

# **Evaluating the Department of Health, England, Code of Practice on International Recruitment**

## **1. Background**

This paper is based on research commissioned by Department for International Development (DFID), with support from the Department of Health (DH) in England, to assess the impact of the Department of Health Code for the international recruitment of health professionals.

International recruitment of health professionals has been high on the policy debate agenda in recent years<sup>1</sup>, with increasing advocacy for the development of an international Code. As the DH Code was the first country level code to be developed there is particular interest in its content and impact. Given current debate about multinational Codes, lessons learnt from the impact of the DH Code have a policy relevance. This paper reports on an evaluation of the impact of the Code in the “destination” country of England, and in two “source” countries.

Active international recruitment of health professionals was an explicit policy intervention by the DH in England, as one key element in achieving rapid staffing growth in the National Health Service (NHS), particularly in the period 2000 to 2005<sup>2</sup>. With subsequent growth in the numbers of nurses and medical staff beginning to emerge from UK based education, and with financial difficulties hitting some NHS trusts in England in 2006, the level of international recruitment has dropped significantly since early 2006. Evaluation of the Code has to take account of these changing circumstances.

The Department of Health in England first attempted to limit the potential negative impact of international recruitment of health professionals in 1999 when it established guidelines which required NHS employers not to target recruitment activities in South Africa and the West Indies<sup>3</sup>. It then introduced a Code of Practice for international recruitment for NHS employers in 2001<sup>4</sup>. The Code issued in 2001 required NHS employers not to actively recruit from low-income countries, unless there was government- to- government agreement. A full list of these countries was made available to NHS employers in early 2003. The list of countries was developed by the Department of Health in discussion with DFID. At the time of conducting the research in 2007 the list included 154 countries. Three countries on the list (China, India and the Philippines) had been exempted at the request of their governments, on the basis of bilateral agreements with the UK government. The Code was strengthened in 2004<sup>5</sup>, and extended to cover recruitment agencies working for NHS employers, temporary staff working in the NHS, and private sector organisations providing services to the NHS.

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

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 low-income countries, but in reality it was not intended for this purpose. The Code aims to prevent “active” recruitment initiated by the NHS in England. It is directed at NHS employers in England, recruitment agencies commissioned to recruit staff on behalf of NHS employers, temporary staffing agencies providing staff to NHS employers, and private sector employers in England, particularly if they are providing NHS funded care (England is the largest of the four countries in the United Kingdom (UK) ; devolved government means that each of the four UK countries has policy

responsibility for NHS workforce issues- however some aspects of immigration and regulation policy are retained at UK level. Scotland has also issued a similar Code)<sup>6</sup>.

In addition to so called “active” recruitment, there are various types of “passive” recruitment which have contributed to increasing the number of international health workers coming to the NHS in England, but have not contradicted the Department of Health Code:

- some international staff apply for UK employment, whilst located abroad (increased access to the internet has made this easier);
- some staff will move to the UK initially for educational and training purposes
- some “international” workers will already be resident in the UK, but not yet in employment - such as refugees;
- some health workers will move to NHS jobs relatively quickly once they have arrived in the UK, initially recruited by employers outside of coverage of the Code<sup>7</sup>.

One limitation in the study is that the NHS in England has not conducted standard or systematic central monitoring of the numbers of nurses that it has internationally recruited. The NHS is the main, but not the only source of employment for healthcare professionals- whilst it is possible to monitor and track “inflow” to the UK, it is not possible to identify which nurses have been actively recruited by the NHS in England and differentiate those who have come to the UK to work for other employers- or for education purposes. (there is more detailed data available on doctors).

### **3. Methods**

The methods used in the study were analysis of professional registration data and work permit data in the UK to examine trends in “inflow” of doctors and nurses from

other countries, and country case studies in two countries with long term migratory links with England - Ghana and Kenya..

Registration data from the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) were examined. All doctors and nurses who wish to practice in the UK must be registered with the relevant UK body – which enables estimates to be made of the annual number of “new” registrants from other countries. The main constraint on interpretation of the data is that it only shows the individual has been registered – the individual may not have actually moved to or begun working in the UK.

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

Professional registration data and work permit data were used as the best proxy measures because, as noted above, there is no systematic and standard national monitoring by NHS England of active international recruitment of nurses.

In assessing the impact of the Code, it has to be borne in mind that there is no single date to focus on, as described above, there have been different versions of guidelines and Codes in use since 1999. It should also be noted that these data record individuals applying to enter the UK to work as health professionals. If a nurse leaves an African or Asian country but works as a care assistant in the UK, this would not be recorded by these data as a nurse “moving” from one country to the other.

