
# International Recruitment of Health Workers to the UK: A Report for DFID

**FINAL REPORT**

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This report is based on data and information provided by a range of informants in the UK, Barbados, Ghana, and internationally.

The authors alone are responsible for the content of this report. Professor Buchan was primarily responsible for preparing Chapters 1, 2, 3, 4, 5 (Barbados) and 6; Dr Dovlo was primarily responsible for preparing chapter 5 (Ghana).

## 1. INTRODUCTION

This report has been prepared on behalf of DFID, to provide an overview of the implications of international recruitment of health workers to the UK.

International recruitment and migration of health workers has been a prominent feature of the global health agenda since the late 1990s (see Buchan, 2001; Chanda, 2002; Martineau et al., 2002; OECD, 2002). Migration of health workers has always been a feature of health systems but in the last few years it has been highlighted increasingly as a factor in undermining attempts to achieve health system improvement in some developing countries.

Whilst the issue of international migration of health workers is sometimes presented as a one-way linear "brain drain", the dynamics of international mobility, migration and recruitment of health workers are complex, covering individual choice, motivations and attitudes to career development; the relative status of health workers in different systems; the differing approaches of country governments to managing, facilitating or attempting to limit outflow or inflow; and the role of recruitment agencies as intermediaries in the process. Against this complex backdrop, the main objectives of this paper, drawing from the terms of reference, are:

- to examine trends in the inflow of health workers to the UK (Section 2)
- to examine the methods used in the international recruitment of health workers to the UK (Section 3)
- to report on the Department of Health Code of Practice (Section 4)
- to provide case studies in the impact of outflow of health workers from developed countries (Ghana and Barbados). (Section 5)
- to discuss the international policy context of health workers recruitment and migration and identify current knowledge gaps for future research (Section 6)

The study is based on analysis of published and unpublished data provided by professional registration bodies and government departments, combined with information from organisational case studies in the NHS, and key informant interviews in the UK, Ghana and Barbados, with international recruitment agencies, and with international organisations.

## 2. FLOWS OF HEALTH WORKERS TO THE UK

***"Stocks and Flows"***

There are two main indicators of the relative importance of international recruitment to a country – by examining the "inflow" of workers into the country from other source countries, and by assessing the actual "stock" of international health workers in the country at a point in time. This section examines the situation in the UK, using available data from professional registers, from work permit data, and data from the Department of Health. Three groups of worker are examined – doctors, nurses and midwives, and physiotherapists.

The data on inflow, derived from registration records and from work permits, confirms that there has been a significant upward trend in recent years. In summary, the key findings for each occupation are:

***Doctors*:** There has been significant upward growth in inflow of doctors to the UK, shown by work permit data, and supported by the registration data for 2001 and 2002. In 2002, nearly half of new full registrants on the GMC register were from overseas (see Table 1).

**Table 1: New Registrations of Doctors in the UK (based on place of primary medical qualification)**

| **Full:** | **1993** | **1994** | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** | **2002** |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| UK | 3,675 | 3,657 | 3,710 | 3,822 | 3,920 | 4,010 | 4,242 | 4,214 | 4,462 | 4,288 |
| EEA | 1,188 | 1,444 | 1,779 | 2,084 | 1,860 | 1,590 | 1,392 | 1,192 | 1,237 | 1,448 |
| Overseas | 2,500 | 2,539 | 3,327 | 4,047 | 3,678 | 3,580 | 2,889 | 2,993 | 3,088 | 4,456 |
| **TOTAL** | **7,363** | **7,640** | **8,816** | **9,953** | **9,458** | **9,180** | **8,523** | **8,399** | **8,787** | **10,192** |
| | | | | | | | | | | |

Source:GMC

In terms of the gender mix of new registrant doctors, in 2002, GMC recorded that 40% of doctors registering from overseas non EEA countries were female, compared to 53% of those from the UK and 22% from other EEA countries (Table 2, below).

**Table 2: Gender mix of full registrants to GMC, by country type, 2002**

| Full registration | Male | Female | Total | Female as % of total |
|---|---|---|---|---|
| **UK** | **1972** | **2316** | **4288** | **54** |
| **EEA** | **1156** | **332** | **1488** | **22** |
| **Overseas** | **2156** | **1424** | **3580** | **40** |

Source:GMC

Table 3 below shows the 'stock' of registered doctors on the UK in May 2003, categorized by registration status and country of qualification – developing countries, EEC/EEA countries, other developed countries and the UK. Overall, one third of all GMC registrants (including those on limited or provisional registration, undertaking further training) reported a non-UK country of qualification. There are more than 20,000 doctors trained in India on the UK register, almost one in ten of the total number on the register. There are also significant numbers from South Africa, Pakistan, Egypt, Sri Lanka and a range of other developing countries. One in five doctors with full registration or full and specialist registration in the UK was trained in a developing country.

**Table 3: Registered Doctors on the GMC Register, by Registration Status and Country of Qualification, 27th May 2003.**

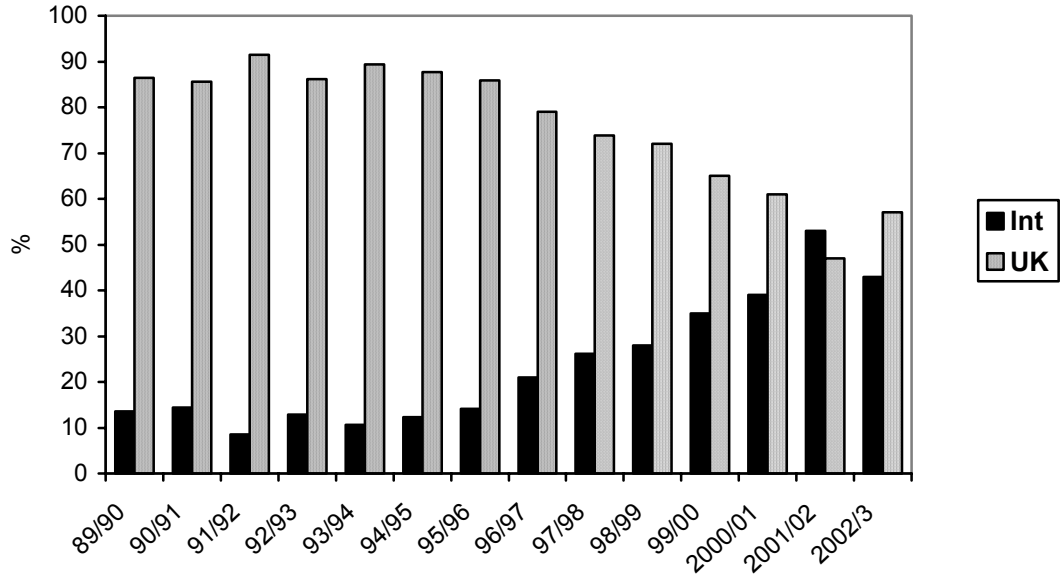
| Country of Qualification | Full Registration Only | Full and Specialist Registration | Limited Registration | Provisional Registration |
|---|---|---|---|---|
| **Developing** | 32,118 | 6,456 | 6,192 | 185 |
| **EU/EEA** | 10,836 | 3,577 | 61 | 393 |
| **Other Developed** | 7,944 | 1,358 | 612 | 44 |
| **UK** | 103,321 | 32,928 | - | 4,611 |
| **TOTAL** | **154,219** | **44,319** | **6,865** | **5,233** |

Source: GMC
Note: Excludes small number of temporary registrations

Key informants for this study suggest that virtually all recruitment of doctors to the UK is to the NHS. The Department of Health collates data on country of training of doctors, and this source gives another indicator of the level of employment of doctors from other countries. The number of non-UK NHS hospital based medical staff in England has risen. About one in three of the 71,000 hospital medical staff working in the NHS in 2002 had obtained their primary medical qualification in another country (Department of Health, 2003). There has not been the same growth in the number of general practitioners recruited from non UK sources, but one in five GPs in 2002 reported a non UK country of primary qualification.

***Nurses:*** There have been significant year on year growth in inflow of nurses to the UK since the mid 1990s. This is highlighted both in registration and work permit data In 2001/02, more than half of new nurse registrants in the UK were from overseas/EU sources (Fig 1).

**Figure 1: International and UK sources as a % of total new nurses admitted to the UK Register, 1989/90 - 2002/2003 (Initial Registrations)**




Source: UKCC/NMC data
(NOTE: see text for possible data limitations in 2002/3)

Between 2001/02 and 2002/03, there is an apparent decline in the number and proportion of non-UK entrants. This is partly due to a significant increase in the number of UK trained entrants entering the register in that year, reflecting increases three years earlier in intakes to UK pre-registration nurse education. However the recent NMC data should be treated with some caution. The NMC have noted that 'New registration data for the UK may be slightly inflated because of registration delays at the end of the previous year. Similarly, new overseas registrations may be understated because a number of applications became ready for decisions at the end of March' (NMC press statement 35/03). It has also stated that 'more than three quarters of all overseas applicants are asked to complete a period of supervised practice…it's quite possible that there will be a boost in overseas registrants this year [i.e. 2003/04] as applicants finish their adaptation and successfully register' (NMC press statement 50/03).

Main source countries for nurses in recent years have been the Philippines, South Africa, Australia and India (Table 4). There was a doubling in the number of Indian registrants between 2001/2 and 2002/3, a significant reduction in registrants from the Philippines and South Africa, a further fall in registrants from the West Indies, and a continued increase from several other sub-Saharan African countries.

In 2002/03, one in four new "overseas" (i.e. non EU) nurse registrants were from developing countries on the DoH 'proscribed' list (i.e. the list of countries appended to the DoH Code of Conduct on International Recruitment, as countries not to be targeted for active recruitment by the NHS). A further half were from the Philippines and India. There has been no growth in the number of nurses coming from the countries of the EEA. Overall, it is not known what proportion of international nurses are recruited by the NHS or by other sectors; however the NHS is the main source of nursing employment in the UK- it employs approximately three out of every four working nurses in the UK (Buchan and Seccombe, 2003).

