered a net negative factor for Kenyan society?
No monitoring of recruitment activity currently occurs. It would be possible for an organisation such as IoM, the NMC or the KMA, or an NGO such as the Capacity Project to log media advertisements and other publicised events in order to monitor trends in volume and distribution across countries seeking to recruit.

4.2 Mapping of policy, data and regulatory situation and developments
Studies being commissioned by the IoM will also helpfully fill knowledge gaps in relation to policy and legislative context, data sources and availabilities and impacts of migration.

5. Conclusions
This section is structured according to the Terms of Reference for the case study.

5.1 Identify and report on data on flows (direction and quantity) of health professionals
These have been outlined as far as we were able to obtain access, in Section 1.1 to 1.3, although there are important gaps and inconsistencies. What is clear is that the flow of health professionals out of Kenya has reduced considerably since its peak between 2001 and 2003. The declining trend in nurses seeking verification may be understated by those data to the extent that it has become increasingly difficult for nurses to complete the process of migration after the verification certificate has been obtained.

5.2 Identify what factors are most likely to change the flows of health professionals from developing countries – including the Code of Practice
Changes to labour market conditions and their implications for migration, work permit and visa rules in recipient countries seem most plausibly to explain and predict migratory flows. The Code of Practice has more plausible implications for standards of recruitment practice, although the absence of UK oriented recruitment activity in Kenya linked to the absence of available employment in the UK makes this difficult to assess.

5.3 Discuss the international policy context of health workers recruitment and migration and identify current knowledge gaps for future research
The Kenyan case study was able to explore Kenyan perceptions of the international policy context of health workers recruitment and migration. These have been described, especially in Section 3.4 and suggest that Kenyans are unconvinced that international policy developments aim to benefit Kenyan society rather than discriminate against Kenyan migrants.

A number of areas of policy relevant to the Kenyan human resource and migration situation have been further discussed in Section 4, intended to stimulate further discussion rather than to put forward firm recommendations.

5.3 Assess as far as possible whether and how the inclusion of the private/independent sector has made a difference
Given the difficulties of attributing effect to the Code as a whole, it was not possible to further attribute effect of the further inclusion of the private sector in 2004. One issue raised that is probably connected to this inclusion is the refusal of employment agencies in the UK to deal with employment agencies in Kenya. This is not necessarily helpful, as good Kenyan employment agencies offer sources of current information to would-be migrants and are not necessarily proactive rather than reactive to those who seek their services.
Ghana case study  
Barbara McPake and Kwadwo Mensah

1. Ghana Context
1.1 Stock and flows of health workers within Ghana

The following estimates of trainee intake for 2006-7 were provided by the Nurses and Midwives’ Council for Ghana:

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>2006 intake</th>
<th>2007 intake</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing training college</td>
<td>2279</td>
<td>2269</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Midwifery training school</td>
<td>447</td>
<td>625</td>
<td>+40%</td>
</tr>
<tr>
<td>Community health nursing training school</td>
<td>1701</td>
<td>1507</td>
<td>-11.4%</td>
</tr>
<tr>
<td>Health assistant training school</td>
<td>444</td>
<td>770</td>
<td>+73.4%</td>
</tr>
<tr>
<td>Rural health training school</td>
<td>432</td>
<td>500</td>
<td>+15.7%</td>
</tr>
</tbody>
</table>

Longer term trends for nurses and midwives (1999-2005), also provided by the Nurses and Midwives’ Council for Ghana are shown in figure 8. These show that investment in training both categories has increased considerably over the nine year period concerned, with growth in nursing numbers occurring earlier than growth in midwife numbers.

These data caused one respondent to query whether quality was being maintained in the training schools. Anecdotal complaints mentioned included class sizes of 140 and more, inadequate increase in the number of tutors to cover the larger numbers of trainees and recruitment of under-qualified tutors, over-crowded practicals leaving students volunteering at non-training institutions at weekends to gain experience, failure to invest in the new infrastructure at a pace that reflects the growing student numbers.


The Ghana Health Services estimate that there were 1,446 doctors and 14,507 nurses in 2006. If the difference between these estimates reflects a time trend, rather than a difference in estimation method, it suggests that Ghana has maintained its stocks of both categories of health professional over this 6 year period with slight net gain of doctors and slight net loss of nurses.

The Registrar, Pharmacy council estimated that there were 1600-1800 pharmacists in Ghana. The World Health Report (2006) estimates 1,388.