## Results

Registration data were analysed to identify how many doctors and nurses had registered in the UK from different types of countries: countries on the “list” of those from whom the NHS was not supposed to actively recruit; high-income countries; and the low-income countries “exempted” from the list at the request of their governments (China, India and the Philippines). Tracking the numbers and relative proportion of health professionals being registered from “list” countries was one way of evaluating the impact of the Code

Figure 1 presents the registration data for doctors. The “spike” in registration in 2003 is reportedly an artefact, rather than an indicator of a true increase in inflow. It occurred as a result of changes to the Medical Act (Statutory Instrument 2002//3135) which was to come into effect at the end of 2003 and accelerated applications from university graduates of certain universities in specified countries. Setting this aside, there has been little change in the annual number of registrants from the “list” countries- which has varied between 1,800 and 2,200 in recent years.

Figure 2 below, presents the registration data for nurses, collated in a similar format. The peak year for nurse registrants from overseas sources was 2001/2. In the period between 2001/2 and 2005/6 the annual number of nurses registering from “list” countries has declined by more than half, the annual number from list exempt countries by more than one third, whilst the annual number registering from UK sources has increased significantly.

Work permit data are not directly comparable with registration data. They cover different calendar years, do not cover individuals from EU countries, and only provide data on non UK sources, so cannot be used to assess the relative contribution of “new” UK sources in overall numbers of new registrants. However they do provide an alternative measure of the inflow of health professionals from non EU countries.

Figure 3 presents the data on work permits, shown in % terms by category of source country. The number of work permits/first time approvals issued to doctors applying for the first time to work in the UK increased rapidly from 1999 (547) to 2004 (2645) and then declined to 1931 in 2006. The data on the allocation of work permits to doctors which are illustrated in the Figure show some fluctuation between “list” and list exempt countries over the period 2001 to 2006, but no overall trend of change. There has been no sign of a relative decrease in the % of approvals for applicants from “list” countries in recent years.

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

As with the data on permits for doctors, there is little sign of any marked trend of change in % of nurses from list countries and from list exempt countries being issued with work permits over the period 2001-2006.

The other source of information for the study was data generated by case studies conducted in Ghana and Kenya. These case studies were conducted to ascertain the current outflow of health professionals to the UK and to other countries to assess the relative significance of the UK as a destination for health professionals, and to assess the “visibility” of the DH Code as a policy instrument in the health workforce policy and planning context in these countries.

### **Kenya**

There is an apparent contradiction in the position that data suggest that Kenya is a country that suffers from an acute shortage of nurses yet there are reports of nurse unemployment<sup>8</sup>. This arises reportedly because the Kenyan health system does not fund employment of sufficient nurses to meet its identified need.

An emergency hire programme supported by international aid and the Government of Kenya recruited an estimate of 3000 nurses, mostly to serve in rural areas in both the Government and FBO health facilities, in 2006 ( see <sup>9</sup> for an update). There is unequal distribution of the health care labour force between urban and rural and especially ‘hard-to-reach’ parts of the country which has been driven by deployment procedures and changing relative reimbursement packages of the faith based organisations who disproportionately serve rural areas, and the public sector.

The only internal source of data on doctor migration is the numbers seeking ‘Certificates of Good Standing’ from the Kenya Medical and Dental Association. These are required for doctors who are planning to practice outside the country or go

abroad for postgraduate medical training. A register of these shows that 28 doctors had sought letters since February 2007, with an additional 3 said to be in process. Training is the usual vehicle by which doctors migrate – it was said to be relatively rare for a doctor to migrate directly to an overseas post other than a training post, or to set up an overseas private practice.

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

There were peaks in the numbers seeking verification for exit to the UK in 2001, and exit to the USA in 2003. In both countries, numbers have fallen sharply since their peaks. The fact that the evidence shows that sharp falls have occurred in both the UK and the USA is not supportive of an explanation based on the impact of UK recruitment policy alone- the USA does not have any Code or restriction on recruitment.

Stakeholders in Kenya provided multiple explanations of the trends observed in relation to the flows of health professionals to the UK, few of which appeared to make a direct connection to the Code of Practice. Better pay and conditions for doctors in Kenya and to a lesser extent for nurses were highlighted, but the main factor that was identified was greater difficulties in achieving access to the UK labour market . Informants in Kenya reported this was due to greater difficulties in obtaining visas, more stringent UK professional 'adaptation' requirements and difficulties in securing UK clinical placements, and increased total costs of the process.

