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Health migration policies and ethical controversies:

The case of African nurses in the UK

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- analyse migration as part of broader global change

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Abstract

The United Kingdom (UK) for the last few decades has been faced with a growing need for health personnel and has therefore attracted professionals, particularly overseas nurses. The country has been characterised by a historical migration policy favourable to the recruitment of foreign health staff. However, in the context of deep shortages and high level of diseases and health system weaknesses, international health professional recruitment from sub-Saharan Africa has created unprecedented ethical controversies, pushing the UK to the centre of discussions because of its liberal policies towards international recruitment that have been considered as aggressive. While the 'brain drain' controversy is well known, less attention has been devoted to the specific international health migration controversy and the pivotal role of the UK in the diffusion of an ethical code of practice. Using mainly the perspective of the policy analysis of controversy (Roe 1994) and the analysis of discourses (de Haas 2008), this paper comes back respectively to the nature of the controversy and the pivotal role of the UK. It also analyses how the implementation of UK ethical policies – the Code of Practice, the banned countries recruitment list, and restrictive immigration policies – have been considered as inefficient and unethical in their contents and their targets.

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1 Introduction

For the past few decades the United Kingdom (UK) has been faced with a growing need for health personnel (Mackintosh et al. 2006) and therefore has aimed to attract health professionals, particularly nurses, who are recruited from mainly Commonwealth countries. Beyond its postcolonial legacy (Buchan 2007), there are some specific factors which make Britain of interest to African health professionals. With the historical consequences of the nationalisation of the National Health System (NHS) in 1947 (Immergut 1992; Hassenteufeul 1997) the UK has been characterised by a historical migration policy favourable to the installation of foreign health staff (Boswell 2003). In addition, the international recruitment of foreign professionals, in the case of a shortage of health personnel, has long been favoured. As many authors have shown (cf. Hardill and Macdonald 2000:684; Mackintosh et al. 2006:105) during the 1950s and 1960s, the NHS relied on overseas nurses coming from the Caribbean. In the 1960s a severe shortage of nurses led the Health Ministry to approach the Government of Barbados to recruit nurses. After World War II, in addition to West Indian nurses, Irish women formed a second group who were encouraged to migrate, to train and/or work in the NHS. In the early 2000s, nurses from Africa, India and the Philippines were also solicited. The UK represented the main European destination country for education of its former colonies and the growth in the gap between supply and demand in the field of health justified, in part, the increased number of overseas nurses employed in the NHS. It has recently been noted that the search for nurses by the UK's health service is global, and according to Buchan and Seccombe 'the continued inflow of nurses from developing countries is explained, in part, by entrants coming for education purposes, by individual nurses taking the lead to apply for jobs in the UK, and by active recruitment by non-NHS employers' (2004:26). Politics was also a factor in the widening search of health professionals, with Buchan noting, 'with the coming into power of the Labour Party, the UK therefore stands out as a country where active international recruitment of nurses, and other health professionals, was an explicit national-level government policy response to the need to increase staffing levels in a public sector, government-funded health care system' (2007:1323).

However, the international mobility of African nurses goes beyond specific national explanations. As the scholars of the Oxford School of Migration[1] show, it can also be understood within a general dynamics of international mobility and can be considered as one of the aspects of the international development process (de Haas 2006:23; de Haas and Vezzoli 2010:9; de Haas 2010; Castles, de Haas and Miller 2014). In comparison with other countries' policies on overseas recruitment of health care professionals the British policy presents an uneven progress. Several explanations have been given, however there are two main arguments which recur in the literature. The first argument suggests the classical British immigration policy option is the 'policy of opening and closing of the valve' (Coleman 1995) and is used in cases of necessity. If this first theory is applied it would mean the UK actively recruits internationals at a time of need, meaning a shortage of personnel, recruitment halting when national objectives are met. As an addition to this explanation, some also add that this 'polic[y] of opening and closing of the valve' reflects the change of political parties and the defense of national interests. Secondly, the internalisation of the specific debate on the migration of health professionals from African countries and the ethical debate that has followed at national level (Bach 2006; Buchan 2007; Mackintosh et al. 2006) has set a sort of paradigm shift in the narratives of public policy. In fact, in the 1990s, the UK established a massive policy of recruiting nurses and doctors from the British Commonwealth area. This was declared as an official measure to meet the expansion of the NHS (Buchan and Dovlo 2004; Buchan 2007). In the late 1990s and early 2000s, the British government

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[1] Represented by the International Migration Institute (IMI).

faced calls to revise its policy because of the negative consequences of its policy of active recruitment (Bundred and Levitt 2000). In the second half of the 2000s, the UK took legislative measures that significantly impeded the recruitment of African health professionals (Mackintosh et al. 2006). The British authorities began to revise policies on overseas staff recruitment. They also released the health sector from the list of the priority sectors and promoted the Code of Practice for NHS employers (Department of Health 2001a, 2001b, 2004).

There have been two changes which are worth briefly signposting here, as they have brought profound changes to the British health immigration policy. In 2004 an Ethical Code of Practice was established and implemented, followed in 2006 by the 'Modernization of Medical Careers'. Historically the British model of overseas health professional recruitment was liberal and open but this has been supplanted by an increasingly restrictive model. This shift in immigration and international recruitment policies has caused two deep and recurrent consequences. Firstly, it implies the possibility for the UK to find professionals of substitution within the enlarged Europe (Mackintosh et al. 2006a; Buchan and Aiken 2008). Secondly the UK has officially submitted to the ethical code of recruitment, which bans the UK from hiring health professionals from certain 'blacklisted' countries (Department of Health 2004). Almost all African countries are on the list of prohibited recruitment countries (Department of Health website 2014). The effects are not yet known as these policies have only recently come into effect. Finally, the question of whether the restriction on immigration in receiving countries will help to improve the health issues in African countries, affected by the shortage of health professionals, is still under debate (Özden and Philips 2014).