**Table 4: Main Source Countries to the UK Nurse Register 1998 – 2003**

| Country | 1998/99 | 1999/2000 | 2000/01 | 2001/02 | 2002/03 |
|---|---|---|---|---|---|
| | | | | | |
| Philippines | 52 | 1052 | 3396 | 7235 | 5594 |
| India | 30 | 96 | 289 | 994 | 1833 |
| South Africa | 599 | 1460 | 1086 | 2114 | 1480 |
| Australia | 1335 | 1209 | 1046 | 1342 | 940 |
| Nigeria | 179 | 208 | 347 | 432 | 524 |
| Zimbabwe | 52 | 221 | 382 | 473 | 493 |
| New Zealand | 527 | 461 | 393 | 443 | 292 |
| Ghana | 40 | 74 | 140 | 195 | 255 |
| Pakistan | 3 | 13 | 44 | 207 | 172 |
| Kenya | 19 | 29 | 50 | 155 | 152 |
| Zambia | 15 | 40 | 88 | 183 | 135 |
| USA | 139 | 168 | 147 | 122 | 89 |
| Mauritius | 6 | 15 | 41 | 62 | 60 |
| West Indies | 221 | 425 | 261 | 248 | 57 |
| Malawi | 1 | 15 | 45 | 75 | 57 |
| Canada | 196 | 130 | 89 | 79 | 53 |
| Botswana | 4 | - | 87 | 100 | 42 |
| Malaysia | 6 | 52 | 34 | 33 | 27 |
| Singapore | 13 | 47 | 48 | 43 | 25 |
| Jordan | 3 | 3 | 33 | 49 | 18 |
| Non EU total | 3621 | 5945 | 8403 | 15,064 | 12,947 |
| (EU) | 1413 | 1416 | 1295 | 1091 | |

Source: NMC

Work permit data for nurses for 2002 confirms the rapid upward trend – the annual number of new permits issued has more than tripled over the four years, reaching more than 25,000 in 2002

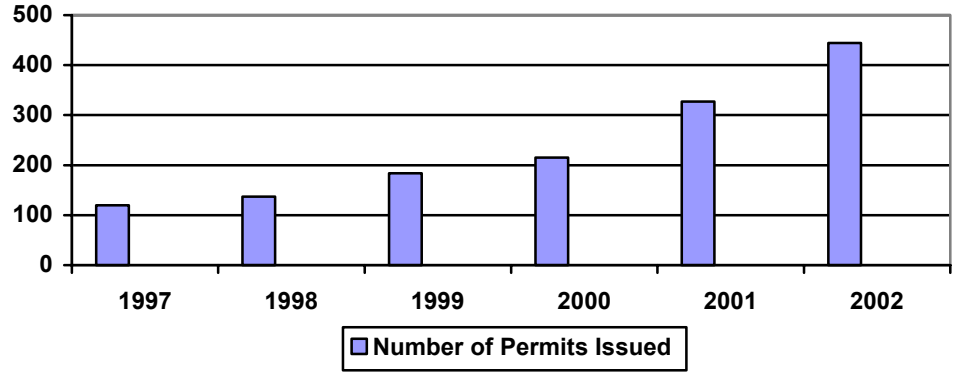
There is no routine information available on the actual stock of international nurses working in the NHS or other sectors but postcode data from the register suggests approximately 42,000 international nurses were located in the UK in October 2002. This is equivalent to approximately 8% of the total population on the register, but there is a much higher proportion in London- approximately 28% of registered nurses with an address in the capital were form international sources (Buchan, 2003).

A survey conducted by the Royal College of Nursing in 2002 (RCN, 2002) provides some more information on the profile and attitudes of international nurses in the UK. Based on a survey of RCN members, it reported that overseas qualified nurses in the UK were younger on average than UK trained nurses, that they were more likely to work full time than were their UK trained counterparts, and that a slightly higher proportion were men (however more than nine out of ten UK trained and overseas trained nurses were female). The RCN survey also suggests that there is a higher proportion of overseas nurses working in independent nursing homes- 14% of the sample of overseas nurses, compared to 5% of UK white nurses reported working in the independent sector, with the converse in community nursing- only 6% of overseas nurses reported working in that sector, compare to 13% of UK qualified nurses. This latter point highlights that the vast majority of overseas nurses registering with the NMC are general nurses, and will not have additional community nursing qualifications.

***Physiotherapists***: A significant upward trend in inflow of physiotherapists to the UK is shown by the provision of work permits, with South Africa being the main source.

Work permit data for physiotherapists (Figure 3) also highlight an upward trend in the number of applicants over the period 1997-2002, with the annual number of permits having quadrupled over the period.

**Fig 2: Number of New Work Permits Issued to Physiotherapists 1997 - 2002**




Source: Work Permits UK

In 2002 the main sources of physiotherapists were South Africa, Australia, New Zealand, Zimbabwe and India. The Chartered Society of Physiotherapy has reported a three-fold rise in enquiries about working in the UK over the past year. No information is readily available on the stock of internationally recruited physiotherapists in the UK.

## 3. METHODS OF RECRUITMENT TO THE UK

### *The need to recruit*

The Department of Health in England, and its counterparts in the other three UK countries are all committed to NHS staffing growth as an integral part of achieving "modernisation" and meeting targets set out in the NHS Plans (see e.g. Department of Health, 2003).Achieving the NHS Plan targets for staffing growth in England and the other UK countries relies on four areas of intervention:

1) attracting more applicants to pre-registration education;
2) encouraging 'returners' to health care employment;
3) improving retention through improved career structures and flexible working practices; and 4) recruiting new staff from home or abroad.

There has been a significant increase in the number of entrants to pre-reg education in nursing from UK sources (Buchan and Seccombe 2003), but international recruitment remains an activity which is an explicit policy intervention developed by the Department of Health in England; more recently the Welsh Assembly has also highlighted international recruitment as part of its overall approach to achieving staffing targets.

### *Methods of international recruitment*

In England, the approaches used to international recruitment have varied for different occupations. The recruitment of doctors to the NHS in England is centrally co-ordinated by the Department of Health but is individualised and targeted and has been supported by a range of initiatives. The Department of Health in England has established a number of entry routes to support NHS Trusts to recruit consultants into the NHS. They have contracted a recruitment specialist to register vacancies and have developed different options for recruitment, including short term visits, and recruitment related to acquiring additional experience in the NHS.

In contrast to the 'individualised' structured approaches used to recruit doctors, the methods used 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 level of reliance on international nurse recruits is extremely high in some NHS Trusts, particularly in the South East of England.

Most recently, the NHS in England has set up a website to recruit directly nurses from other countries (www.nursinguk.nhs.uk) . It notes: "Speculative applications are welcome from anywhere in the world. You can apply here using the online application form. However, the NHS is sensitive to the rights of all people to have access to quality health care in their own community. Therefore applications from the countries identified on [the Code list of prescribed countries] will not be considered without prior approval from the respective government. If you're from a country not included in the list your application will be considered" . Applicants from Spain, India and the Philippines (the three countries with which there are country to country agreements to recruit nurses) have dedicated sections on the web site.

Generally the approaches used to facilitate international recruitment to the NHS have become more systematic in recent years. As well as the various methods of targeted recruitment at individual doctors, and the website for nurses, there has been the development of regional recruitment co-ordinated through NHS Workforce Development Confederations, the issuing of guidance on provision of adaptation

(Department of Health, 2003,b), and the publication of a monthly international recruitment newsletter, begun in March 2003.

In the seven NHS case studies conducted as background for this report, the current representation of international nurses in the NHS trusts varied between 9% to 50% of the total qualified nursing workforce. Higher levels of employment of international nurses –up to two thirds of the workforce- have been previously reported in organisations in the independent sector health care in the UK (Buchan, 2003).

Some of the NHS employers in the case study sites could give a precise figure for the number of international nurses in their employment, but others could provide only an estimate. In part this relates to differences in definitions of "international" (i.e. some, but not all international nurses require a work permit and some "international" nurses are foreign nationals who have trained as nurses in UK etc). 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.

***"Active" and "passive" recruitment***

Most of the NHS case study organisations reported actively recruiting nurses from more than one country. In terms of active recruitment by the NHS employers in recent years, the Philippines was the most common reported source country, with India, Spain and Australia also reported for nurses. None of the NHS respondents reported actively recruiting from developing countries (other than India and the Philippines) in recent years, but some acknowledged that they had employed 'walk-ins' – individual nurses from developing countries who had applied on their own initiative, or were already based elsewhere in the UK.

As well as active recruitment, there are four types of "passive" recruitment which contribute to increasing the number of international health workers coming to the UK but which do not 'break' the Department of Health Code. As noted above, some staff are employed after they take the initiative to apply as individuals from other countries. Secondly, some workers will be resident in the UK, but not yet in employment- such as refugees. Some London based NHS organisations are now actively tapping into local labour markets to recruit refugee health workers. This activity is being facilitated by the Department of Health support for the development of data-bases of refugee doctors (BMA) and nurses (RCN).

Thirdly, some health workers will move jobs relatively quickly once they have arrived in the UK. Recent research has reported that many international nurses recruited by independent sector employers move on to NHS employment (Buchan, 2003). In some cases independent sector employers have deliberately targeted overseas nurses from the Indian and African sub continents, charging them a fee, and offering them an adaptation course so that they could become UK registered and move on to NHS employment.

The fourth development is the increased access to employment opportunities which has been created by the internet. The Barbados case study reported later in this report highlights that nurses in that country have become more aware of employment opportunities in developed countries because of access to recruitment agency and employer web sites. In this situation, the employer may not be directly "active" in beginning the recruitment process, but the web is certainly making it easier for nurses in developing countries with internet access to identify career opportunities in developed countries.

***The recruitment agencies***

The growth in the international recruitment activity has led in turn to a growth in recruitment agency activity, and in the number of agencies. Key informants interviewed for this report suggest that some of the newer (often smaller) agencies may not have the same level of commitment to quality assurance as some of the larger and longer established agencies. This issue was reported to be of particular concern with some in-country agencies, in India and in African countries.

The main feature of international recruitment to the NHS in recent years is the extent to which the recruitment process has become systematized and co-ordinated. Individual initiatives or the exploitation of individual contacts have been superceded by planned and targeted efforts, often using recruitment agencies. The rapid growth in inflow, noted in the previous section, is a reflection of this more systematic and policy-led approach.

***International health workers in the UK***

There is relatively little information on the profile or motivations of international health workers in the UK .It is possible to develop a typology of different 'groups' of overseas nurse in the UK (Table 3.1), but not currently possible to identify how many overseas nurses conform to each type.

The significant recent increase in active recruitment of nurses and other health workers from abroad who require work permits to enter the UK points to a relative growth in the numbers of “contract workers” and potential economic migrants in recent years.

One major distinction which has to be drawn is that between internationally recruited health workers anticipating a permanent move to the UK, and those planning only a temporary move. For example, many nurses entering the UK from Australasia, are likely to conform to the "working holiday" or "contract worker" types. These nurses anticipate working in the UK for a relatively short period of time, prior to moving on, or back to the home country. One unpublished survey of 41 nurses recruited from Australia in 1999, found that 61% had chosen the UK for travel reasons, or to visit friends or relatives, and that 27% had moved for career development reasons (Unpublished data from a London Recruitment Agency, 1999).