Many respondents in Kenya commented on past history in the country of very active recruitment on behalf (direct or indirect) of the UK NHS. They remembered seminars in hotels, visiting agents, and newspaper advertisements. Respondents reported that these activities were not now occurring on behalf of the UK. One reported example was a recruitment agency in Kenya which had in the past supported many nurses who wanted to migrate to the UK - it stated that it would no longer advise nurses to consider the UK but would point them in the direction of the USA or Australia instead. It cited problems related to increased difficulty of access to the UK as the reason for this advice.

Few accounts of unscrupulous recruitment agent activity were reported in Kenya. This was reportedly mainly a problem associated with the recruitment of unskilled labour force. However, it was perceived as unethical to recruit qualified professional nurses for relatively unskilled jobs in nursing homes and similar. A number of respondents were conscious that Kenyan nurses had found themselves working in such jobs and this was considered demeaning and exploitative.

## **Ghana**

The Ghana Health Services estimated that there were 1,446 doctors and 14,507 nurses employed in 2006. Longer term trends for numbers of nurses and midwives in Ghana (1999-2005) provided by the Nurses and Midwives' Council for Ghana show that numbers of registrants has increased considerably over the nine year period. The numbers of unemployed nurses and doctors in Ghana was reportedly estimated to be insignificant.

The Ministry of Health, which includes the public services of the Ghana Health Services and private and military sector services estimates the total loss of staff from

the public, Christian Health Association of Ghana (CHAG) and military health facilities (Fig 5) These data indicate that staff losses have reduced since 2004, having shown an increase between 2001-4 in the cases of nurses/midwives, and medical officers. Data also show that 'vacation of post', the usual description for migration out of Ghana has declined as a cause of attrition (Note: These total movements of health workers from individual health facilities will include some who move between facilities rather than being lost to the system).

Additional information on outflow to other countries was obtained from health professional bodies. Data provided by the Pharmacy Council showed that the number of pharmacists requesting letters of confirmation of qualifications reached a peak in 2003 and had stabilised at about half their peak levels between 2004 and 2006. Data provided by the Ghana Nursing and Midwives Council show a declining trend in rate of requests for verification of qualifications from a peak in 2003, with an overall 34.5% reduction between 2003 and 2005. The dominant target destination in recent years had been the UK (71%) followed by the USA (22%). The Nursing and Midwives Council further reported that validation requests had fallen to 56 in 2006, from a figure of 686 in the previous year. This rapid decline was attributed by respondents to two main factors: : Government of Ghana policy changes and international labour market changes.

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

- Improved pay and conditions packages of doctors and other health professionals.

- New procedures that make it more difficult to evade the provision of the bond by which nurses trained with public funds are required to work for 5 years for the Ministry of Health or repay the cost of training.

For doctors, similar measures to enforce a bond policy with similar intentions have not been taken, but there had been an extension to the period of house officership, and the Ghana College of Physicians and Surgeons had been instituted in 2003 to expand provision of post-graduate medical training.

International market developments have had also reportedly had significant impact on migration trends. Increasing barriers to entry to the UK were seen by most respondents in Ghana as the most important explanation of the decline in migration trends. These included:

- Greater difficulties in obtaining visas and jobs.
- More stringent 'adaptation' requirements and difficulties in securing placements.
- A perception of difficult conditions in the UK NHS.

Respondents noted that the dominant mode of recruitment of health professionals to the UK has been by word of mouth and operating through collegiate networks. None of the respondents in Ghana believed that the Code of Practice had produced a significant effect, and they attributed recent reduced international recruitment activity to the reduced employment opportunities in the UK.

## **Discussion**

As noted earlier, third party commentators have often misunderstood the actual content and coverage of the DH Code. The Code places restrictions on active recruitment by the NHS but it does not prevent recruitment of other kinds. It includes

good practice information on how to conduct effective and so called “ethical” international recruitment. It does not cover the whole of the UK- it covers primarily the NHS in England, which is the main but not the only employer of healthcare professionals in the country.

It is not possible to identify in detail the actual number of health care professionals who have been recruited by the NHS, or which proportion of this group have been “actively” recruited. The absence of systematic monitoring of NHS international recruitment activity means that any evaluation has to rely on proxy measures related to professional registration and to work permits issued. Neither measure is ideal or provides a complete measure of inflow.