1.1 Research questions

This paper is an analytical literature review. It situates the issue of African health professional migrants within the general problem of international health migration, involving both the North and South. In this general problematic, the UK as a receiving country remains incontestably a critical actor. This can be seen in the orientation of debates and decisions that have taken place at the international level. Why did the UK's political choice spark an ethical debate during the 1990s and 2000s? What are the impacts of this ethical controversy on the international recruitment of African nurses in the UK? These research questions will orient the analysis and we will firstly consider the UK's health migration policies and the challenges of ethical debate on the international mobility of African nurses. Secondly we will analyse the Code of Practice and its political implications relating to the mobility of African nurses in the UK. Finally, we describe and discuss the immigration and the registration procedures and how they have been perceived by the main actors.

2 Methodology

This paper is a critical narrative review of the international literature, complemented by four interviews with overseas nurses and use of the overseas health personnel databases. The issue of international migration of overseas nurses has received a torrent of criticism and attention because of ethical concerns. Therefore we have only selected publications that focus on the specific objectives of this paper. The aim of the interviews is to have an overview of the nursing profession and its procedures beyond the description of official documents. The analysis of data uses the databases of the Nursing and Midwifery Council (NMC), responsible for registering all nurses and midwives who have registered an interest in working in the UK, the Royal College of Nursing (RCN), a professional association that advocates for nurses in the UK, the National Health Service (NHS), the largest employer of African nurses in the UK, the UK statistics of overseas health personnel related to work permits (delivered both inside and outside

the UK)[2] and the World Health Organization (WHO) databases. The analysis framework is broadly guided by the perspective of the policy analysis of controversy (Roe 1989, 1992, 1994; Radaelli 2000) with critical attention to the context effects and the evolution of discourses (de Haas 2008; Schimdt, 2008a; 2008b). Firstly, the paper focuses on an analysis of development discourse of public policy (Roe, 1994). Public policies are perceived 'as decisions made by governments to reach certain stated objectives, which are officially seen as desirable based on social values and ideals' (de Haas and Vezzoli, 2011:6). However, the authors have noticed that the desirability of the stated objectives are difficult to define namely because of the multiplicity and often contradictory interests: '(…) political processes and policy formation almost inevitably involve tensions, contradictions and compromises between a variety of, often conflicting, interests' (de Haas and Vezzoli 2011:6). The narrative analysis in situations of controversy from the public policies (Roe, 1992) can show how narratives are constructed and how they are used to create new policies (Roe, 1994). In addition, it can also illustrate how the different actors present and defend contradictory stories in the debates. According to Radaelli (2000:257), the stories translate the meanings of thoughts that are transformed in public policies. Equally, the stories have the particularity of making social policies understandable and accessible and they suggest a series of actions rather than another by establishing the link between the present and the future. Therefore, in the British case, controversy and pressures from different actors are not sufficient to explain the development and gradual implementation of the Code of Practice symbolising the new recruitment policy based on ethical values. The effects of political, national and international context (cf. de Haas, 2008:2) help to understand the change of discourses and the context of their emergence.