Numbers of unemployed nurses and doctors are estimated to be insignificant. Both will be absorbed into the Ghana Health Service if they meet entry criteria. There may be a few voluntarily unemployed, or a few who fail to meet criteria, for example because of years of non-practice.

Not all pharmacists are absorbed by the Ghana Health Service and there is no automatic intake of new graduates as for nurses and doctors. Unabsorbed pharmacists are more likely to work in the private sector than be unemployed.
The Ministry of Health, which includes the public services of the Ghana Health Services and private and military sector services estimates the total loss to public, Christian Health Association of Ghana (CHAG) and military health facilities according to figure 9. These total departures of health workers from individual health facilities may move between facilities rather than be lost to the system.

These figures indicate that losses have reduced since 2004 in all categories, having shown an increasing trend between 2001 and 2004 in the cases of nurses/midwives, and medical officers.

Figure 10 gives the breakdown of causes of attrition for years 2004, 2005 and 2006, supplied by the Chief Nursing Officer for all Ghana Health Services facilities. ‘Vacation of post’ is the usual description in the case of migration out of Ghana.

1.2 Internal distribution

Figure 11 shows the population to doctor and nurse ratios by region in 2006. Northern Region has 1 doctor for every 85,957 people while Greater Accra has 1 doctor for every 5,806 people. Nurses are less unevenly distributed. Western region is worst served with a population per nurse of 2,368, and Northern, Brong-Ahafo and Ashanti are nearly as poorly served with populations per nurse of 2,126, 2,036, and 2,136 respectively. The ratio of population to health professional of the best to worse served region is 14.8 for doctors and 2.4 for nurses.

Just under half of district hospitals (53/130) have no pharmacists

1.3 External migration

Sources of estimation of migration from inside Ghana were identified for nurses and pharmacists. The Registrar of the Pharmacy Council collects data on the number of pharmacists who request letters of confirmation of qualifications, presumed to imply an intention to migrate. Numbers from 2000 to 2006 are presented in figure 12 below. This shows that numbers requesting letters reached a peak in 2003 and had stabilised at about half their peak levels between 2004 and 2006.

The Ghana Nursing and Midwives Council collects data concerning nurses seeking verification of qualifications. Data up to 2005 were reported in the West African Journal of Nursing (Darko et al., 2006). These data are reported as figure 13. This shows a declining trend in rate of validation requests from a peak in 2003, with an overall 34.5% reduction between 2003 and 2005.

The Nursing and Midwives Council further reported that validation requests had fallen to 56 in 2006. We queried the reliability of this estimate given its level in relation to the previous year (686), and its explanation and were told that validation requests had indeed fallen to this degree, for a series of reasons discussed below (later this section). Many other respondents agreed that migration was no longer prevalent, especially to the UK.

The same source collects the target destination of validation applications across the four years for which data are analysed. These data are reported as figure 14. The dominant target destination was the UK (71%) followed by the USA (22%).

It was reported that pharmacists migrate in larger numbers to the USA than UK, although data were not available.
Clemens and Pettersson estimated the number of Ghanaian doctors working overseas according to census data as 1,639 in total (56% of all Ghanaian doctors) and 590 in the UK. These are likely to be over-estimates of Ghanaian trained doctors working overseas because they include everyone born in Ghana who now works as a doctor, for example, those who emigrated as children and trained in countries outside Ghana.

Clemens and Pettersson estimated the number of Ghanaian nurses working overseas as 4,766 in total (24% of all Ghanaian nurses), 2,381 in the UK. The same basis of estimation and limitations apply.

There are no data concerning the characteristics of health professionals who are leaving. One respondent considered that it is now younger nurses who are leaving in contrast to the past. It was argued that older nurses have encountered more feedback about the difficulties of working in the UK and are less likely to be able to work there at an appropriate level of seniority.

Two important explanations of these trends were advanced by respondents in Ghana: Government of Ghana policy changes and international labour market changes.

The Government of Ghana have put in place a number of policy measures designed to reduce the rate of migration of health professionals.

There have been significant developments over a number of years in the pay and conditions packages of doctors and other health professionals. At the end of the 1990s, doctors' lobbying and strike activity secured payment of the Additional Daily Hours Allowance that quickly extended to all doctors irrespective of their daily hours and had the effect of an approximate doubling of salary level. This allowance was then consolidated into the salary scale in 2005, as part of a rationalisation and job evaluation process. Nurses and other health professionals also secured large pay increases as part of the same process.