**Table 3.1: Internationally Recruited Nurses in the UK: A Typology**

| | | Main current source countries for UK? |
|---|---|---|
| "Permanent" Move | | |
| The Economic Migrant | attracted by better standard of living (overlap with contract worker- see below) | Philippines, South Africa, West Indies, etc |
| The Career Move | attracted by enhanced career opportunities | Philippines, South Africa, West Indies, etc |
| The Migrant Partner | unplanned move, as a result of a spouse or partner moving | various |
| "Temporary" Move | | |
| The Working Holiday | nursing qualification used to "finance" travel | Australia, NZ, Canada |
| The Study Tour | acquisition of new knowledge and techniques, for use in home country | various |
| The Student | acquisition of post basic qualifications, for use in home country | various |
| The Contract Worker | employed on fixed term contract; either awaiting improved job prospects in home country, or time limited because of work permit. | Philippines, South Africa, West Indies, Australia, Spain etc |

Source: Buchan et al., 1997, updated

An opinion poll survey of 1,119 foreign nurses who were members of the RCN was conducted in early 2002. It found that more than half intended to stay in the UK on a long term basis, if possible. The two most often reported "best" aspects of working in the UK were professional development and pay. One third of the nurses reported that they had to pay a fee to a recruitment agency or employer for travelling expenses and agency fees (Pearce, 2002). A key informant study of overseas doctors reported that the main reasons they came to the UK were better economic and lifestyle opportunities, the reputation of UK Royal Colleges, and the opportunities to speak English (National Primary Care Research and Development Centre, 2003).

Health workers coming from other countries where there is current home country "push" factors, due to relatively low pay or career prospects (e.g. sub Saharan Africa, India, Philippines) are more likely conform to the "contract worker" / "economic migrant" model. Many of these workers may wish to prolong their stay in the UK beyond the completion of their first one- or two- year work permit - if they are allowed. A recent survey of 24 Filipino nurses in London reported that the main reasons they had come to the UK were career prospects and financial

security, with most intending to remit part of their earnings back to family and relatives in the Philippines (Daniel et al., 2001).

There have also been reports of "exploitation" by some employers, of internationally recruited health workers in the UK. This has been mainly related to reports of independent sector employers (i.e. non NHS ) and has been linked to poor accommodation, undervaluing of skills in terms of pay rates, poor or misleading information about contracts of employment, and the payment of commissions to recruitment agencies (these reports mainly tend to focus on poor practice by private sector employers, and by some recruitment agencies) (see e.g. Nursing Times Vol. 98 (18), p11.).

One nursing home was barred by the UK registration authority from offering supervised practice placements for overseas nurses because of reports that it misled nurses and threatened them with the loss of their work permits (UKCC, 2001). There have also been reports that internationally recruited nurses have experienced racism, from other workers or managers (Royal College of Nursing, 2003), and by patients (Nursing Times, 2002). Whilst all NHS nurses are paid on a single national pay/grading scheme, there have been suggestions that some overseas nurses are paid at a lower grade than they deserve. Some positive experiences for internationally recruited health workers have also been reported, where locally co-ordinated schemes have been established to assist overseas nurses to adjust to working in the UK (Nursing Times, 2002).

There are no detailed published data on the length of stay of non-UK educated nurses in the UK. Analysis of unpublished UKCC data in 1999 suggested that more than half (56%) of overseas registrants first registering in 1995 did not re-register in 1998 (UKCC unpublished analysis cited in Buchan and O'May, 1999). Since then the number and proportion of overseas nurses requiring a work permit has increased significantly, and they will normally have to apply for new permits every one or two years.

## 4. THE DEPARTMENT OF HEALTH CODE

### *Developing the Code*

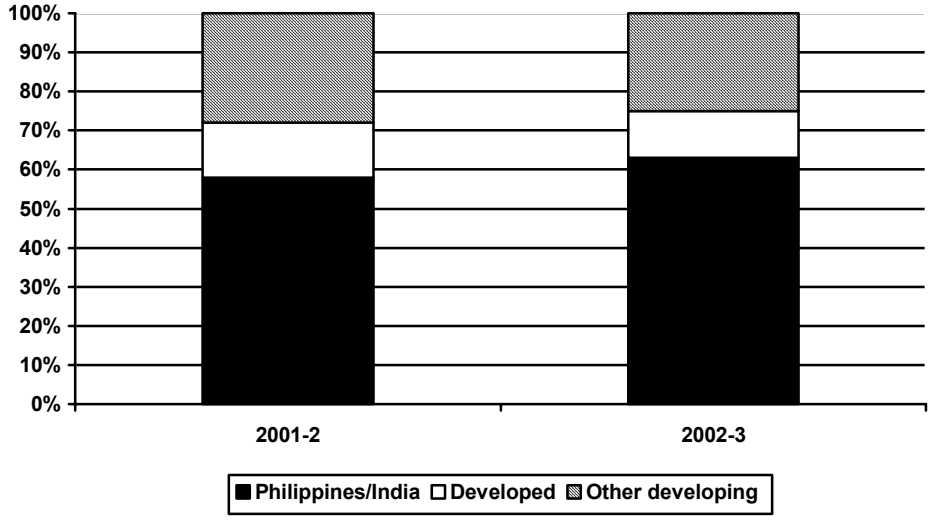
In response to concerns about active recruitment from developing countries the Department of Health, England, issued guidelines on international recruitment in 1999 (Department of Health, 1999); this was replaced by a Code of Practice on International Recruitment, dated October 2001 (Department of Health, 2001. Available at www.doh.gov.uk). The guidelines in 1999 required NHS employers not to actively recruit from the West Indies and South Africa. 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 'proscribed' countries was made available in early 2003.

Whilst some international recruitment of health workers is also being conducted in the other three UK countries, this has been primarily as a result of local initiatives; it is England that has been initiating most of the active international recruitment, and has also taken the lead on developing a Code for international recruitment.

### *The impact of the Code*

Fig 3 explores in greater detail the composition of the inflow of nurses to the UK in 2001/02, and 2002/3 in order to highlight the proportion coming from developing countries. More than half of the new international registrants in each year came from India and the Philippines. the two "developing" countries explicitly excluded from the Department of Health 'proscribed' list, as these are the two developing counties with which the Department has established country to country bilateral agreements. However, a further quarter of the total "inflow" of nurses (at least 3,500 in 2002/03)

**New nurse registrants: % by type of source country, 2001/2 and 2002/3 (excludes EU and "other")**




came from other developing countries which <u>are</u> on the DoH list of countries 'proscribed' for NHS active recruitment (e.g sub Saharan Africa).

Source: NMC Annual Statistics

***How does the UK compare to other developed countries?***

It is difficult to undertake direct comparisons of the relative level of inflow of health workers, partly because data varies greatly in terms of definitions and accuracy between countries. However, a research study on nurse recruitment and migration to five developed countries (Australia, Ireland, Norway, United Kingdom and the United States) was recently completed (Buchan, Parkin, Sochalski, 2003). This provides an assessment of registration data from the five countries in 2000-2002 (Fig 4).

The information from the countries highlights some key trends and significant variations between countries. Two 'importer' countries (UK and Ireland) reported significant upward trends in international recruitment activity. Australia, at State level, reports more moderate growth, whilst there does not appear to have been significant recent growth in the USA and Norway. One common trend is a broadening out of recruitment activity to a wider range of 'source' countries. Overall, the UK appears to be relatively more active in recruiting from developing countries than the other countries examined.

**Fig 4: Composition of Inflow of International Nurses to UK, Norway, Ireland and Victoria State, Australia with Source Countries defined by World Bank Classifications**


Note: For purposes of analysis, data from all Caribbean countries has been incorporated into the 'Lower Middle Income' category

Source: Buchan, Parkin and Sochalski (2003)

***NHS employers views***

NHS recruitment managers in the seven NHS Trusts interviewed in the study reported generally that the 2002 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'). The main limitation identified by the NHS respondents was the absence initially of a detailed list of specified countries (although the Code was dated 2001, the full list of 'proscribed' countries was not available on the website until 2003).

All were in favour of detailed guidelines setting out which source countries were, or were not 'ethical' sources. Recruitment agencies interviewed during the study were more mixed in their opinions – in part at least because they perceive the Department as a competitor. None of the other guidelines and position statements on international recruitment (e.g. that issued by the Commonwealth) were known to the respondents. (NOTE: at the time of writing, the UK has not signed up to the Commonwealth guidelines).

***Limitations of the Code***

The major limitation of the Code, in terms of preventing all active recruitment from developing countries (it should be noted however, and as discussed below, this was never its explicit intention) is that it does not cover the independent sector, which continues to recruit from countries on the proscribed list. The Independent Healthcare Association has published guidelines on international recruitment but these relate primarily to the provision of adaptation courses in the UK. The other limitation, from a UK perspective, is that the Department of Health Code only covers NHS employers in England.

This was highlighted in a recent exchange in the House of Commons:
"Dr Starkey : I welcome the fact that the NHS has a code of conduct about recruiting nurses from countries where recruitment would otherwise affect health services in those countries. The private sector in hospitals, nursing homes and care homes however, does not exercise similar restraint. I ask the Minister to look carefully at ways in which the private sector can be made to adhere to the same code of conduct, and if necessary to have discussions with the Home Office to ensure that the private sector in this country is nor pillaging health services abroad in countries where those staff are needed much more than here.

Ms Winterton (speaking on behalf of Dept of Health) My hon. Friend is right to raise the issue, which we take very seriously, and my right hon. Friend the Secretary of State has had a number of discussions about it. There is a limit to the control that we can exert on the private sector, but we have made it absolutely clear that agencies that recruit nurses for the private sector contrary to the NHS code of conduct will not be allowed to recruit nurses for the national health service. That lever is available to us. In addition some measures can be taken by the Department of Trade and Industry if, for example, agencies charge an exorbitant fee to nurses for recruitment. Our Departments are continuing to work closely on that matter" (Hansard, 4 Nov 2003, Column 666)

It is not possible with available data to assess the extent to which all NHS organizations comply with the Code. A recent report noted that the Department had intervened when it found out that two (un-named) NHS Trusts were recruiting directly from South Africa (O'Dowd, 2003). In 2002, the Chief Nursing Officer Bulletin from the Department of Health reminded NHS Trusts that Ghana was 'off limits' for active recruitment. These examples highlight that there have been some instances of individual NHS organizations breaching the Code, but that the Department of Health has attempted to intercede.

The continued inflow of nurses and doctors from developing countries which is evident from registration data is not in itself evidence of the code being 'broken' – it is explained, in part at least, by entrants coming for education purposes (particularly the case for doctors), by individual health workers taking the lead to apply for jobs in the UK, and by non UK nurses actively recruited by non-NHS employers. It is not possible to quantify the relative size of each of these 'inflows' with current information.