3 Evolution of discourses in the international migration of health professionals
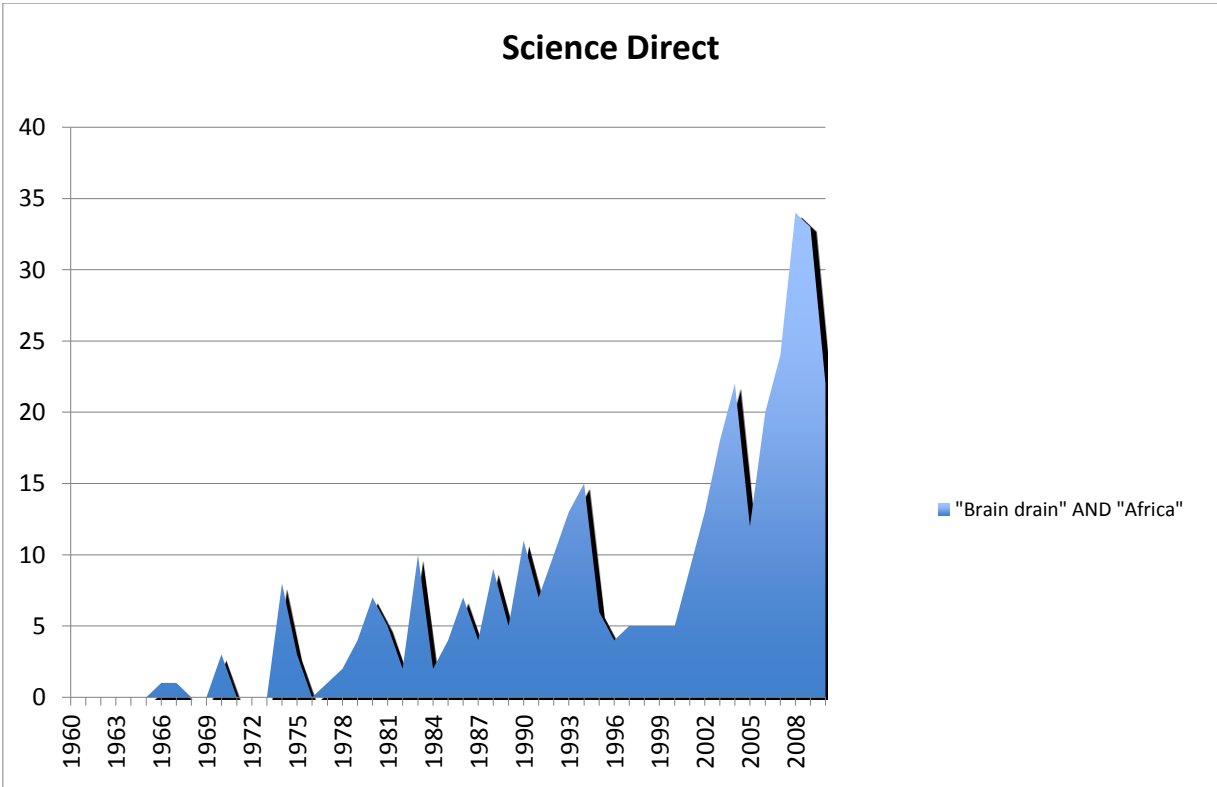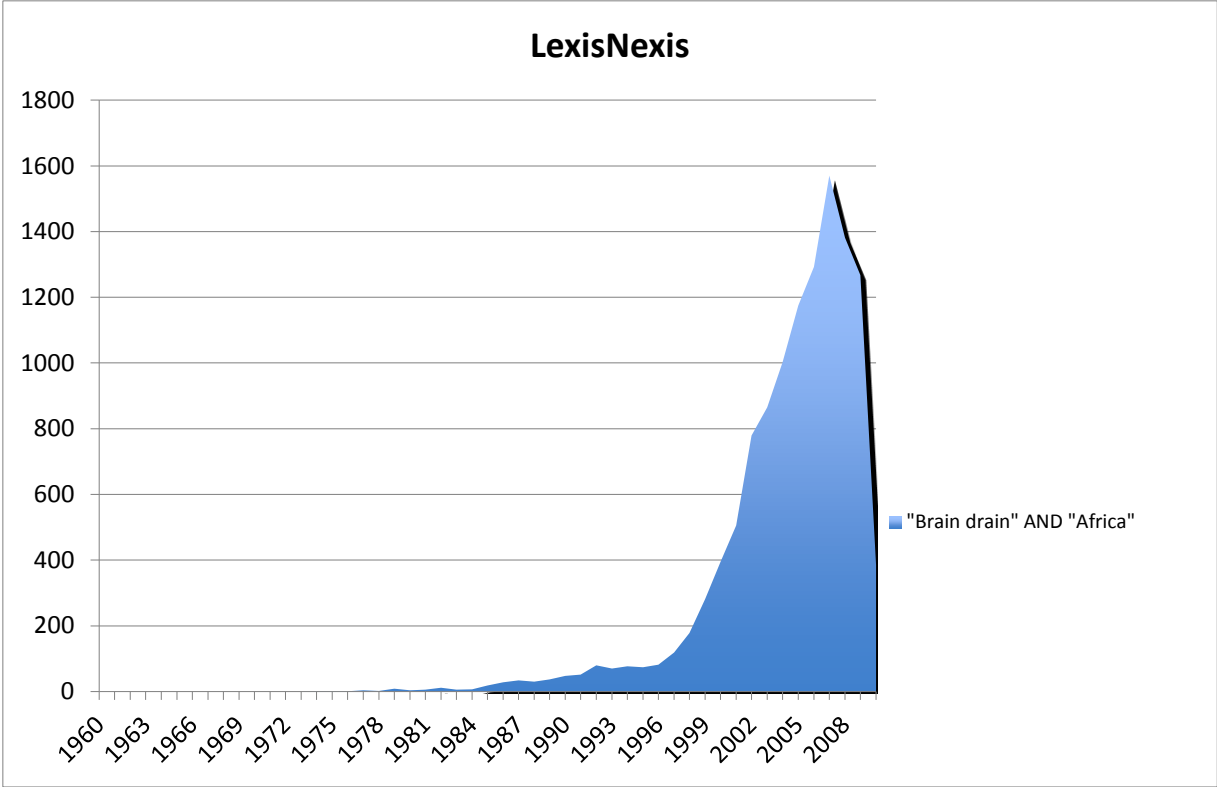
The issue of the international migration of health professionals is not new (Bach 2003). Ethical issues surrounding the recruitment of international health staff were highlighted as early as the 1940s (Buchan and Sochalski 2004). A study commissioned by the WHO in the late 1970s (Meijà et al. 1978) was conducted to understand the 'phenomenon' of the high number of migrant health professionals, which had begun to worry the international community. The controversy that took place during the last two decades (1990–2000) around the migration of health professionals from developing to developed countries, was located in an apprehensiveness about the significant increase in the flow due to international mobility and concerns about the impact that this specific migration could have on developing countries (Buchan and Sochalski 2004; Bradby 2014). More recently debate relating to the international migration of health workers has experienced a significant discursive evolution. As part of migration and development issues, this evolution can be broadly understood though the 'main phases in migration research and policies conceptualised by de Haas' (2008: 2). While debates around health migration were mainly positive in the 1990s they took a dramatic turn in the 2000s towards more negative views (Bach 2003, 2006). Previously the main discourse, in the 1990s, was marked by advanced liberal policies and the globalisation of services. Migration was commended and the international recruitment of health professionals was seen as one of its great achievements (Dollar 2001; WHO/WTO 2002; Drager and Fidler 2004; World Bank 2005). Whereas the discourse of the 2000s,
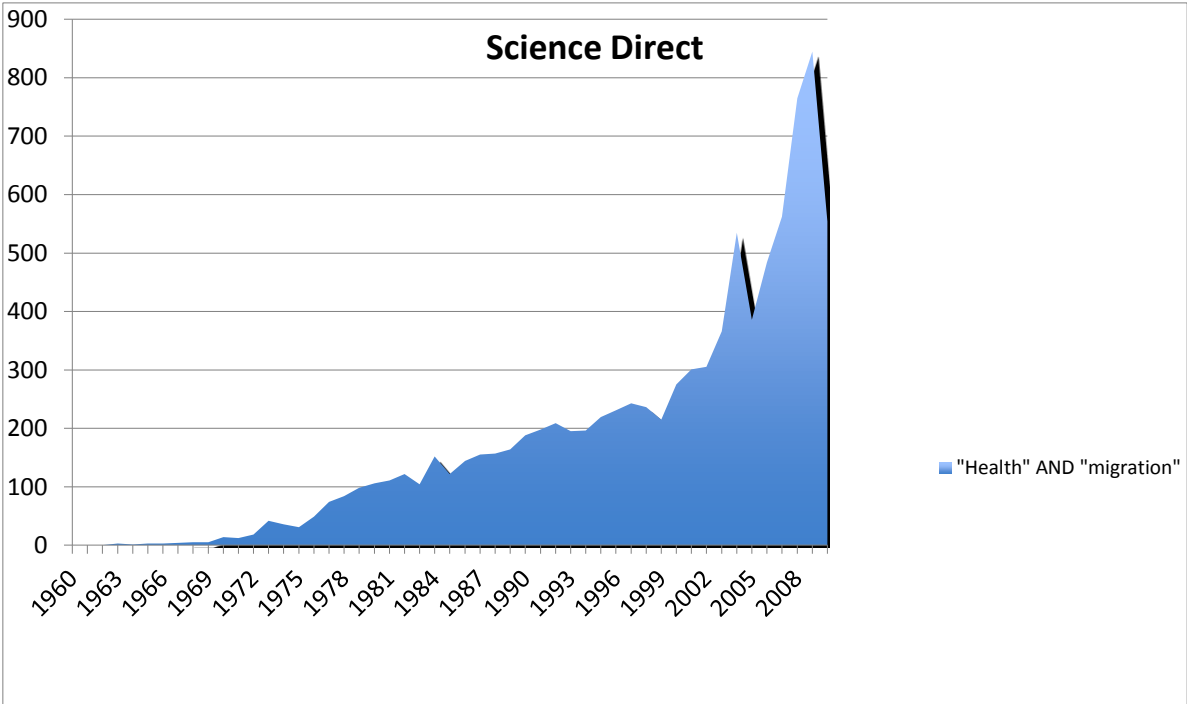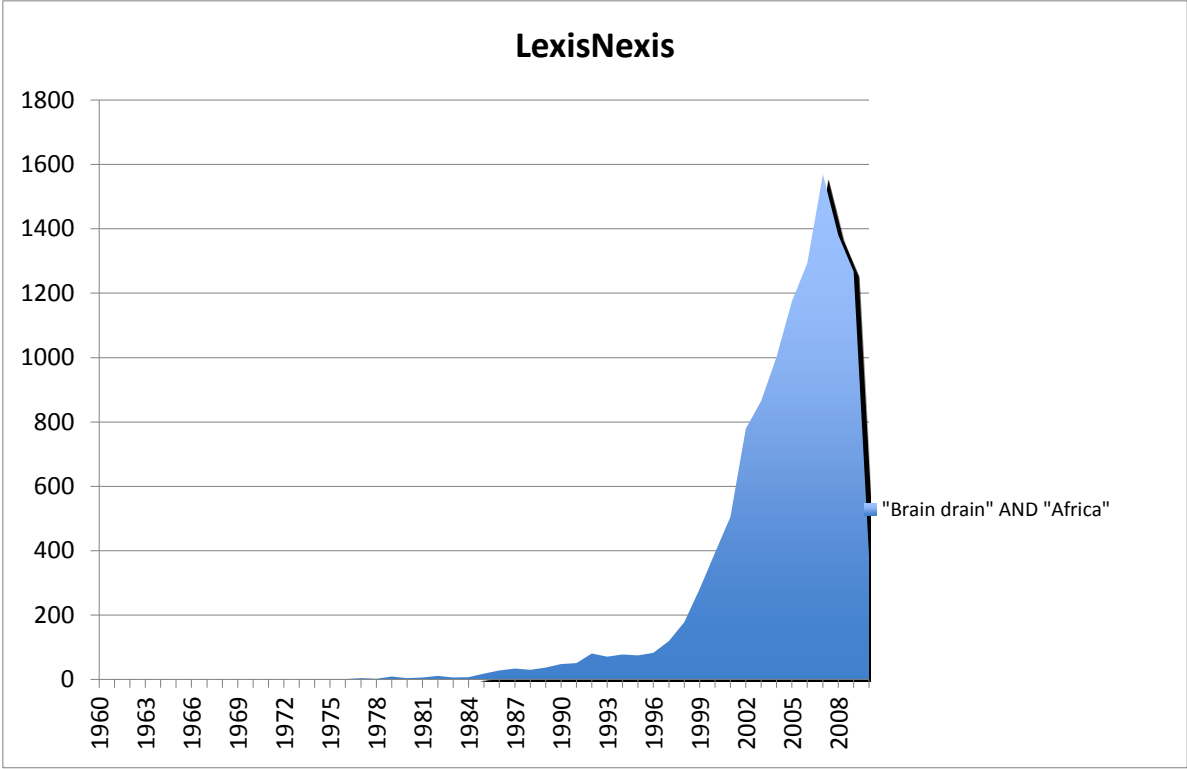
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marked by ethical considerations, denounced the international recruitment of human resources from developing countries as negatively impacting the health needs of the South (Bach 2003; Kline 2003; Connell et al. 2007). Initially actors had perceived international migration as an exchange of expertise and surplus of skilled labor (cf. Mejià et al. 1978), however the publication of specific reports on health concerns in Africa in the late 1990s radically changed the perception of international health mobility (Bach 2003; Awases et al. 2004). These reports mainly showed that African health indicators were at their worst when, at the same time, developed countries faced a health labour shortage, which was filled by recruitment from mainly developing countries (WHO 2004b, 2004c; Buchan and Scholaski 2004; Eastwood et al. 2005; Wright et al. 2008).