One respondent estimated current pay scales for doctors and nurses. House officers were estimated to receive C7m per month after tax (approximately $800), specialist consultants about C22-24m before tax; nurses between c3.5m and c15m before tax. For nurses this is estimated at approximately a ten-fold increase in pay since 2001.

There are questions about the sustainability of these rates of pay. Some respondents believed that the pay settlements were based on optimism that the National Health Insurance Fund which is currently being initiated will generate sufficient funds, though this was not thought by those respondents to be realistic. If there is a shortfall between the salary bill and available resources, new staff members are likely to wait ever longer periods before being effectively added to the pay bill. There are no changes planned to the automatic absorption of all new nursing and medical graduates. However, a new contract basis of employment in the public sector may present legal difficulties in a solution that delays adding new staff to the pay roll.

The process of developing and implementing the new salary scales appears to have encountered a number of difficulties with the effect that despite the sizes of these settlements, nurses in particular are dissatisfied with the new pay structure on the basis of its changed differentials between nurses and doctors. It is expected that nurses will ultimately receive even larger settlements, although that is not finalised and to date, pay increases have not been implemented while that happens.
Since 2005, new procedures make it more difficult to evade the provision of the bond by which nurses trained with public funds are required to work for 5 years for the Ministry of Health, or repay the cost of training. An updated, more accurate and much higher bond value has been calculated and was reported to be C200m, increased from C2m. Additionally, there is a new agreement between the Nursing and Midwifery Council and the Ministry of Health/Ghana Health Services that certificates of validation will not be issued unless the Ministry/GHS confirms that the Bond has expired or been paid. This is credited by Darko et al. (2006) as the factor underlying the falling migration rate. A group of nurses we interviewed confirmed the importance of this measure as a constraint to migration, although thought that some nurses were still able to evade the provision through personal contacts.

For doctors, similar measures to enforce a bond policy with similar intentions have not been taken. However, other measures have been put in place that constrain migration, according to a group of doctors we interviewed. These include the extension of the period of house officership from one to two years and to include rotation through all 4 major specialties rather than a choice of 2. Doctors may also be directed to a rural posting for a period, although it seems to have become increasingly easy to evade such a posting. It was pointed out by the group of doctors that these measures have the potential to backfire by making migration a more attractive option.

The Ghana College of Physicians and Surgeons was instituted in 2003 to expand provision of post graduate medical training. Among other factors, this development recognised that post graduate medical training opportunities overseas are a major factor in the loss of doctors to the Ghanaian health system. The College has received more applications than it has capacity to accept and is currently dealing with qualified candidates in batches, implying a growing waiting list for places. A greater emphasis on qualifications relative to experience in the new pay scales is seen as partly responsible. It is possible that a higher qualification standard will be set in order to cope with demand. This implies that the College can only partially play the role intended for it. The relative status of the Ghana College compared to the West African College and the London Colleges is yet to be established and will be important in determining the ultimate impact of the College on migration. A further issue raised by one respondent is the effect of the distribution of accredited facilities on the ability to post doctors to rural areas. Urban areas have almost exclusively been accredited as post-graduate training centres.

International market developments have had an apparently equally important impact on migration trends.

As shown in figure 14, the UK has predominated in comparison to other countries as the target destination for nurses, and this is reputed to be the case also for doctors, although data are not available. Hence increasing barriers to entry to the UK were seen by most as the most important explanation of migration trends. The UK was widely perceived as a ‘closed door’ by nursing, medical and pharmacist respondents. The raised barriers identified by respondents included:

- Greater difficulties in obtaining visas and jobs. Almost unanimously, Ghanaians believed these difficulties were related to EU expansion and that new accession European states were securing jobs that had previously been available to Africans
- More stringent ‘adaptation’ requirements and difficulties in securing placements. The UK Nursing and Midwifery Council’s Overseas Nursing Programme, instituted in September 2005 has increased the cost and decreased the opportunities...
greater difficulties in earning as a nurse alongside the adaptation process were said to lead to some having to work in menial jobs to support themselves before registration would be possible; The cost of 'adaptation' was estimated at £2-3,000 by one respondent. Buchan et al. (2005) confirm that almost all nurses coming from Africa, apart from those coming from South Africa are required to complete the Overseas Nursing Programme.