Available data does show a considerable recent reduction in inflow of health professionals to the UK during the period that the Code has been implemented and strengthened, from the peak years of inflow up to 2002 (for nurses) and 2004 (for doctors). However there are multiple reported causes of this recent decline, including declining demand in the UK, and the introduction of more stringent entry requirements. Furthermore trend data alone are not sufficient to demonstrate causality in relation to any one policy instrument.

The case studies in Kenya and in Ghana also highlighted recent apparent reductions in outflow of nurses and doctors, but this was in part reportedly a result of relative improvements in working conditions in the countries, and was also attributed (in the case of flows to the UK) to tougher entry requirements and a reduction in demand.

There was little reported knowledge of the Code in the case study countries and some misunderstanding about the extent to which Code was, or could be, responsible for the increased difficulty in accessing the UK health labour market in the last two years. Dissemination and communication of the contents of the Code to relevant parties within the case study countries have apparently been largely absent.

## **Conclusions**

The DH Code is a single country instrument, and it has been applied in a country where there is considerable scope for compliance and control because so much employment activity is located within the NHS, and where there is in essence a “single point of entry” for international recruits- via one point of registration, and one point of work permit application. Attempts to use a single country code in other countries where there are a multiplicity of independent health care employers, or where there is a federated political and regulatory structure would be a more challenging and complex issue.

The issue of the “visibility” of any recruitment Code – amongst policy makers, employers and potential recruits- is also important. The DH Code has a good level of recognition in the NHS, but would benefit from better dissemination in low-income countries, particularly in Africa, together with further consultation on the appropriateness of its provisions in specific countries.

## **Acknowledgements**

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The views expressed are those of the authors.

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<sup>1</sup> See e.g. Stilwell B, Diallo K, Zurn P, Dal Poz M, Adams O, Buchan J. Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges. *Human Resources for Health* 2003, 1:8 <http://www.human-resources-health.com/content/pdf/1478-4491-1-8.pdf> accessed October 5th 2008

World Health Report (2006) Working Together for Health, Geneva, 2006 [http://www.who.int/whr/2006/whr06\\_en.pdf](http://www.who.int/whr/2006/whr06_en.pdf) accessed October 5<sup>th</sup> 2008

<sup>2</sup> Department of Health. *NHS Plan Delivering the NHS Plan: next steps on investment, next steps on reform*. Department of Health, London, 2002 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4005818](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005818) accessed October 5<sup>th</sup> 2008

<sup>3</sup> Department of Health. *Guidance on International Recruitment*, DoH, London, 1999

<sup>4</sup> Department of Health. *Code of Practice for NHS Employers Involved in International Recruitment of Healthcare Professionals*, DoH, London.2001

<sup>5</sup> Department of Health. *Code of practice for the international recruitment of healthcare professionals*. Department of Health, London. 2004

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<sup>6</sup> Scottish Executive. *Code of Practice for International Recruitment of Healthcare Professionals*. Edinburgh: Scottish Executive. 2006

<sup>7</sup> Buchan J, Jobanputra R, Gough P, Hutt R. Internationally recruited nurses in London: a survey of career paths and plans. *Human Resources for Health*, 4:14, 2006 <http://www.human-resources-health.com/content/pdf/1478-4491-4-14.pdf> accessed October 7th 2008

<sup>8</sup> See e.g Riley P, Vindigni S, Arudo J , Kamenju A , Ngoya J , Oywer E , Rakuom C , Salmon M , Kelley M , Rogers M , St. Louis M, Marum L Developing a Nursing Database System in Kenya. *Health Services Research* 42 ( 32), Pages 1389 – 1405. Capacity Project *Africa Health Workforce Observatory Meeting, Arusha-Tanzania;26th-29<sup>th</sup> September, 2006; presentation by the Nursing council of Kenya* <http://www.hrresourcecenter.org/node/974>

<sup>9</sup> Adano U. The health worker recruitment and deployment process in Kenya: an emergency hiring program *Human Resources for Health* 2008, 6:19

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<http://www.human-resources-health.com/content/pdf/1478-4491-6-19.pdf> accessed  
October 7<sup>th</sup> 2008