As the figures on occurrences[3], shown below, were published, a rising interest in the subject developed, both among the scientific community and, at a global level, the international press. In the late 1980s, the terms 'migration' and 'health' experienced a surge in use and were found in more than 500 citations in 1990, which rose considerably to 2500 in 1997. This period corresponds to the aftermath of the creation of the World Trade Organization (WTO) in 1995 and the commencement of the agreements on trade in services (GATS), which included trade health services and addressed issues of the migration of skilled health professionals. Similarly, if we look at the words 'brain drain and Africa' and 'health and migration', the following graphs also show a growing attention to the issue. The graphs below show that from 1996 discussions around the subject had increased in the international press, reaching a peak in 2005. In fact, the interval from 2004 to 2006 corresponds to the period when many studies on skilled migration, including African health professionals, were published (WHO 2004a, 2004b; OMS 2004, 2006; IOM 2006; World Bank 2005; Awases et al. 2004; Hagopian et al. 2005). Most of these researchers concluded that there is a negative impact of the migration of skilled labour on African countries. In this context, active international recruitment of African health professionals by the UK, considered as one of the most liberal models of recruitment (Immergut 1992, Coleman 1995; Boswell 2003), created an unprecedented national and international controversy, (Bundred and Levitt 2000; Mackintosh 2006:104) which can justify, in part, the call for responsibility.