- A perception of difficult conditions in the UK NHS. The UK and Australia were perceived as places where the general public was hostile to Africans, in comparison to the US and Canada.

An additional factor seen to have influenced migration trends is the security situation in Ghana. In the 1980s, concerns about the political situation led Ghanaians to seek stays in the UK that would enable the migrant to obtain a UK passport as security against future instability. Confidence in the current political situation in Ghana may have some more limited influence on the trends in migration, although the falling migration rate appears more clearly a shorter term phenomenon.

It was believed by many that migration to the US would continue to be a major and even growing source of loss of all types of health professional from Ghana. One respondent cited a US conference speaker as saying that the US would have 1 million vacancies for doctors by 2010. There is a more complex regulatory process of migration to the US for both doctors and nurses that have made it a less popular destination than the UK in the past. There are also different medical terminologies to be learned though this was not considered a major issue by the group of doctors. Most important in making the US a less popular destination in the past was perceived to be its further distance and larger scale, making it more difficult for Ghanaians to expect to find a familiar Ghanaian community with which they could relate there. As a source of training opportunities, the US was seen as the most advantageous for a range of specialties, though not all, by the group of doctors.

There is a small degree of medical in-migration to Ghana. Nigeria and Egypt were mentioned as countries from which doctors migrated to Ghana, and there is a Cuban doctor programme that supports services in some remoter locations.

1.4 Developments in human resource policy

The International Organisation for Migration, with the support of the Dutch Embassy is implementing a programme known as MIDA (Migration for Development in Africa). The programme was funded from January 2005 to June 2007 to facilitate the movement of Ghanaian health professionals back from European countries and out of Ghana for training in European countries. It has been implemented on a small scale, with targets of recruiting 30 health professionals to both programmes. The programme component of recruiting Ghanaian diaspora health professionals to assignments in Ghana has been successful and more than filled its quota of places. 37 health professionals have returned to Ghana under the Programme. The (unstated) ultimate objective is that some of these should accept permanent assignments and this seems to have been achieved in at least one case. The components of sending Ghanaian professionals to Europe failed to establish itself because of difficulties of establishing workable systems for ensuring the return of trainees and identifying those with appropriate qualifications.

Little progress has been made in tackling the maldistribution of health professionals across Ghanaian regions. The situation described by figure 11 is deemed to have changed little over the last decade. However, two policies are in early stages of implementation that may tackle this more effectively.
A new cadre of rural health worker has been created, with the capacity to support professional health staff operating in remoter areas. Some doubts were expressed about the feasibility of the plans. Most of those recruited have been younger women who may not be able to operate securely in isolation in these areas. A study of mid level cadre workers more generally is underway\textsuperscript{1}. To date its findings seem to point to a difficulty of retaining these workers in their occupations, although migration outside Ghana does not seem to be the main problem. A second phase of this study will seek to find out more about where these workers are going.

An attempt to better match individuals to the post to which they will be sent is planned by the Ministry of Health. At present, there is in principle, a random system of allocation of graduates to posts within the services of the Ministry. It is planned to introduce a system of interviews so that individuals’ preferences can play some part in the allocation. In the past it has been widely assumed that rural postings are universally unpopular and that random allocation is the only system to identify those who should take them up. It seems now more widely recognised that there are opportunities and advantages in rural postings that have been little appreciated and advertised, and that some rural graduates at least might opt for, or be persuaded to try periods in remoter regions. It is not clear when this system will be introduced.

While there have been some attempts to implement bilateral agreements between the Ghana and UK health services in health professional exchange and training, these have floundered on the difficulties of securing the return of trainees supported to spend periods in the UK. Health Authorities involved in these are viewed as reneging on their commitments. There is as a result some scepticism about the potential for these sorts of arrangements which in part explains the difficulties experienced with the out-migration component of MIDA.

1.5 Relevance of context for review

Out-migration is viewed as an important problem by doctors, nurses and pharmacists among respondents in Ghana. However, opportunities to migrate and benefit from training and other opportunities in the UK and other countries are also universally valued and measures perceived to close those opportunities to Ghanaians are not appreciated.

Shortages of health professionals are almost universal relative to WHO standards in all regions in Ghana. For doctors, they are considerably more acute in remote regions. For nurses, there is less variability. Given the absence of effective policy to attract doctors to rural areas in Ghana, it is not clear that out-migration of doctors, has significant effect on shortages in the most deprived regions. The more equal distribution of nurses suggests that overall numbers available are more likely to be important for availability in the most deprived regions.