Against the backdrop of incomplete information, it is difficult to assess in detail the impact of the Department of Health Code, but it is important to be clear about what it does- and does not- cover. It only relates to active international recruitment by NHS employers in England, and by recognised recruitment agencies on behalf of NHS employers. This activity should only be focused on countries which are not on the "proscribed" list- where for example there is a bilateral agreement with the country government. The Code does not cover non- NHS employers, and does not relate to the various "non – active" types of recruitment, such as individual initiatives by health workers, and inflow related to educational reasons etc.

The Code, by its very existence has drawn attention to UK international recruitment activity. Other developed countries have also been active but have not introduced similar frameworks (with the exception of Ireland). Arguably, because the UK is more prominent in recruiting from developing countries than most other recruiting countries, it has more need of a Code.

The limitations of 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 its limitations, as set out above, make it clear that in reality it does no such thing. The misunderstandings about the coverage of the Code have not diminished over time- this may be partly because it has changed in content and detail since the first guidelines were introduced in 1999. It was not until 2003 that a full list of developing countries was made available to NHS employers.

Furthermore, the dynamics of international recruitment and migration are such that new methods are being developed which require that the Code is kept under review. One example, noted elsewhere in this report, is the developing user of the internet as the focal point for international recruitment. Another example is the shift in England towards some time limited entry of clinical teams from other countries. The announcement that South African companies are amongst those being considered for the provision of UK based clinical teams in the NHS would mean that South African doctors and nurses will travel to the UK to undertake clinical work on behalf of the NHS. This prompted a "NHS is recruiting from South Africa" headline in one of the UK nursing journals in July 2003, relating to the recruitment, to the NHS in the North West of England, of 174 nurses and 19 medical staff from a South African company (Mulholland, 2003). The article counter-pointed this activity with the fact that South Africa was on the Code's list of proscribed countries. It also reported a Department of Health spokesperson commenting that the contract was acceptable because the South African staff were not part of the public health care system in South Africa: "The arrangement is in line with our ethical recruitment policy. The NHS does not actively recruit from developing countries unless we have their agreement. We have been in discussion with the South African government and they are content with this arrangement".

This recent example serves to highlight two developments. Firstly, new modes of recruitment and deployment of international health workers are being developed- in this case a time limited deployment of full teams from other countries to specific locations in the UK to undertake NHS funded clinical activity. Secondly, the comment from the Department of Health spokesperson suggests some softening on the line that the South African government has taken previously on international recruitment. This may be because they perceive advantages to this relatively "managed" and possibly short term outflow which will generate income for South African businesses. One recent press report suggests that representatives of the Ghanaian government were also considering increasing the numbers of health professionals being trained, and encouraging some managed out-migration of health workers after they had served 10 years in Ghana (Ghana Newsweb, 2003). Similar possible developments in the Caribbean are discussed later in this report.

It is clear that it is not just the pace and level of international recruitment to the UK that is growing. There is also growth in the variety of approaches to recruitment, and possible changes in the perceptions of other country governments. Some of these newer methods, such as the South African example outlined above, are likely to require periodic review of the content and coverage of the Code.

***The Commonwealth and EU.***

The other major potential "ethical" framework for international recruitment would be that being developed by the Commonwealth, led by the Commonwealth Secretariat. This was finalised in May 2003; however at the time of writing the UK has not signed the agreement, apparently because of the late addition of clauses related to the possibility of compensation for source countries. Australia and Canada have also not signed.

Whilst the EU has expressed interest in issues related to health professional migration (partly in relation to implications for EU accession states entering the EU in 2004) it has not developed any "ethical" framework, and undertakes only limited monitoring of flows of health professionals within EU states (based on often inadequate or incomplete data provided by member states).

## 5. COUNTRY CASE STUDIES

The county case studies involved the collection and synthesis of information on Ghana and Barbados (the later with a broader focus also on Caribbean issues) – countries which have seen significant outflow of health workers, especially nurses, many of whom move to the United Kingdom. There is however one significant difference between the two countries in terms of their links to the UK. Whilst the number of nurses annually entering the UK register from Ghana has increased year on year in recent years, the number entering from the West Indies has declined since 1999/2000.

The study involved interviews with key informants in government, senior health sector management positions, senior staff of health professional regulatory bodies and professional associations/ trade unions , as well as focus group discussions with a group each of nurses and doctors.

### A. GHANA

The issue of emigration of health workers, especially of nurses and doctors is causing much concern in Ghana. However, despite reports of increasing numbers applying to work abroad, it was difficult to assess actual trends because of limited data.

Data on the count of health workers in Ghana was hard to come by. The main difficulty was with private sector data and with establishing the validity of data. There is also reported to be significant "dual practice" among doctors and pharmacists, which could lead to "double counting" and the Private Hospitals census and the MOH data cannot differentiate between these dual sector practitioners.

***Health workers in Ghana***

Approximately 940 doctors, and 6,500 nurses, are employed in the public sector (Table 4).

**Table 4: Current Health Worker Numbers in Ghana**

| **Cadre 2002** | | Total | Public | Private[1] | NGO |
|---|---|---|---|---|---|
| Doctors | | ***2449** | **940** | **929/1509** | |
| Registered Nurses/midwives | | **10265** | **6481** | **3784** | |
| Pharmacists[2] | Male | **968** | **150** | **818** | |
| | Female | **297** | **47** | **250** | |

The assessment of the labour market situation by study respondents was unanimously described as one of significant to very severe shortages of all professional health staff in almost all regions of the country. The situation was reportedly much more severe in the northern deprived regions and all other rural areas.

[1] from 2001 Dec. Census of Private Medical Practice in Ghana.

[2] Data from Pharmacy Council database.

Levels of production of health professionals from the nation's training institutes were reported to have remained stagnant for many years. In 2001-2002 however, a Ministerial edict was issued to training schools to double the intake of students. This was in recognition of the severe shortage and high rates of emigration as perceived by the Ministry of Health.

***Public / Private mix***

Public-private mix has been a fairly fluid work situation in Ghana for many years with many health workers involved in dual practice in both sub-sectors, but the public sector appears to remain the major employer of health professionals. For doctors, the recent census of private health facilities indicated a higher number of doctors in the private than public sector but this is thought to indicate the confusion of dual role doctors. Unemployment of health workers is almost unknown though there was a lot of anecdotal evidence about health professionals who worked in other spheres. However, these were uniformly thought to be a very low number.

***Reasons for poor staff retention***

Reasons for poor retention of health workers in Ghana were highlighted in the focus groups discussions with doctors and nurses. The themes of reasons may be grouped into the following:

- ***Salary and remuneration***: All respondents agree that salaries were too low although this had been relieved somewhat by recent increases and the Additional Duty Hours Allowance (ADHA). However, respondents were convinced that much higher remuneration was obtainable in the UK or USA, and that working extra hard and doing extra duties in these countries would bring even more money and would help sustain a reasonable lifestyle. Nurses in particular felt the disparity between ADHA for doctors and for other health staff was too high and this meant their efforts were not appreciated.

- ***Career prospects***: This was reportedly a major concern for both doctor and nurses discussants. For doctors it was a prolonged process of specializing during which there was no promotion at different stages of achievement. Nurses' problems were reported to be about lack of opportunities to attain further education. No opportunities existed for nurses to obtain additional qualifications whilst still at work (distance education, evening courses). The nurses "saw no future in working here".

- ***Respect/value placed in health workers by country/system***: The nurses group felt strongly that the government, the Ministry of Health did not value nurses and they felt expendable. There are never-ending negotiations to improve conditions that "never seem to come to fruition". Discussions "go on forever". The provision of cars for health workers has by-passed nurses and are all give to doctors. Unlike the Ghana Medical Association, the GRNA is not involved in allocation of cars. Nurses only got about 5 out of 200 cars during the previous allocations. Doctors reported similar feelings of their value to the system being underestimated.

- ***Governance***: This is less about politics as about confidence in the administration of personnel and the general management of the country including the control of corruption. Doctors in particular felt that things were not managed well, performance was not the primary criteria in taking career management decisions, the wrong decisions were being made and the system was not flexible enough to respond to changing needs.

- ***Management of the health system***: The reported bureaucracy that characterizes the health services was a major source of difficulty for both nurses and doctors. Promotions take several years beyond when due to become valid. The nurses in particular felt that things cannot get better and lacked confidence that things would improve anytime soon. New "Diploma" nurses have not received appointment letters a year after graduation. Nurses lacked transport systems to and from work, no housing schemes, poor management at work and then lack of basic tools and protective equipment.

- ***Retirement Prospects:*** A major issue especially strong with the nurses groups was the problem of securing a safe retirement. Retirement benefits were exceedingly low compared to other para-statals such as the government banks.

***Vacancy rates***

The overall impact of recruitment and retention difficulties in the Ghana Health Service is shown in Tables 5 and 6 below, which indicate the vacancies levels experienced in the sector.

**Table 5: Estimates of vacancy levels in the Ghana Health Service 2002[3].**

| STAFF TYPE | Current Status | Workable No. | Shortfall & % | Ideal No. | Shortfall & % |
|---|---|---|---|---|---|
| **Doctors** | 633 | 1200 | 567 **47.3%** | 1804 | 1171 **65%** |
| **Prof Nurses** | 4319 | 10,000 | 5681 **57%** | 13,340 | 9021 **68%** |
| **Pharmacists** | 161 | 280 | 119 **42.5%** | 371 | 210 **56.6%** |

**Table 6: Estimated Vacancy levels in Ghana MOH 1998[4] and 2002[6]**

| CADRE | 1998 | 2002 |
|---|---|---|
| Doctors Vacancy Rates | 42.6 % | 47.3 % |
| Registered Nurses Vacancy | 25.5 % | 57.0 % |

From the comparative analysis on Table 6; between 1998 and 2002 vacancy rates for doctors can be said to have increased moderately (GHS data excludes Teaching Hospitals with about $^1/_3$ of Public Sector doctors) but have almost doubled for nurses over the same period.

[3] Prof. AB Akosah, Director General, Ghana Health Service: memo- Re: Staffing Situation in the Ghana Health Service. November 2002.

[4] From Dovlo, Delanyo. "issues affecting the mobility and retention of health workers/professionals in Commonwealth African states". Report Prepared for the Commonwealth Secretariat, London. 1999 Unpublished

***Recruitment of staff and new incentives***

Recruitment of health professionals into Ghana's health services is reported to be quite poorly managed. The onus is on individual applicants to "apply" for appointments and posts are not routinely advertised or applications solicited. The employment process, from application to receipt of first salary, can take up to 30 months (HRD Director). This bureaucratic situation which is duplicated for promotions, and order personnel administration items serves to seriously de-motivate staff. Thus there is no "active" recruitment of the scarce human resources.