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[3] To better understand the evolution of international ideas about the migration of African health professionals, we applied the method used by MacNeill (2006). It uses international databases (academic and general) to measure the occurrence of a word or series of words in a given period. This allowed us to measure accurately the birth and growth of a concern. Thus we have selected two groups of words: 'brain drain' and 'Africa', 'health' and 'migration' the frequency of use of which from 1960 to 2008 we sought to determine. To do this, we chose the database of *Science Direct* for academic work. It has the advantages of integrating the leading journals on the development and major journals in social health sciences. The same investigation was carried out in the LexisNexis database (general international press). The review of the academic literature and the general press on international migration of health shows that it is from the 1970s that the focus is gradually this migration, but it is from the late 1990s that the phenomenon begins to seriously worry the international community and the academic community.

LexisNexis

"Brain drain" AND "Africa"

Science Direct

"Brain drain" AND "Africa"

LexisNexis

"Brain drain" AND "Africa"

Science Direct

"Health" AND "migration"

3.1 The call for responsibility and the policy shift

Among the factors justifying the call in the 1990s for increased responsibility, launched by national and international actors, were the poor African health indicators. Internationally it is estimated that 20 per cent of doctors and 10 per cent of nurses from Africa, who work overseas, have been considered as representing, theoretically, a potential impediment to their source countries' capacity to deliver health care, and to do so equitably (Stilwell et al. 2003; Bradby 2014). In the UK international recruitment has been officially declared as one of the policies chosen to improve human resources in the health sector (Buchan 2007). At the same time, the health sector is part of the short list of occupations for which recruitment is facilitated. The British Labour Government planned to improve the NHS through international recruitment as, at the time, it faced a shortage of 20,000 nurses (Buchan and Dovlo 2004). The UK national statistics, especially the Nursing and Midwifery Council data, record the highest rates of overseas nurses registered during the 1990s (cf. NMC 2002, 2004, 2007). This British international recruitment policy of the time has been considered as aggressive and unethical (cf. WHO 2004 special review, Vol. 82, No. 8).

From this perspective, two major events have been perceived as the main factors, defined theoretically as 'critical junctures' (Mahoney 2000; Schimdt 2008a), which have contributed to involving the international community in the debate and initiating policy change. The first major event that centralised and politicised discussions on African migrant nurses recruited by the UK happened when Nelson Mandela, an international figure and former President of South Africa, called for the cessation of the recruitment of nurses from South Africa when on an official visit to London in 1997 (Willets and Martineau 2004; Kingma 2006). He denounced the high numbers of South African health personnel recruited in the UK and the difficulty South Africa had in meeting its health personnel needs. Meeting the interests of professional groups and anti-immigration lobbies, Mandela's speech contributed to giving the UK's internal debate on overseas health personnel recruitment an essentially ethical slant and contributed to the gradual implementation of the Code of Practice (Mackintosh et al. 2006a). Beyond South Africa (Ehman and Sullivan 2001), actors in India, the Philippines, and Zimbabwe also decried the loss of human resources (Kline 2003).