Improving retention and return rates, especially of doctors, seems a reasonable policy objective by which the Code and other policies can be judged, although Ghanaian policy makers will not support a policy that curtails rights to international mobility or allows discrimination against Ghanaians in international labour markets.

\textsuperscript{1}Nyonator, F. et al. The mid-level health professional. A study funded by TDR (WHO).
2. Code of practice: evaluation of impact

2.1 Evidence on extent of active recruitment and trend

Recruitment activity was strongly discouraged from the early phases of the mass migration of health professionals. For example, a team from a UK Health Authority who came to recruit Ghanaian health professionals in 1999 were warned by the Ghanaian intelligence service to conduct such activities only in cooperation with Ghanaian health officials.

This may explain why active and open recruitment has not been common even before the period covered by the Code of Practice. The dominant mode of recruitment has been by word of mouth and operating through collegiate networks. Respondents almost universally described the recruitment process in these terms. For example the group of nurses we spoke to were aware of colleagues in Australia and the US who could provide information and contacts if any were interested in jobs in those countries. They did not know whether these colleagues acted only out of a willingness to spread helpful information or whether they would benefit financially from recruitment activity.

It is not clear how the Code of Practice would be anticipated to affect this mode of recruitment.

2.2 Evidence of unscrupulous agent activity

Two respondents were aware of the activities of a professed priest who under the rubric of the African Medical Trust involved himself in the migration of health professionals in the early years of this decade. He claimed to be operating an exchange programme, sending teams of nurses to the UK, took commission from their salaries and did not facilitate their return to Ghana. Nurses in the UK eventually rebelled and found different jobs whose salary payments he could not intercept. His activities eventually came to the notice of the Ghana police and were curtailed.

A NHS Managers’ Conference in 2000 in Birmingham circulated a document: ‘How to undertake international recruitment’ with a picture of Ghanaian nurses on the cover. The Human Resource Director of the Ghana Health Service objected to this as inappropriate and the leaflet was withdrawn.

The ‘duping’ of health professionals was not perceived to have been a common or extreme practice at any stage of the health professional migration trend.

2.3 Explanation of falling migration to the UK

Respondents did not link falling migration to the UK to the Code of Practice but instead to the factors outlined in section 1.3. These place equal weight on Government of Ghana policy which has been appropriate and plausibly effective in deterring health professional migration, and on conditions in the UK health labour market.

2.4 Perceptions of the desirability of Code

In general, measures to reduce recruitment activity in Ghana on behalf of the UK NHS are seen as desirable in Ghana. However, no respondent believed that the Code of Practice had produced a significant effect, and attributed what reduced
recruitment activity they recognised to the reduced employment opportunities in the UK.

The Code of Practice was perceived as linked to the greater constraint to entry to the UK by some, although few respondents were aware of its existence.

A further perception is that the code’s espoused principles of transparency and fairness are flouted by the recruitment of qualified nurses to relatively unqualified roles in nursing homes.

3. Lessons learned

3.1 Potential alternative approaches involving UK participation

Scepticism exists about the potential for collaborative agreements to support professional mobility in modes conducive to workforce balance in the Ghanaian health sector. The MIDA programme offers a model by which the return of health professionals can be facilitated. Although it has so far been active on a modest scale, it offers few of the pitfalls other types of measures have introduced. It is not clear, given modes of ODA agreed between the governments of Ghana and the UK, whether or not there is scope for the UK to support the expansion of this programme. In principle, a partnership between the Ghana and UK National Health Service, operating outside ODA would be a promising basis for a partnership.

One respondent suggested that registration requirements in the UK be extended to require a check that any relevant bonds are paid or expired in any proposed employee’s country of training. This was said to be the case in the US and might form a promising extension to the Code. The Ghana Health Service does not refuse to supply these letters for doctors on the grounds that they could unlikely secure a doctor’s return by refusal, but appreciate the system because it enables them to monitor where Ghanaian doctors are.

It was suggested that the growing numbers of private nursing schools in Ghana could provide a suitable partner for UK investment in Ghanaian training.