Since 2000, the Government of Ghana has implemented two types of interventions to try and provide incentives for health professionals. These are as follows:

**Additional Duty Hours Allowance** (ADHA): The ADHA paid an allowance based on a computed number of additional hours of work performed above the normal working hours. Most of the respondents think has slowed the emigration of doctors significantly initially (but that this is again picking up). Other cadres receive less ADHA than doctors which according to all nurses and managers in the GHS/MOH, has led to the de-motivation nurses. Indeed the numbers of nurses seeking verification with external employers has risen significantly since the introduction of ADHA. (In district hospitals doctors may take ten times greater more than nurses).

**Cars for Health Workers Scheme**: Two sets of cars have been procured for health workers:- 150/200 of the cars were reserved for the Ghana Medical Association's members and 50 distributed by the MOH including less than 10 each for nurses and pharmacists.

These interventions have not been formally evaluated and the impact has not been assessed. Any stated results of the effectiveness of these interventions have been anecdotal.

***Workforce Planning***

The unanimous feeling of respondents of various types has been that workforce planning has made no attempt to respond to the situation of brain drain. Both the MOH and the GHS have produced Strategic 5 year Human Resource Plans in late 2002 and 2003 that have tried to quantify the losses and estimate numbers needed to fill the vacancies. These plans have mainly dealt with projections of staffing needs/demand but have not addressed in detail the strategic analysis and options on how to meet the challenges posed by the loss of health professionals, either within the country or to other countries.

A clear action taken has been to double intake into all health-cadre training programmes. This has been done without any significant investments into the infrastructure and logistics. For example, nursing tutors are estimated to have lost between 20-30% of their number due to emigration[5].

***"Stock" of health workers outside Ghana***

There is no reliable estimate of how many health professionals work outside Ghana. Whilst verification data may give some indication of outflow, registration is often given

[5] Personal Communication from Nurses and Midwives Council.

up once a staff member moves outside Ghana. Even when registration is maintained this does not indicate whether the staff member is outside or working in the country

However, in a memo to the Chairman of the Ghana Health Service in November 2002[6], the Director-General provided the following estimation of Ghanain doctors outside and indicated that more Ghanaian doctors worked outside Ghana than within (Table 7).

**Table 7: Countries Hosting Ghanaian Doctors 2002**

| Country | Number of Ghanaian Doctors |
|---|---|
| USA | 1200 |
| UK | 300 |
| South Africa | 150 |
| Canada | 50 |

Source: Estimate from GHS

***Flows of health workers leaving Ghana***

The Director General also estimated that in 2001, 2972 nurses left Ghana compared to 387 in 1999 mainly in this case to UK, USA and Canada. The General Secretary of the Ghana Registered Nurses Association (GRNA) reports that membership had reduced from over 12,000 in 1998 to under 9,000 in 2003.

Verification data from the Ghana Nurse and Midwives Council shows an upward trend in verifications to the year 2001, a dip in 2002, and apparent increase in 2003 (data for first five months only of this year). The UK is the main source of verification requests, accounting for three quarters of the total.

**Table 8: Ghana Nurses Verification: Country verified for and Year.**

| Country of Destination | Number & Year of Seeking verification | | | | | | |
|---|---|---|---|---|---|---|---|
| | **1998** | **1999** | **2000** | **2001** | **2002** | **2003[20]** | **Total** |
| **USA** | 50 | 42 | 44 | 129 | 81 | 80 | **426** |
| **UK** | 97 | 265 | 646 | 738 | 405 | 317 | **2468** |
| **CANADA** | 12 | 13 | 26 | 46 | 33 | 10 | **140** |
| **S-AFRICA** | 9 | 4 | 3 | 2 | 6 | - | **24** |
| **OTHERS** | 4 | 4 | 8 | 8 | 5 | - | **29** |
| **Total:** | **172** | **328** | **727** | **923** | **530** | **407** | **3087** |

Source: Ghana NMC
Note: 2003 is until May only

Country preference was reported to depend on some factors which include ease of registration with a country's bodies. Thus nurses are reported to prefer the UK which does not require examinations and only requires an adaptation once registration and qualification in Ghana has been verified and accepted. For the USA however, they need to write examinations which, in addition to rather higher costs, (exam fees, air

[6] Prof. AB Akosah, Director General, Ghana Health Service: memo- Re: Staffing Situation in the Ghana Health Service. November 2002.

ticket costs etc) makes the USA less attractive. For doctors, the USA is the most desired destination and focus group respondents say that time working in the UK may be utilized to move on to another country (mainly USA).

***Internal flows of health workers***

Not much data exists on internal flows of staff between private and public and to non-health sectors. It is reported that there is a noticeable increase in Private Sector doctors seeking to work in public facilities, which was said by respondents to be a result of the ADHA introduction and a possible slump in private attendances due to the high competition.

***Impact of outflow***

No studies have been made on impact of emigration of health workers to date though several anecdotal information existed. Focus group respondents told of problems with "handing-over " because qualified nurses were unavailable, and of a single professional nurse required to oversee a full ward of some 30-40 beds with a couple of enrolled nurses or untrained attendants.

The Nurses Council (also responsible for nurse education) estimates that they have lost 20-30% of tutors over the past few years. Registered Mental Nurses (already in low numbers) appear to be prime targets for recruitment to the UK. The main Psychiatric Hospital in Accra reported losing 101 of its staff between 2000 and 2002[7]

***Attempts to constrain outflow***

The Nurses and Midwives Council in Ghana has instituted a policy that restrains nurses from obtaining verification of their certificate until they had worked for at least two years in Ghana post registration. In addition nurses (indeed all health staff trained at government expense) were expected to be bonded for an unspecified period (3-5 years) and in lieu of this shall need to refund training costs. The general opinion is that bonding has been a failure in Ghana, as a result of poor compliance and ease of 'buying out'.

***Remittances from health workers***

There is no accurate or detailed assessment available of remittances from health workers. Nursing respondents in particular felt that there were visible signs of nurses working abroad who are returning to invest in building homes, starting small businesses (for their families) and providing financial support for their families in Ghana. However, no reliable estimate exists of the volume of such remittances. (NOTE: WHO has just begun a study to examine in more detail the issue of health worker remittances)

The doctors group reported that they were not aware of significant levels of remittance and returns by doctors. This may be linked to differences in respondents that indicate that nurses thought more of working for a while and returning home whilst the doctors were not so sure of returning to practice ("maybe at retirement"). At various times the newspapers have reported estimates of about US$400m being the volume of remittances sent home by all Ghanaians living abroad.

[7] Dr. JB Asare, Chief Psychiatrist, Psychiatric Hospital quoted in Daily Graphic (20th May 2003).

***Attempts to encourage returners***

There is not much evidence of migrating doctors returning but it is reported that Ghanaian doctors sponsored for various post-graduate training programmes do return. The number is limited. Respondents interviewed in the study were quite confident that returns were a rare occurrence.

Apart from the ADHA and the distribution of cars reported above, which are aimed generally at retention, not much has been done to improve retention and reduce the mobility of Ghanaian health workers. However, there is indirect effort to match the international demand by increasing the number of health workers produced

The interventions have therefore been focused primarily on providing incentives. Whilst the results for doctors appears rather mixed (a slowing of migration, no change in distribution, and return of private sector doctors to public service) it appears to be decidedly negative for other health professionals especially nurses. The disparities in treatment between nurses and doctors have led to nurses complaining that they are not valued by the sector. The focus groups with nurses were explicit about being treated as second-class professionals and despite the somewhat significant increase in remuneration the impact of the interventions on morale has been negative.

**B. Barbados**

Healthcare in Barbados is primarily provided through a public sector system but with a growing private sector provision, particularly in primary care. A comprehensive ten year strategy for health was initiated, after multi stakeholder discussion and agreement in 2002 Ten key priority issues were identified in the strategy:

-health system development
-institutional health services
-family health
-food, nutrition and physical activity
-chronic non communicable diseases
-HIV/Aids
-communicable diseases
-mental health and substance abuse
-health and the environment
-human resource management

***Human Resource (HR) Management***

The ten year strategy identifies current HR challenges and limitation and sets out a "way forward" to achieve an overall goal of "appropriate human resources available to support the health systems".

The strategy notes that "meeting the future need for health professionals requires a national human resources strategy…….Recruiting and retaining nurses is a challenge in a market with strong competition from the United States, Canada, the United Kingdom and other Caribbean countries……..The shortage of public health nurses may be explained by the rate of training not keeping pace with the rate of retirement from the system. Yet the shortage of other categories of nurses is due to emigration.".

The strategy document also argues for the need for a pro- active approach to human resource management, including the introduction of performance appraisal, and improvements to the working environment.

A comprehensive nursing strategy is currently being developed in Barbados, based on a wide ranging consultation exercise with stakeholders. The strategy ("Excellence in Nursing Through Empowerment of Citizens") is currently in draft form. The strategy for the time period up to 2012 includes several proposals which directly or indirectly relate to human resource management. Relevant details will be highlighted later in this report.

***Health Sector Workforce***

Registration data provided to the consultant give the following current mix of health professional personnel in Barbados:

**Registered Health Professionals, Barbados, 2003**

| | |
|---|---|
| Doctors | 332 |
| General Nurses | 617 |
| Psychiatric Nurses | 245 |
| Physiotherapists | 27 |
| Occupational Therapists | 6 |
| Speech Therapists | 2 |
| Psychologists | 7 |

(NOTE: The requirement for annual re-registration means that data is relatively up to date; data will include public sector and private sector workers).

The only general hospital on the island – the Queen Elizabeth Hospital (QEH) – represents the main source of healthcare employment (reportedly employing approximately 500 general nurses). The remainder of the workforce in the public sector are working in polyclinics and other smaller establishments. There are also a number of private sector clinics/nursing homes and a 24 bed private sector acute hospital.

As a relatively small country, with well educated English speaking health professionals, Barbados, like other Caribbean islands, can be vulnerable to the effects of out-migration. If only twenty or thirty nurses were to make the individual decision to migrate, this could represent a significant reduction in the available stock. The vulnerability of the Caribbean to the possible negative effects of out-migration of health professionals is exacerbated by its geographical proximity to North America and by its long established migratory paths both to North America and the United Kingdom.

***Migration of Health Workers***

There is a long tradition of out-migration of health professionals to the UK and also to North America. A history of QEH in Barbados (Walters) notes that in the mid 1960s "the exodus of nurses to England and the United States, who had commenced in the fifties continued unabated … It was at this time that Matron decided to get to the root of the problem by initiating research amongst the grades of staff affected; the findings revealed two areas of major concern for the nurses; poor salaries and the lack of recognition of graduates …". The plan developed in the 1960's to counter these "push factors" included an increase in salary for nurses, the recruitment of overseas nurses on 1-2 year contracts, upgrading of training and increase in numbers of nursing students.

These developments in the 1960s highlight both that out-migration of health workers is a well established factor in Barbados and that identifying "push factors" and policy interventions to combat them are also not new.