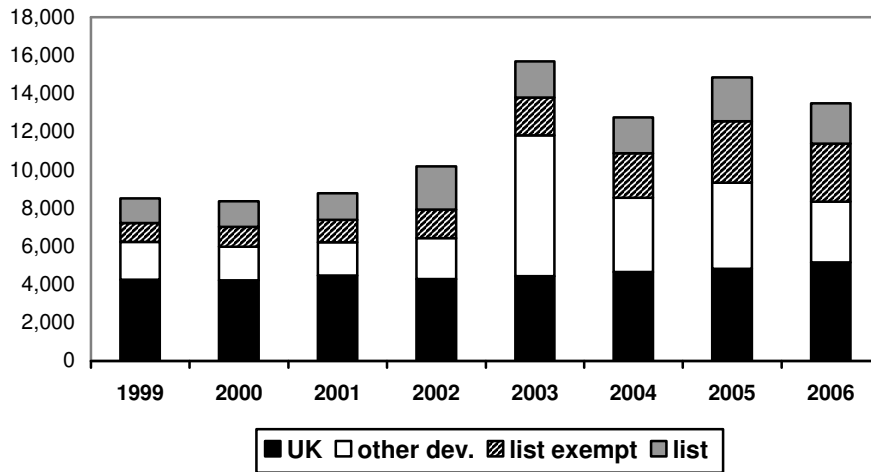
**Table 1: Kenya: Total number of nurses verified to apply for foreign registration from January 1993 to December 2006**

Country	1993	94	95	96	97	98	99	00	01	02	03	04	05	06	TOTAL
UK	20	15	16	20	32	32	80	199	687	210	253	324	158	72	2118
USA	6	5	4	10	16	40	46	45	174	356	656	263	255	220	2096
Others	8	23	30	26	31	29	25	42	52	26	31	56	78	98	555
TOTAL	34	43	50	56	79	101	151	286	913	592	940	643	491	390	4769

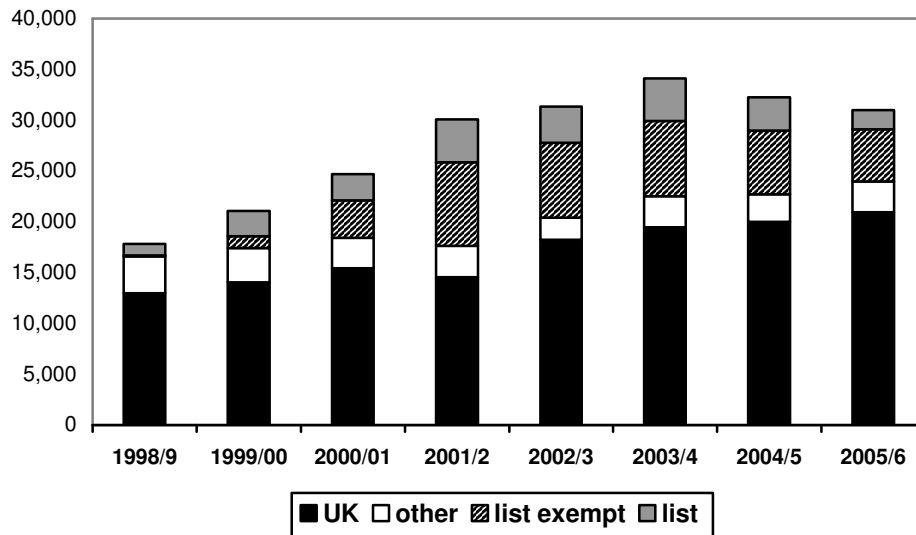
Source: Kenya Nursing and Midwives Council NB. Totals have been adjusted to add correctly. The table provided cites the total number of nurses verified over the period as 4783.

Source: General Medical Council, UK

**Fig 1: Doctors: New GMC Full Registrants- from UK, other developed countries, list but exempt countries, and other list countries, 1999-2006**