3.2. Government of Ghana policy to support retention

Pharmacists were perceived as marginalised and unrecognised in government policy making, and under-valued in the management of the district health system. The differentiated recruitment procedure for pharmacists compared to doctors and nurses was one among many examples of disadvantageous treatment cited. Although data were not available, one respondent estimated that one third of Ghanaian pharmacists were outside the country. If correct, this implies a rate of emigration comparable to the probable over-estimates of Clemens and Pettersson.

Nurses cited problems of inconvenient accommodation, lack of equipment and low pay as reasons for dissatisfaction that lead them to consider migration. Nurses had not yet received the pay increases expected.

These issues highlight the inadequacy of improving remuneration as the sole plank of a policy that aims to increase health professionals’ satisfaction with their work situations. Retention is likely to require further improvements to non-financial aspects of working conditions. Government of Ghana policy is likely to have played some part the maintenance or even growth in health professional numbers in country over the period since 2000.
The new salary structures place increased emphasis on qualifications relative to experience in career progression. Unless there are adequate training opportunities in country, the result may be to encourage migration for further training, with the risk that nurses will not return. The creation of the Ghana College of Physicians and Surgeons recognises this. There is a need to make similar provision for nurses and pharmacists.

In general, there is a need for a stronger policy framework in relation to the expansion of training schools, the funding of pay agreements, and the addressing of health worker distribution.

4. Knowledge gaps

4.1 Data for monitoring purposes

There are limited data covering the migration of doctors, and it is unclear the extent to which requests for verification certificates represent actual numbers emigrating. The operation of a more effective bond system premised on the need for such certificates may change the ratio of verification applications to actual emigrants, as may the greater difficulty of securing registration in the UK, after verification letters have been applied for.

It is not possible to describe the characteristics of emigrants from any professional group in terms of demographics, career stage or last post in country.

There are no data monitoring recruitment activity, in part at least because this activity is covert.

4.2 Mapping of policy, data and regulatory situation and developments

Although we have been able to map on a rapid basis, relevant areas of policy and regulation, and available sources of data, this is not carried out on a regular basis, making it possible to misattribute changes taking place.

5. Conclusions

This section is structured according to the Terms of Reference for the case study.

5.1 Identify and report on data on flows (direction and quantity) of health professionals

These have been outlined in Section 1.1 to 1.3. The flow of nurses and pharmacists out of Ghana appears to have peaked in 2003 and according to respondents, the flow of doctors peaked around the same time. The declining trend in nurses seeking verification may be understated or overstated by those data given other changes taking place in procedures for migration both in Ghana and the UK.

5.2 Identify what factors are most likely to change the flows of health professionals from developing countries – including the Code of Practice

Both national Ghanaian human resources policy and conditions in international labour markets, most notably those of the UK and US are likely to have the biggest impacts on flows of health professionals and appear to have explained the declining trend in out migration.
The Code of Practice was little known and even less understood among respondents. Those with knowledge of it did not believe it had been influential in the migration situation.

5.3 Discuss the international policy context of health workers recruitment and migration and identify current knowledge gaps for future research

A number of areas of policy relevant to the Ghanaian human resource and migration situation have been further discussed, intended to stimulate further discussion rather than to put forward firm recommendations.

International policy appears to have been less important than Ghanaian national policy and labour market conditions in destination countries and especially the UK. Further Ghanaian policy measures to support the planning of workforce balance including managing the growth of investment in training and taking further actions to improve the internal distribution of the medical workforce appear warranted.

The international policy context is also shaped by the actions and perceptions of civil society organisations. An attempt to gather information about these has so far elicited the response only of Equinet and Southern and Eastern African research and policy NGO. Its response is included in Annex 1.

International and UK policy could play a larger role in supporting these developments as suggested in section 3.1.

5.4 Assess as far as possible whether and how the inclusion of the private/independent sector has made a difference

Given the difficulties of attributing effect to the Code as a whole, it was not possible to further attribute effect of the further inclusion of the private sector in 2004.
Conclusions

- The Code does not “stop” health professionals being recruited by the NHS in England- it placed restrictions on active recruitment by the NHS, from designated developing countries. Third party commentators have often misunderstood the actual content and coverage of the Code.

- The Code is a single country instrument, and does not have complete coverage within the UK- in particular the private sector was not fully covered. The NHS is a relatively straightforward system in which to apply the Code- attempts to use such a policy instrument in other developed countries where there are a multiplicity of independent health care employers would be problematic and this may prevent more general EU adoption.