More recently, out-migration of nurses and other health workers has again been identified as a major factor. The 2002-2012 Strategic Plan notes "Recruiting and retaining nurses is a challenge in a market with strong competition from the United States, Canada and United Kingdom and other Caribbean countries. The shortage of public health workers may be explained by the rate of training not keeping pace with the rate of retirement from the system. Yet the shortage of other categories of nurses is due to emigration". [Note: It was reported to the consultant that the annual intake of student nurses to training had been suspended for several years during the 1980's]

The draft nursing strategy states "Records show that between 2000 and 2001 approximately 10% of nurses have left the nursing sector, with a significant percentage seeking employment overseas" (p.11). It also notes (p.22): -
"There are a number of push and pull factors responsible for the external migration of nursing personnel. In the short term migration is viewed as a threat, since it reduces the availability of nurses. In the long term however, it presents many opportunities for the professional by way of transferring skills, knowledge, experience as well as facilitates upward mobility of other nurses within the system. It also contributes to

the economic development of Barbados through financial remittances from abroad. It is therefore necessary to manage this migration process by implementing the following short-term measures:-

The establishment of alternative career paths in clinical settings
Establishment of agency nursing in both the public and private sectors
Freedom of movement amongst institutions for flexible responsibility allowance (flexi-time)
Improving conditions of service

Furthermore it is important, to note that given the increasing demands for nursing personnel, locally, regionally and internationally that there be no interruption of nurse training in the future as has occurred on some occasions in the past".

It should be noted that the statement in the report that "the rate of training not keeping pace with retirement from the system" is not supported by any data or analysis. The fact that training of nurses was reportedly suspended for several years in the 1980s will have been a contributory factor to any shortages in the successive decades.

***Data and Information on Migration***

It was not possible to obtain comprehensive data on numbers of health workers out-migrating from Barbados. Current data is on manual records and is incomplete (the development of an HR database, with Health Canada technical support, is underway).

Information was obtained on out-migration of nurses, based on an analysis of manually kept records. The annual number of general nurses resigning from the QEH reportedly to migrate, over the period 2000-2003 is shown below:-

**Annual number of nurses resigning to emigrate, QEH, Barbados**

| | |
|---|---|
| 2000 | 26 |
| 2001 | 16 |
| 2002 | 18 |
| 2003 (partial) | 14 |

Measured against a working'stock' of approximately 500 nurses working in the hospital, this represents an average outflow due to migration of approximately 4% per annum in recent years. These nurses were reported to have gone to the UK, US, Canada and other Caribbean Islands (eg Bahamas).

Data was also provided on outflow of psychiatric nurses. Approximately 50 were reported to have migrated in the period 1998 to 2002, mainly in the earlier part of that time period, with the vast majority having been reportedly recruited to the UK. This represents a higher proportionate impact against an establishment of only approximately 250.

It should be noted that this data relates only to nurses that are known to have migrated. Others who left may have migrated but not been recorded or may have migrated soon after resigning. Key informants reported that some nurses do not resign prior to having emigrated- they may either take holiday or sick leave , and then travel abroad, only actually "resigning" at a later date; in some individual cases it will be unclear if the nurse has actually left the country, or just left the hospital. As such the above estimates are "not less than" figures.

Currently Barbados has an intake of 60 student nurses per year. With attrition during training, approximately 35-50 annually have been qualifying and entering the workforce. (There are current plans to increase intake). Combined with return migrants and some immigration of nurses (Barbados has actively recruited nurses from Guyana), this represents the total annual new inflow to the workforce. This has to be set against outflow due to retirement, out-migration and other resignations.

As noted earlier, the Strategic Plan suggests about 10% of nurses annually have resigned for migration and other reasons. The more detailed data on out-migration from Queen Elizabeth Hospital and from the psychiatric service suggests that migration alone has accounted for approximately 4% of nurses in QEH and a higher proportionate outflow from psychiatric nursing (with the latter being primarily due to a high level of recruitment to the UK in 1999/2000). If these data are comparable, it suggests that migration will have accounted for almost half the outflow due to all types of "resignation".

***Reasons for Out-Migration***

There have been a number of attempts to assess which pull and push factors are impacting to stimulate out-migration of health workers from the Caribbean. As noted earlier, an assessment in the 1960s had pointed to low salaries and poor recognition of qualifications as being key "push factors" in encouraging nurses at QEH to consider migrating, to the USA, Canada and the UK. More recently, the Caribbean office of the Pan American Health Organisation (PAHO) audited the nursing workforce and migration factors as part of its work on managed migration. Focus group interviews of nurses were conducted in different countries across the Caribbean. The PAHO assessment identified the following key factors influencing nurses decisions to stay or leave employment in the Caribbean:

**"Push" Factors Encouraging Caribbean Nurses to Emigrate**
Financial
Poor Working Conditions
Lack of Professional Development Opportunities
Lack of Promotion Opportunities
Non involvement in Decision Making
Lack of Support from Supervisors
**Source: (PAHO, 2001)**

The PAHO study also identified reasons for staying in the Caribbean – these related to family commitments "patriotism"; the opportunity to "give something back" to the country. The "push" factors to leave were directly related to negative aspects of the work environment, whilst the "retention" factors reported by PAHO are broader based and not related directly to the work situation.

Currently (2003) the pay rate for a staff nurse is approximately 28,000-40,000 Barbados dollars (exchange rate approximately 3 Barbados dollars to £1 sterling). No information relating to the level of remittances from migrant health workers could be obtained.

Unpublished research based on interviews of nurses in Barbados was provided to the consultant (Mascoll et al, 2003). This study identified the main push/pull factors encouraging nurses to consider migration. The research used interviews with current staff (the "reasons" are not ranked).

**Issues contributing to "push factor", Barbados nurses, 2003**

| Psychiatric Nurses | General Nurses (QEH) |
|---|---|
| Career opportunities | Stress/burnout |
| Pay, other benefits | Pay |
| Work overload | Lack of Training & Development |
| Poor working conditions | Poor working conditions |
| Low morale | Low morale |
| Lack of organisational vision | Lack of organisation vision |

Source: Mascoll et al, 2003

It should be noted that the draft nursing strategy identifies a similar range of issues as impacting negatively on the current motivation of nurses. It also sets out action points and time lines to address these issues:

> "The nursing profession in Barbados is at a crossroad. It is confronted by a number of deeply entrenched forces: power, hierarchy and tradition which have all impacted on the conditions of service for nurses. These factors, which in the past may have accounted for the very strength and excellence of the profession, are now failing to provide nursing with the leadership and strategic focus required to delivery quality care in the context of rapid internal and external change.
>
> Four strategic issues have been identified below in determining the future of Nursing Services in Barbados. A common theme linking the issues is health sector reform. There will be need to reorient nursing to embrace health promotion which has been the approach adopted at the national level for the delivery of health care.
>
> The four strategic issues are:
>
> Nursing Services Development
> Community Health
> Governance and Regulation
> Human Resources Development
>
> The highly centralised decision making process, lack of managerial support, issues of confidence and fear are present at all levels of the health care infrastructure. At the senior and operational levels there is lack of application of management principles and training respectively. These factors inhibit the ability of nurse managers to initiate change and introduce innovative approaches to improve the quality of practice".

Focus groups of nurses were also conducted in October 2003. 15 nurses were invited and 11 participated, ranging in age from to 20s to 50s. A range of workplaces and specialties was also represented – student nurses, general nurses, psychiatric nurses and public health nurses. The three older nurses were return migrants (all had worked in the UK) and two of the other nurses had also worked abroad (one in the Bahamas, one in the UK).

When asked, all the participants stated that they would advise other Barbadian nurses to migrate, at least for a period of time; the main factors given were personal and career development. However all also noted that the overall impact of out-migration of nurses was detrimental to the health system in Barbados. This was

primarily characterised in terms of the impact on staffing shortages, quality of service and workload of remaining staff.

Broader discussion on push and pull factors related to migration identified the following key drivers:

***Key Drivers in Migration from Barbados: Focus groups, 2003***

Lack of career development opportunities
Frustration with current centralised/hierarchical management
Pay (NOTE: It was generally agreed by participants that pay differential was not the main driver for migration)
Heavy workload
Lack of flexible hours (the vast majority of nurses are required to work full time; shift patterns are rigid)

**Source: Focus Groups, October 2003**

Many of the participants were critical of the current career and development opportunities for nurses in Barbados; several alluded to the fact that promotion was based on seniority rather than merit and that it was extremely difficult to achieve flexible working hours because of the rigid management. (One participant reported that a nurse colleague was moving to the UK with her three children primarily because she would have the opportunity of a job share in the UK, whilst this opportunity had not been made available in Barbados, despite the nurse requesting a part time career opportunity).

***Active Recruitment?***

The focus group participants were asked about current methods by which health workers in Barbados would out-migrate. The main factors facilitating migration were identified as follows:

**Main Factors Facilitating Out-Migration, Focus groups, 2003**

Tradition of migration, with Barbadian communities/relatives in destination countries
Recruitment visits to Barbados by agencies (mainly USA)
Recruitment facilitated by Barbados based agencies
Personal contacts with Barbadian health professionals in destination country
Internet search/web based recruitment by agencies

**Source: Focus Groups, October 2003**

None of the focus group respondents reported current active recruitment by UK based agencies or employers but some emphasised that internet access made it relatively easy to establish contact with UK based recruiters. One respondent (a psychiatric nurse) was due to leave to take up a UK based NHS post later in the year.

Whilst the three older nurses in the focus group had all worked in the UK (two had travelled to the UK for their nurse education, the third had migrated after qualification) some of the younger nurses who were considering migrating reported that the USA would be their first preference, partly because of the pay levels, partly because it is nearer Barbados. However a number of respondents reported that the need to sit

the NCLEX examination in order to become eligible for state registration and employment in the USA was a relative disincentive to apply to work in the USA. Currently nurses have to travel to the USA to sit the exam but the US examining authorities are reported to be considering offering the exam in some source countries to facilitate recruitment.

***The "Managed Migration" Initiative***

"Managed migration" was a label initially developed in Jamaica. In the context of migration of health workers it refers specifically to the "Managed Migration" project, which has been initiated by the Caribbean Nurses Association (CNA) and the Caribbean office of PAHO. CNA is the umbrella organisation of 26 National Nursing Associations (NNAs) in the Caribbean.

CNA and PAHO have joined with other organisations including the Regional Nursing Board (RNB – the umbrella body for the chief nurses from Caribbean countries) to develop a framework which is intended to provide a regional strategy for retaining sufficient nurses in the Caribbean whilst also respecting the individual nurses right to choose where they work and live.

The initiative began in 2001, with a review of the current impact of out-migration of nurses from the Caribbean. At that time it was estimated that there was a 35% vacancy rate of nurses across the Caribbean and that out-migration of nurses was contributing to reductions in the level of health service provision. As noted earlier in the report, research conducted for PAHO at the time pinpointed a range of "push" factors, mainly linked to low pay, and poor career prospects.