The second major factor centres on a campaign launched by *The Lancet*. The publication in July 2000 of an article entitled 'Medical migration: who are the losers?' (Bundred and Levitt 2000), renewed and extended the ethical discussion. Articles mainly from the *British Medical Journal* (*BMJ*) raised problems from an ethical standpoint and strongly condemned the recruitment practices of developed nations (MacLachlan and Auliffe 2005; Eastwood et al. 2005; Bevan 2005; Johnson 2005; Heath 2007; Mills et al. 2008). Based on statistical data, the terms of the debates remained almost the same but certainly became more aggressive: developed countries rely on labour from developing countries while the mass emigration of health professionals from these countries created a workload for those who remain in the countries. Giving examples of countries like Zambia, Uganda, South Africa, Bundred and Levitt (2000) stressed that these countries face a 'bleeding' of health professionals with medical schools that are emptied of physicians and health systems in distress because of a lack of qualified staff. Whereas developed countries such as the UK, Canada and the USA do not make efforts to train more health professionals. These countries rely on voluntary health professionals in developing countries to serve in rural areas. While the Bundred and Levitt paper focuses only on African doctors, it does create a more dramatic narrative of the migration of African health professionals. This narrative is reinforced by the South African case symbolised by Mandela's speech in London. A large part of the British public professional associations (the RCN and the BMC) and the anti-immigration lobbies joined the campaign of denunciations (Mackintosh et al. 2006).

In this debate data was essential to corroborate these arguments, even though the processes of collection divided scholars. Almost all of the studies conducted in the late 1990s, to understand the international migration of health professionals, highlighted the difficulty of obtaining relevant results because of the lack of reliable statistical data (Meija 1978; Docquier and Markouk 2004; Hagiopian et al. 2004; Alkire and Chen 2004; Awases et al. 2004; NMC 2004; Astor et al. 2005; Buchan 2007; Clemens and Petterssons 2006; OECD 2010). In fact a quantitative assessment of the migration of African health professionals raises an important methodological problem related to the diversity and the reliability of databases and most scholars challenge the modalities of censuses in both countries of origin of migrants and in countries of destination.

The studies and data show that African health indicators are below international standards and health levels are catastrophic in some African countries. In fact the analysis of the various health indicators (WHO 2006; World Bank/IFC 2007) and the mid-term review of the Millennium Development Goals (Rhazaoui et al. 2005) in the field of health have revealed that sub-Saharan Africa suffers from a lack of doctors, midwives and nurses (Liese et al. 2003:5; Hagopian et al. 2004:2; Awases et al. 2004:21; World Bank 2005) with health conditions at serious levels and set to deteriorate further due to HIV-AIDS, malaria and tuberculosis (WHO 2006; UNAIDS 2007). Based on the recommendations of the WHO's macroeconomic and health committee agency there should be between 70 and 95 nurses and midwives per 100,000 population and 40 to 60 doctors per 100,000 population to satisfy priority health needs (Kurowski 2004). The ratios of physicians per 100,000 residents are particularly low in sub-Saharan Africa compared with those of emerging and developed countries (ratio of professionals to 100,000Hb international comparison). The average ratios of physicians and nurses per 100,000 populations were respectively 17:1 and 87:4 per 100,000 population in sub-Saharan Africa. Excluding South Africa, these ratios are down to 16:1 for physicians and 77:3 for nurses, as they are averaging 106:1 and 256:4 in North Africa, 98:7 and 221:1 in four emerging countries (India, Korea, Singapore, and Vietnam), 303:7 and 723:6 for industrialised countries. African countries have on average about 17 times fewer doctors and nurses, which is eight times less than developed countries.

4 Codes of practice and ethical debates

4.1 The NHS Codes of Practice

It is worth stressing that even though the UK was cited amongst the more liberal models in active recruitment in the 1990s, it also represents the first country where mobilisation was denounced, especially regarding the international recruitment of overseas health professionals (Mensah et al. 2005; Mackintosh et al. 2006). The result of this denouncement was the introduction of international recruitment guidance based on ethical principles (Department of Health 2004:3). Other factors in the 1990s which drove this change were the negative discourses originating from a number of sources, most notably from professional medical associations, mainly *The Lancet*, The Conservative Party, and a gathering sentiment amongst the British public discourse that developing countries should have a sufficient health service of their own, which was reinforced by work by NGOs who were promoting health care in developing countries. The response of the British government to this campaign of derogation was to progressively implement a policy of ethical recruitment and to ban active recruitment of health professionals in Africa (Mackintosh et al. 2006), this resulted in the first Code of Practice published in 1999 for NHS employers. The Code of Practice made recommendations not to recruit nurses and midwives from South Africa and the Caribbean (Willets and Martineau 2004), even though,

as emphasised by the Director of Personnel at the Department of Health, during this period the UK could not afford to stop to using the extra health professionals[4] because of a national shortage.