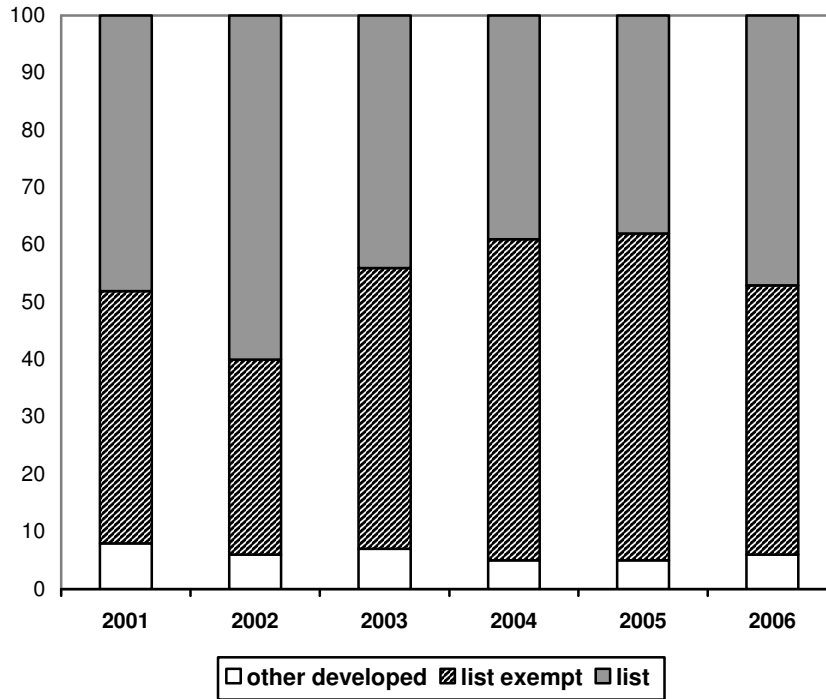


**Fig 2 :Nurses: New Registrants- from UK, other developed countries, list exempt countries and list countries, 1998-2006**



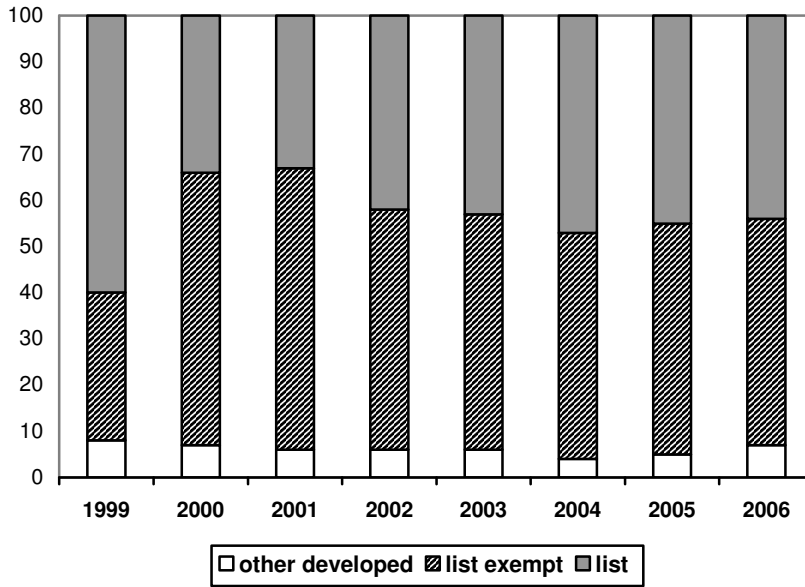
Source: UK nurses and Midwives Council

**Fig 3: Work Permits Doctors: % allocation by type of country 2001-2006**



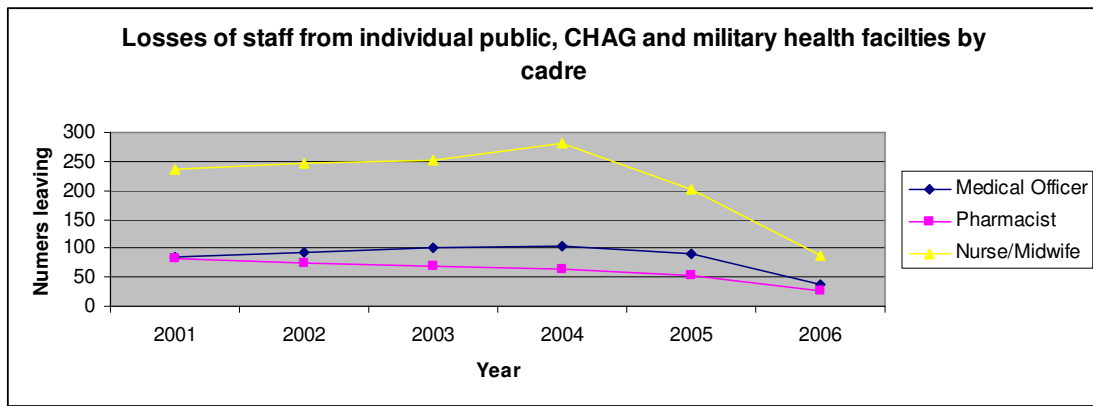
Source: Work Permits UK

**Fig 4: work permits issued to nurses % by type of country  
1999-2006**



Source: Work Permits UK

**Figure 5**



Source: Data provided by Ministry of Health, Ghana