The organisations developing the managed migration project recognised and respected the right of the individual to move, whilst also highlighting the potential damage to health systems that out-migration could create, as one type of outflow of staff. The project also pinpointed that that unplanned "random" migration of individual staff was particularly damaging, because it was unplanned, un-predictable and often happened with the employing organisation having no notice that the nurse was leaving. As noted earlier, in some cases, knowledge that the nurse had emigrated would only occur after the event. These nurses would often leave at short notice, sometimes taking vacation to travel to the USA, sit the licensing examination and then send back word that they had resigned. This type of random outflow of staff was one- way, usually long term, and varied unpredictably in magnitude from one year to another and from one organisation to another.

"Managed migration" was therefore an attempt to establish a policy framework in which there was an emphasis on improving the retention of nurses in the Caribbean but to also encourage a more proactive approach to migration.

There are six elements to the framework which focus on improving retention; these are set out below, along with some of the current initiatives underway.

***Managed Migration Initiatives***

| | | |
|---|---|---|
| **1.** | **Recruitment and Retention** | **Recruitment video/TV advertising**<br>**"Year of the Caribbean Nurse" Mentorship programme** |
| **2.** | **Education and Training** | **Study to evaluate current training capacity**<br>**Development of distance learning, base nursing degree at University of West Indies (UWI)** |
| **3.** | **Utilisation and Deployment** | **Introduction and evaluation of workload measurement tool** |
| **4.** | **Terms and Conditions of Employment** | **Healthy Workplace Initiative**<br>**Promotion of ILO resolutions on nursing** |
| **5.** | **Management Practices** | **"Magnet Hospital" Programme**<br>**Leadership for Change Programme**<br>**Nursing/HR database** |
| **6.** | **Policy Development** | **Evaluation/ country "report card"** |

The overall initiative has received support from various agencies and organisations, and provides a framework in which various activities (some of which would have been happening even without the overall managed migration initiative) can be more effectively co-ordinated.

Examples include: Health Canada is supporting the development of the distance learning degree at UWI, and is also providing technical support to develop the HR database (this latter initiative should provide more detailed and accurate data on flows of health workers within the Caribbean and outflows due to migration and other factors); the Department of Health, England, has had an input on healthy workplaces, the International Council of Nursing is supporting the Leadership for Change programme (leadership development facilitated learning sets); the American Nursing Credentialing Center is involved in the magnet hospital initiative; Johnson and Johnson funded the recruitment video and LIAT (a Caribbean airline) is supporting the "Year of the Caribbean Nurse" which is a year long celebration of nursing in the Caribbean.

The other main aim of the managed migration project is to encourage bilateral or multilateral approaches to migration where there is greater scope for a "win-win" situation. Whilst this aspect of the project is at an early stage, a number of initiatives are reported to be in development. One example is that of one island which is in discussion with a US based hospital system, with a view to 100 additional nurses being trained per year in the island – the nurses will be 'bonded' to provide three years of employment on the island but they can leave at any time to take up employment in the US hospital. If this happens the hospital will reimburse training costs at a pre-agreed level. Another initiative, linked to the "Year of the Caribbean Nurse" is to build on the links that already exist between specific Caribbean island hospitals and hospitals in the UK, Canada or the USA, to encourage exchanges of staff, and to support some "reverse migration" of staff to the Caribbean. A similar development is planned to temporarily employ university faculty and tutors from UK, Canada and USA to provide post basic specialty training; the host country will provide financial support at local levels of pay.

Another US hospital corporation is reported to be in discussion with Barbados government representatives about the development of "structured recruitment" of health workers, linked to the provision of education and with some staff going to the US temporarily for work study.

***Barbados Summary***

There has been a decline in the annual number of nurses entering the UK register from the West Indies. It is not possible directly to attribute causality to this decline, but it began at the same time as the initial guidelines on international recruitment were introduced in November 1999- when the West Indies was one of two countries explicitly listed as "no go" by the Department of Health. However the decline has been in contrast to many sub Saharan African countries which have seen a year on year increase of registrants on the UK register. There are two other possible factors- either that the managed migration project has begun to have some effect, and / or that just as many nurses continue to leave the West Indies, but they are now going to Canada or the USA rather than the UK. The focus groups suggested that the USA is the preferred location for some younger nurses, but that the UK is perceived as being "easier" to enter than the USA.
Data on out-migration and other aspects of labour market dynamics is incomplete, so only broad estimates of the impact of out-migration can be determined. Overall in recent years, the available data suggested that out-migration of nurses has been equivalent to "not less than" 4 to 5% per annum and may be up to 10%. Given the available data it is not possible to assess how significant outflow due to migration is in comparison to other forms of staff wastage from the public sector health system.

As a small island with well-established out-migration links and a well trained English speaking health workforce, Barbados could be vulnerable to the impact of any increase in migration – a relatively small numerical increase in staff outflow could have a proportionately large impact.

A number of strategies have been identified to improve staff retention but it is also clear that stakeholders in Barbados regard migration as a fact of life. Most informants saw merit in working to "manage" the outflow of health professionals so that any negative impact is minimised and the opportunities for "win-win" situations at the level of the individual and the system are maximised.

The "managed migration" initiative in the Caribbean in which Barbados is playing an active role, represents a model, which has potential to enable country governments and other relevant stakeholders to play a more active role in the out-migration of health workers. Its key characteristics – regional co-ordination of multi-country, multi-stakeholder and multi-intervention initiatives, based on respect of the individual's right to move – may have a resonance and applicability in other regions. Some factors, such as the pre-existence of regional representative bodies, the shared culture, language and educational system and the long tradition of out-migration, may be more specific to the Caribbean than to some other regional healthcare labour markets, and may facilitate managed migration in the region. The potential for managed migration to support a situation that is nearer to "win –win" in health professional migration over the next few years should be closely monitored. Evaluation of the full implementation of the project can inform broader based policy analysis of the impact of migration of health workers, and may contribute to more positive developments in other regions.

## 6. HEALTH WORKER MOBILITY: GENERAL POLICY IMPLICATIONS

The earlier sections of this report have focused in detail on the issues of active recruitment to the UK, and the policy challenges and impact of outflow of health workers from Ghana and from Barbados. The report has highlighted the growing level of active recruitment to the UK as a result of the NHS plan targets, has examined the impact of the Department of Health Code on international recruitment, and has also contrasted the policy interventions adopted in Ghana and in Barbados, the latter as part of the "managed migration" project in the Caribbean. This section of the report examines in more detail some of the more general policy questions that are raised by this analysis, and highlights key current knowledge gaps.

### *Policy questions*

The increases in flows of health workers across national boundaries — partly as a result of the growth of active recruitment by some industrialized countries — creates a series of policy questions for national governments and international agencies. These are summarized in Box 1.

**Box 1. International health worker mobility: policy questions and subsidiary research questions**

**Source countries**

***Policy***

- Should outflow be supported or encouraged (to stimulate remittance income or to end oversupply)?
- Should outflow be constrained or reduced (to reduce brain drain)? If so, how (what is effective and ethical)?
- Should recruitment agencies be regulated?

***Research***

- What are the destination countries for outflow?
- How much outflow is permanent or temporary (short or long term)?
- How much outflow is going to health sector-related employment and education in other countries? What proportion is going to non-health-related destinations?
- What is the size of outflow to other countries compared with outflow to other sectors within the country?
- What is the impact of outflow?
- Why are health workers leaving?
- How should flows be monitored?

**Destination countries**

***Policy***

- Is inflow sustainable?
- Is inflow a cost-effective way of solving skills shortages?
- Is inflow ethically justifiable?
- Should recruitment agencies be regulated?

***Research***

- What are the source countries for inflow?
- How much inflow is permanent or temporary?
- How much inflow is going to health sector-related employment and education in the country? What proportion is going to non-health-related destinations?
- Is inflow effectively managed?
- Why are health workers coming?
- How should flows be monitored?

**International agencies**

- How should international flows of health workers be monitored?
- In the context of the working relationship with the country government, what is the appropriate role and response of the agency to the issue of international mobility?
- Should the agency intervene in the process (for example, develop an ethical framework, support government-to-government contracts, introduce regulatory compliance)?

Source: adapted from Buchan, Parkin, Sochalski, 2003

***"Source" countries***

Ghana, Barbados and other countries that are experiencing a net outflow of health workers need to be able to assess why this is happening and evaluate what impact it is having on the provision of health care in the country. Reliance on incomplete data or incompatible data from different sources often means that it is not possible even to have an accurate picture of the trend in outflow of health workers, let alone any assessment of the impact of this outflow on the health services.

It is important that the available information base enables policy-makers to assess the relative loss from outflow to other countries in comparison with other internal flows, such as health workers leaving the public sector to work in the private sector or leaving the profession to take up other forms of employment. International outflow may be a very visible but relatively small numerical loss of workers compared with flows of workers leaving the public sector for other sources of employment within the country.

Unmanaged outflow of health workers may damage the health system or erode the current and future skills base. Ghana is one country that has initiated policy responses, including bonding nurses to home employment for a specified period of time after completion of training. This does not appear to have been effective - with compliance not being effectively monitored, and with scope to buy out of the bond. The managed migration initiative in the Caribbean is a broader based attempt to take a more proactive stance on migration- recognising that it is not possible to stop it where there are severe push/ pull imbalances.

Preventing health workers from leaving through the use of monetary or regulatory barriers is one policy response, but it does nothing to alleviate the push factors that stimulated the workers desire to leave and also cuts across notions of free mobility of individuals. Other policy responses to reducing outflow relate to a more direct attempt to reduce the push factors: by dealing with matters concerning poor pay and career prospects, poor working conditions and high workloads, responding to concerns about security, and improving educational opportunities, etc.

The case studies in both Ghana and Barbados highlight that individual health professionals regard poor pay and career prospects as a push factor- and that employers and governments are aware of this situation.

Events in the Caribbean highlight another policy response- based on the recognition that outflow cannot be halted where principles of individual freedom are to be upheld, but that interventions can be developed to ensure that such outflow is managed and moderated. The "managed migration" initiative being undertaken in the Caribbean is an example of a coordinated intervention that attempts to minimize the negative impacts of outflow while hoping to secure at least some benefit from the process.

***Source Countries: issues for further research***

There is a need to "place" the level and impact of international out-migration of health workers in a broader labour market context. For example, in many countries, such as Ghana, there is a need for a more detailed assessment of the actual impact of outflow of health workers to other countries, in comparison to that caused by outflow out of the health sector, but remaining in country. The other main issue, which is under-explored, is a more detailed evaluation of the various attempts to constrain outflow, or encourage returners. The report from Ghana suggests that some of these interventions may have been counter-productive because of a perception that they

were unfair- rewarding some groups at the "expense" of others. Case study research would provide more evidence on "what works" (and is appropriate); such research could be linked to broader based studies which looked at all interventions to improve the recruitment and retention of health workers in the country. This in turn is related to issues of capacity, governance and planning within the country.