In 2004 a much broader Code of Practice for the international recruitment of health care professionals summarised previous versions of the Code of Practice and brought about vigorous changes. The Code is now applied to all recruitment of health care professionals including agencies that employ temporary/locum and permanent health care professionals, and all health care organisations and the independent sector are all strongly required to adhere to the Code of Practice. The NHS committed to using only those recruitment agencies that comply with the Code of Practice for both domestic and international recruitment (Department of Health 2004:4). At a glance, the legitimate contribution of the international recruitment to the development of the health care workforce is the right of individuals to extend their opportunities in terms of training and education. In return, the international health care professionals will have a level of knowledge and proficiency comparable to that expected of an individual trained in the UK and will demonstrate a level of English language proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues (Department of Health 2004:7-9).

As previously mentioned, the key component of the Code of Practice is to 'preclude the active recruitment of health care professionals from developing countries, unless there exists a government-to-government agreement to support recruitment activities' (Department of Health 2004:4). Accordingly, 48 countries in sub-Saharan Africa are blacklisted (OECD 2004:159–160) with the total number of blacklisted countries at 50 (NHS website, August 2014). The Code of Practice does not explicitly deny the right of overseas health professional to move and their passive recruitment is not prohibited, stressing that 'the international movement of health care professionals is a long established practice that will continue' and 'many international health care professionals have developed their own individual career pathways' (Department of Health 2004:4). This means that overseas health professionals from those countries on the blacklist can be recruited in the UK if they decide to apply by themselves. Beyond the controversy related to the international recruitment from Africa, the Code of Practice, by its contents, raises previous international ethical debate between two dominant tendencies: the ethics of development versus the ethics of the person (Kingma 2001). The basic premise of this argument is the call to stop the recruitment of health professionals on behalf of the rights to health and development of Southern populations verses the right to mobility of individuals which is based on the international conventions of human rights[5] (Mackintosh et al. 2006:106).

4.2 The ethical debates: health and development vs. right to mobility

If discussions are mainly focused on the rights of African populations versus the rights to health professional mobility, theoretically the divergence of points of view between the different tendencies

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[4] 'If I go back to 2000–2001 when we were tasked with these massive increases in the NHS workforce… we knew that we did not have enough input of nurses and doctors from domestic sources to deliver the capacity that was required to achieve the main objectives of improving access. Thus we set up the international recruitment programme…' (Buchan 2008:38).

[5] The International Covenant on Civil and Political Rights – article 12.2; the Universal Declaration on Human Rights – article 13; the African charter on Human and Peoples' Rights – article 12 (2).

extends the reflection on the ethics of migration by including the basic principle of human rights and the principle of national sovereignty (Boswell 2003). Accordingly, the controversy has involved ethical issues that seem difficult to reconcile: for some, the mobility of African health professionals is ethically unacceptable because of the fact that it violates the health and development rights of developing country populations, whereas for others, the individual's mobility is perceived to be an inalienable universal right. Both of these positions have to take into account the principle of sovereignty that allows states to protect and control their borders.

The first position generally raises and denounces the active recruitment of health resources from developing countries within the context of world health shortage and, more broadly, the implementation of agreements on trade in services (GATS) as a result of globalisation (Mackintosh 2003; Smith et al. 2009). At this argument's core is the threat to developing countries that are unable to compete with developed countries in the employment market and therefore struggle to retain their qualified professionals. There was a general tendency by OECD countries to pursue policies which were favourable to the international mobility of highly skilled migrants (cf. OECD 2010; Czaika and Toma 2015), which contributed to developing countries losing highly skilled professionals.

For those who defend the universal right to mobility, the questions are: is it an ethical position to resolve the issue of development by the restriction (absolute or strong) to the right of movement and settlement of health professionals? Is this position likely to lead to improved health conditions in Africa? Similarly, the superiority of the ethics of development compared to the ethics of human rights has been questioned. Citing Article 13 of the Universal Declaration of Human Rights (UDHR) (1948, Article 13.1 and 13.2), some argue the inalienable right of health professionals to settle where they find the best conditions to exercise their profession, further stressing the fact that the new ethical discourse leads to the establishment of a basic unfairness between qualified citizens from developed countries allowed to enforce their fundamental human rights and qualified citizens from the South (Kline 2003), particularly coming from Africa, who are deprived of individual rights in favour of the right to development (Mackintosh et al. 2006).

The case of Africa is based on studies showing that the migration of health professionals is not the cause of the failure of health systems and health provision (Stilwell et al. 2004; Dovlo 2005; Connell et al. 2007; Özden and Philips 2014). These publications have created contention as they have revealed the absence of a link between African health professional mobility and a shortage in personnel: Clemens (2007:2) particularly highlights this in his case study which showed that 'Africa's generally low staffing levels and poor public health conditions are the result of factors entirely unrelated to international movements of health professionals'. Recently, this has led Bradby (2014) to stress that from the beginning, the terms of the health migration controversy are 'confounding' between the provision of health professionals and the efficiency of health care systems (Johnson 2005; Larsen et al. 2005; Mills et al. 2008). Similarly, Özden and Phillips (2014:2), whose study examined the case of Egypt, revealed that the 'brain drain, viewed with significant unease due to the vital role played by human capital in economic growth and development processes' is overestimated because of 'several simplifying assumptions, such as education being obtained in the birth country'.

Finally, there are a variety of reasons for the labour shortage in Africa. According to Clemens:

> The absence of an effect of emigration on basic primary care availability and public health conditions may be due to the determination of these outcomes primarily by factors unrelated to cross-border movements of health professionals. These include the geographic and public/private sector distribution of health professionals in the sending country, the skill mix of the health workforce, performance incentives faced by health professionals in the

sending country, and the relative importance of primary care versus prevention
to the disease burden in Africa (2007:2).