- Data on UK registrations and work permits issued to international doctors and nurses highlight rapid inflow in the period up to 2002 (for nurses) and 2004 (for doctors) which has since declined rapidly- due in part at least because of a reduction in demand in the NHS, reflecting increased supply of staff from UK training, and reductions in vacancies. Trend data are not sufficient to demonstrate causality.

- Other regulatory changes have also impacted to reduce the likelihood of successful applications from international nurses and doctors. In 2005 the English language requirement for nurses was increased, and in 2006 most categories of nurse and doctor were removed from the list of “shortage” occupations which receive preferential treatment in the issuance of work permits. The Code is not the only factor which can explain the recent reduction in inflow.

- There is no systematic and standard monitoring of NHS England active international recruitment activity, which prevents any detailed assessment of the impact of the Code on trends in inflow of health professionals from developing countries. Any future attempt to evaluate the use of such an instrument would require systematic monitoring as is now being conducted in NHS Scotland.

- Previous research has highlighted that NHS managers have found the Code helpful in directing their international recruitment activities. Much of the content of the Code does support effective practice in international recruitment, and highlights the need to conform to equal opportunities good practice. The Code promotes local level good employment practice; it is not just a national policy instrument.

- There is little knowledge of the code in the case study countries and some misunderstanding that the code is responsible for the barriers to the UK health labour market which have emerged in the last two years. Appropriate dissemination and communication have been largely absent.

- Appropriate UK policy can support appropriate human resources for health policy in source countries but can have little effect otherwise. Policy developments recommended for consideration, bearing in mind local contextual factors include:
  - Extensions to the code to cover the practices of training schools and regulatory agencies in the UK and private sector recruiters in source countries;
  - Support to those who having worked in the UK for a period would like to return on a short or long term basis;
  - Support to monitoring flows, stocks and policies in source countries;
  - Targeted and agreed investment in training institutions in source countries.
References


<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
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<td>Ongewe Deborah A.</td>
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<tr>
<td>A group of 13 senior nurses</td>
<td>Leading Private Hospital</td>
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List of people met, Ghana, 4th-8th June, 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Title / Organization</th>
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<tbody>
<tr>
<td>de Jong, Marius, W.</td>
<td>First Secretary, Health and Gender, Embassy of the Kingdom of the Netherlands</td>
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<td>Appiah, David</td>
<td>MIDA field manager, International Organisation for Migration</td>
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<td>Professor Nyame, P.K.</td>
<td>Rector, Ghana College of Physicians and Surgeons</td>
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<td>Kumapley, Cecilia</td>
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<td>Boni, Prince</td>
<td>Deputy Director, Human Resources Development Division, Ghana Health Services</td>
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<td>Sagoe, Ken</td>
<td>Director, Human Resources Development Division, Ghana Health Services</td>
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<td>Nyoagbe, Joseph</td>
<td>Registrar, Pharmacy Council</td>
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<td>Osae-Addae, May</td>
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<td>Perry, Steven</td>
<td>Associate Consultant, Liverpool Associates in Tropical Health (Accra)</td>
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<td>Boateng, Frank</td>
<td>President, Pharmaceutical Society of Ghana</td>
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<tr>
<td>Adu-Ababio, Francis</td>
<td>President, Ghana Medical Association</td>
</tr>
<tr>
<td>Group of newly qualified nurses</td>
<td>Korle Bu Hospital</td>
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<tr>
<td>Group of 2nd year House Officers</td>
<td>Korle Bu Hospital</td>
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Fig 1: Doctors: New GMC Full Registrants - from UK, other developed countries, list but exempt countries, and other list countries, 1999-2006

Fig 2: Doctors: New GMC Full Registrants - % from UK, other developed countries, "list" but exempt countries, and other "list" countries, 1999-2006
Fig 3: Nurses: New Registrants - from UK, other developed countries, list exempt countries and list countries, 1998-2006

Fig 4: WorkPermits Doctors: % allocation by type of country 2001-2006
Fig 5: work permits issued to nurses % by type of country 1999-2006

Fig 6: UK work permits issued to nurses from select countries, 1999-2006
Fig 7: South Africa- verification issued for nurses- total, and number for UK and Aus

Source: SANC

Figure 8 Trends in training numbers: Nurses and Midwives, Ghana

Source: Data provided by Nurses and Midwives' Council for Ghana
Figure 9 Losses of staff from individual public, CHAG and military health facilities by cadre, Ghana