Another important associated issue is gender within the health care workforce. This is in terms both of the link to differing patterns of migration, or migration experiences, for male and female health workers, and to the issue of whether particular staff groups receive differential treatment because they are perceived to be gender specific. In particular the undervaluing of nurses as "womens work" in some countries may be both a direct driver for mobile nurses to leave that country, and an indirect reason why interventions to reduce outflow may be ineffective.

As well as being the focus of policy research studies, these subjects could also be the focus of regional workshops, bringing together Ministry health and human resource planners, health sector employers, health professional associations, NGOs and representatives of civil society to share knowledge and develop a better understanding of which policy interventions can assist is ameliorating the negative impacts of outflow of health workers.

***"Destination" countries***

The policy challenges for destination countries such as the UK mirror those of source countries. The first concern is monitoring and assessment, as the ability to monitor trends in inflow (in terms of numbers and sources) is vital if the country is to be able to integrate this information into its planning process. Equally important is an understanding of why shortages are occurring — is it because of poor planning, unattractive pay or career opportunities, early retirements, etc? An initial assessment of the contributing factors for the staffing shortages in any country needs to be undertaken and those factors taken into account. This assessment would include that of health worker "wastage" to other sectors or regions within the country.

It is crucial to assess the relative contribution of international recruitment compared with other key interventions (such as home-based recruitment, improved retention, and return of non-practising health professionals) in order to identify the most effective balance of interventions. This assessment has to be embedded in an overall framework of policy responses to health sector workforce issues if it is to be relevant.

The second policy challenge for destination countries can be characterized as the "efficiency" challenge. If there is an inflow of health workers from source countries, how can this inflow be moderated and facilitated so that it makes an effective contribution to the health system? Policy responses in the UK have included "fast tracking" of work permit applications; developing coordinated, multi-employer approaches to recruitment; developing multi-agency approaches to coordinated placement, and providing initial periods of supervised practice or adaptation as well as language training, cultural orientation and social support.

The third policy challenge of destination countries concerns ethics. Is it justifiable, on moral and ethical grounds, to recruit nurses from developing countries? The simple response may be that it should not be justifiable to contribute to brain drain in other countries, but a detailed examination of the issue reveals a more complex and blurred picture. Active recruitment by employers or national governments in the destination country has to be contrasted with a situation in which the workers

themselves have taken the initiative to move across a national border. Account must also be taken of the development of bilateral and multilateral agreements, as well as of the right of the individual to move where she or he may wish.

***Destination countries: issues for further research***

Various types of bilateral and multilateral recruitment agreements are being developed by different recruiting countries, some of these approaches have an explicit "ethical" dimension, or attempt to focus on encouraging a "win-win" situation, where the source country is not only a loser in the process. The UK, particularly England, is one of the higher profile recruiters at the moment, but is also taking the lead on some of these other associated developments. Detailed case studies examining the content and actual operation of some of these agreements would be instructive in highlighting the pros and cons of different approaches, and identifying which appeared to be most effective and appropriate for source countries.

The other main area for further research would be undertaking more detailed cohort studies of international recruits in the destination countries, to develop a better understanding of their career plans, reasons for moving, how long they plan to remain in the destination country, level of remittances sent "home" etc

***Monitoring the flows***

One key issue, for country governments and for international agencies, is developing a better understanding of the level and dynamics of the flows of health workers. In the UK it is not possible to quantify the relevant flow related to active recruitment, and that related to other methods of entry to the country. The UK case study information highlights that active intervention in the recruitment process by employers and/or government has become a more significant feature in recent years, as a response to staff shortages.

Further research could also be supported in source and destination countries to improve monitoring of flows; this could be undertaken in association with other agencies with an interest in this issue (i.e WHO, ILO).

***Conclusions and Recommendations***

This report has examined trends in international recruitment of health workers to the UK. It has highlighted significant growth in the inflow of doctors and nurses from other countries to the UK professional registers in recent years. This has been partially at least because of active recruitment by the NHS, but also (for nurses) because of recruitment of the private sector. The Code of practice on international recruitment implemented by the Department of Health in England only covers NHS employers and recruitment agencies; with the available data it is not possible to examine in detail the overall impact of the Code. Case study informants in NHS organisations knew of the Code and its requirements, but the fact it does not cover the private sector means that the unknown proportion of nurses entering the UK to work in the independent sector are not covered by the Code.

International recruitment of health workers creates challenges for "source" and "destination" countries, and for individual health workers themselves. Some of the key issues for country governments and health workers are summarised in Table 6.1. It also highlights some of the potential opportunities created when health workers are, or can be, internationally mobile.

**Table 6.1: International recruitment of health workers: opportunities and challenges**

| | Opportunities | Challenges |
|---|---|---|
| **Destination countries** | Solve skills/ staff shortages. "Quick fix". | How to be efficient, and ethical in recruitment. |
| **Source countries** | Remittances.<br>Upskilled returners (if they return) | Outflow causes shortages; negative impact on delivery of care. Costs of "lost" education. Increased costs of recruitment of replacements. "Manage" migration? |
| **Internationally mobile health workers** | Improved pay, career opportunities, education. | Achieving equal treatment in destination country |
| **Static health workers** | (if worker oversupply)<br>Improved job and career opportunities | Increased workload as staff leave. Lower morale. |

It was argued at the beginning of this report that international recruitment and mobility was a complex issue, not one that was merely about linear one way flows of staff. It is clear from the case studies in Ghana and Barbados that many nurses, doctors and other health professionals will be interested in accessing the "pull" factors that are on offer in developed countries. The demographics in many developed countries- a growing, ageing population and an ageing nursing workforce- make it likely that many of these countries will be actively encouraging inflow of health workers (Buchan 2002). Stopping migration is unlikely to be a viable option - which essentially leaves two other policy stances- non intervention, or some level of intervention to attempt to manage the migration process so that it is nearer "win – win", or at least is not exclusively "win- lose", with the countries that can least afford to lose being the biggest losers.

Some of the possible interventions for "win-win" are summarised in the table below. Some are drawn from initiatives already underway in the NHS (see e.g Department of Health 2003c) or in the Caribbean managed migration project. Few have been tested or evaluated to any extent. The next focus of research on the trends and impact of health worker migration should focus on assessing these interventions and possible interventions.

**Table 6.2: Examples of Potential Policy Interventions in International Recruitment**

| Level | Characteristics/ examples |
|---|---|
| **Organisational** | |
| "Twinning" | Hospital in "source" and "destination" country develop links, based on staff exchanges, staff support and flow of resources to source country. |
| Staff Exchange | Structured temporary move of staff to other organisation, based on career and personal development opportunities / organisational development. |
| Educational support | Educators and/ or educational resources and / or funding in temporary move from "destination" to "source" organisation. |
| Bilateral agreement | Employer(s) in "destination" country develop agreement with employer(s) or educator(s) in "source" country to contribute to, or underwrite costs of, training additional staff, or to |

| | |
|---|---|
| | recruit staff for fixed period, linked to training and development prior to return to "source" country |
| **National** | |
| Government- to government bilateral agreement | "Destination" country develops agreement with "source" country to underwrite costs of training additional staff, and/ or to recruit staff for fixed period, linked to training and development prior to staff returning to "source" country, or to recruit "surplus" staff in "source" country |
| Ethical recruitment Code | Destination country introduces Code that places restrictions on employers - in terms of which source countries can be targeted, and/ or length of stay. Coverage, content and compliance issues all need to be clear and explicit. |
| Compensation | Much discussed, but not much evidence in practice- destination country pays compensation- in cash or in form of other resources- to source country. Possibly some type of sliding scale of compensation related to length of stay and/ or cost of training, or cost of employment in destination country; possibly "brokered" via international agency? |
| Managed migration (can also be regional) | Country (or region) with outflow of staff initiates programme to stem unplanned out-migration, partially by attempting to reduce impact of push factors, partially by supporting other organisational or national interventions that encourage planned migration. |
| Train for export | [can be a subset of managed migration] Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market- to generate remittances, or up- front fees. |
| **International** | |
| International Code | As above, but covering a range of countries- and as above, its relevance will depend on content, coverage, and compliance- Commonwealth code is an example |
| Multilateral agreements | Similar to bilateral (above), but covering a number of countries (region?). Possible of brokering/ monitoring role by international agency |

The Table above sets out some options for intervention; some are relevant for source countries, some for destination countries, but few have been fully implemented or evaluated. The next round of policy research on the trends and impact of health worker migration should assess these interventions and possible interventions, to identify which, if any, have the potential for mutual and beneficial impact.

The recommendations for further policy related research are made on the basis of identified key current knowledge gaps. They are also made on the basis that it is unlikely that there will be any slackening in the prominence of UK international recruitment activity in the next few years. All four UK countries are committed to further NHS staffing growth over the decade. Whilst all are succeeding in increasing the numbers of health professionals being trained, international migration of health workers is also likely to continue, and this activity will continue to be facilitated by the significant inter- country imbalances in the pay and career prospects for doctors and nurses. The current historically high levels of international recruitment are likely to continue- and as such national governments and international agencies will have to be clear about their own policy standpoint.

The main recommendations drawn from this report are:

One crucial gap is the absence of data on the numbers of international nurses recruited by, and working in, the NHS. It is recommended that consideration should be given to assessing the potential to routinely collect this data, as part of current developments with the Electronic Staff Record (ESR) and other improvements in NHS workforce data (such data is collected for doctors);

The Department of Health Code does not cover the independent sector; whilst a recent Parliamentary Answer suggests that extension to the independent sector cannot be easily achieved, if this is not possible, it is recommended that DFID examine the potential (along with DH) to work with representative bodies from the independent sector to develop a parallel Code which covered the majority of independent sector employers

Relatively little is know about the international health workers in the UK- in terms of their experiences and future career plans (including likelihood of return to source countries or onward movement to other countries). This is one area that it is recommended be a priority for future research

The position of many developing countries which are sources of international health workers is weakened by inadequate workforce data and planning capacity. It is recommended that DFID and other donors give consideration to supporting improvements in HR databases in source countries (two current examples are the Health Canada supported work in the Caribbean, and the CDC supported work in Kenya)

The gender issue in relation to the migration of nurses is an important factor; another recommendation is that donors give consideration to supporting strengthened nurses professional associations in source countries, so that the position of nurses in society can be supported by stronger advocacy (current examples include the Commonwealth Nurses Federation, Emory University and Commonwealth Secretariat support)

Finally the issue of how – or if - to “manage” migration is important, and requires more considered investigation. It is recommended that further policy research be supported to examine some of the issues highlighted in Table 6.2 above.

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