![Losses of staff from individual public, CHAG and military health facilities by cadre](image)

Source: Data provided by Ministry of Health

Figure 10 Causes of attrition, 2004 (n=1214), 2005 (n=922) and 2006 (n=843), Ghana

![Causes of attrition](image)

Source: Chief Nursing Officer
Figure 11 Population per doctor and nurse, Ghana 2006

Population per doctor
- National
- Western
- Volta
- Upper West
- Upper East
- Northern
- Greater Accra
- Eastern
- Central
- Brong-Ahafo
- Ahsanti

Source: Ghana Health Service

Population per nurse
- National
- Western
- Volta
- Upper West
- Upper East
- Northern
- Greater Accra
- Eastern
- Central
- Brong-Ahafo
- Ahsanti

Source: Ghana Health Service

Figure 12 Pharmacists requesting letters of confirmation, Ghana

Pharmacists requesting letters of confirmation

Source: Pharmacy Council of Ghana
Figure 13 Nurses requesting validation letters, Ghana

Number of nurses requesting validation letters

Source: Darko et al. (2006)

Figure 14 Target destinations of nurses seeking verification of qualifications, Ghana, 2002-5 (n=3126)

Source: Darko et al. (2006)
Annex 1: Responses of Equinet to questions about the Code of Practice

Question 1. Do you think that the aims of the Code of Conduct – to lessen the impact of recruitment into the UK health sector on health systems in low income countries and to safeguard the rights of migrant health workers – are the right aims? Or should the whole issue of migration between low-income countries and the UK be seen in a completely different way – for instance as a natural process in increasingly integrated health workforces, that needs to be managed?

RL: Codes of conduct should stipulate commitments to prevent active recruitment, work through transparent, publicly monitored bilateral agreements for any forms of managed migration, lessen the impact of recruitment into the UK health sector on health systems in low income countries, invest in options for production and retention through bilateral agreements to address push factors, and safeguard the rights of migrant health workers.

Question 2. Do you think that the methods that the Code of Conduct proposes to achieve these aims are the right ones? Principally, the Code of Conduct tries to make sure that UK employers do not recruit from countries with health worker shortages. Is that an appropriate mechanism – alongside other strategies – for achieving better staffing of health systems in those countries? Are there any negative implications, and if so, are they outweighed by the benefits? Is it possible to trade positive and negative effects off against each other? Are the aims of safeguarding the employment rights of migrant health workers ever counterproductive?

Question 3. Given what the Code of Conduct is trying to achieve, what is the evidence that it is achieving its aims? Can you provide quantitative evidence to the evaluation that would indicate whether the Code has had any impact on the levels of recruitment of health workers from particular countries to the UK in particular, and to other countries in general? Can you provide anecdotal evidence of the Code’s success or failure in alleviating impact on the health systems of developing countries? Can you provide anecdotal or quantitative evidence to show that the Code’s provisions on labour rights are working? In particular, do you or your members have testimony of the role played by private sector recruiters, either in having negative impact on the labour rights of migrant workers, or of violating the recommendations of the Code?

RL: for both questions 2 and 3 - Review of the codes suggests that codes have been relatively ineffective due to weak or non-existent frameworks for implementation, voluntary nature of the instruments, lack of advocacy for subscription to the codes and a lack of adequate and effective data collection and monitoring systems. They have no legal status and no sanctions for non-compliance. There are no formally constituted bodies to provide an oversight and watchdog role for countries that have subscribed to the instruments. It is suggested that bilateral and multilateral agreements that apply resources to mutually agreed strategies to mitigate the factors pushing health workers out
of their country and to funding health worker incentives for retention would be important to pursue, in the context of strengthened frameworks for country and region-specific needs. Further international NGOs should also be subject to codes of practice on health worker recruitment (locally and internationally) and countries should include these in their framework for managing migration.

Question 4. Given the evidence from the questions above, is there merit in expanding the Code of Conduct to other countries? Should it be strengthened? Weakened? Or are there arguments for abolishing the Code altogether? Do you have testimony on other policies that are similar, and the effect they have on developing countries – for example, the Commonwealth Code?

RL: Codes as statements of commitments to ethical positions are important but need to be complemented by mechanisms for public information, enforcement and monitoring (as noted above) and for organised investments through agreements to source countries to address push factors and promote retention.