In addition, factors are structurally common in some countries (Dussault and Franceschini 2006). These include a lack of or low investment, increased in the 1980s in a context of budgetary restrictions and structural adjustment policies that have long-term adverse impacts on African health systems (Chen et al. 2004); the lack of long-term health policies and guaranties for health personnel; the unequal distribution of health professionals between urban and rural areas and between private and public sector industries (World Bank/IFP 2007), and inadequate medical education, to name a few (World Bank 2005; WHO 2006).

The particularity of this ethical debate is that the data mobilised by the two camps each confirm the relevancy of both positions. Indeed, data show that some sub-Saharan countries are deeply affected by the health shortage exacerbated by international migration (Awase et al. 2004; WHO 2006), but other studies show this does not necessarily equate to international migration being the cause of the failure of some African health systems and health provision. From a theoretical point of view, the evidence through research, reports and publications has shown that the migration of African health professionals can affect the service provision in the sending countries but cannot be considered as the cause of the shortage. This finding has played a critical role in the shift of the nuances in the debate.

4.3 The British ethical orientations policy and its critics

Since they represented the base, recommendations from the Code of Practice became the guidelines to the new British policy orientations relating to the migration of overseas health professionals from countries on the banned list. The implementation of ethical measures and its application in the field of recruitment was called 'radical' (Brau 2011) given the historical legacy of the UK's recruitment and employment policies of health professionals. The policy measures are particularly distinguished by their prohibitive character (Buchan and Aiken 2008) whereas, traditionally, for health professionals coming from the Commonwealth – especially doctors – occupational mobility is one of the aspects commonly accepted, valued and desired (Mackintosh et al. 2006:5).

The UK has overcome the shortfall by promoting self-sufficiency in the health workforce. In this sense, the British government has rapidly increased its capacity of medical and nursing education at the national level. It has also implemented a wage policy to attract and retain British citizens with the objective of achieving 'self-sufficiency' (Buchan and Sochalski 2004), even if some scholars challenge the basic ideology of this policy. According to Mackintosh et al. (2006), the idea of self-sufficiency at national and EU level is perceived as indefensible. One of the main strands of their arguments contends that British health professionals continue to move in a globalised international context. Meaning that while the UK exploited its market advantage in recruiting English-speaking nurses from Asia and Africa, it will be the target for increased recruitment activity from OECD countries attempting to solve their own nursing shortages (Mackintosh et al. 2006:26). Historically the main recruiters of UK health professionals are the USA, Canada and Australia, (Buchan and Seccombe 2004); similarly, European states with ageing populations have also relied on the new European member states to fill their gaps (Mackintosh et al. 2006:110).

Meanwhile, the UK health care system faces a great dilemma between ethical issues, health personnel shortage and national imperatives. In fact, the international recruitment is recognised as having made a critical contribution to staffing growth, particularly in England (Department of Health 2004; Home Office 2006). It remains among the four policies – improve retention, new intakes,

returners, and international recruitment – implemented to achieve an increase in NHS nurse staffing. As Buchan and Seccombe (2004:20–21) showed, 'the UK is a major player in the international nursing labour market and has to compete with other developed countries such as the USA, Australia, Ireland and Canada, countries that are also facing demographic-related nursing shortages'. Buchan and Seccombe's study stresses two critical findings: firstly, it shows that an 'increased activity by the USA and other recruiting countries into English-speaking international labour markets could make it more difficult for the UK to recruit' and secondly, the 'strict compliance with recruitment code will mean that some recent main source countries are no longer acceptable targets'. In the context of the application of the new policies, 50 of 57 African countries in the continent are blacklisted, including South Africa (Department of Health 2014), which is one of the four most important source countries – along with the Philippines, India and Australia – which provided international nurses to the UK in 2003 (Buchan and Seccombe 2004). The question that arises in the global context is how the UK will face these challenges, including the ethical recruitment challenge, given the need of health personnel to achieve the NHS objectives of health provision.

The initiative to increase the training capacity of the health workforce at a national level has been welcomed in the literature. However, the unethical part of the new political orientations has been emphasised, mainly related to the conditions of life and work of African nurses (Buchan et al. 2009; Kingma 2007; Mackintosh et al. 2006; Brau 2011). The new policy has been denounced as unethical as it is potentially discriminatory and ineffective. The vulnerability of overseas health personnel is broadly mentioned (Alexis and Vydelingum 2007; Allan et al. 2004) even though empirical studies have stressed that the discrimination existed before the introduction of the Code of Practice (Kline 2003). For instance, the RCN has underlined the discriminatory practices and misleading information provided by some recruitment agencies to internationally recruited nurses (RCN 2002). Instead of protecting migrant health professionals, the ethical measures are seen by some actors as measures that reinforce the vulnerability of migrant health workers because equal treatment is not guaranteed. Its application however has been implicated in the creation of a category of health professionals discriminated against because of the economic situation in their countries of origin. These criticisms will again extend the debate on the new immigration policy based on a points-based system (PBC) which basically puts at its core the economic interests of the UK (Home Office 2006).

5 Immigration and registration procedures related to the migration of African nurses

Within the UK the debate surrounding the implementation of the Code of Practice and its consequences for overseas health professional mobility tends to obscure the other controversial debate on the reforms of the immigration policies and the nurses registration procedures that also concern the mobility of overseas health professionals. Broadly speaking, a number of recent studies illustrate, to a certain extent, how immigration procedures constrain and impact upon certain categories of migrants, mainly from the South (cf de Haas 2006; de Haas and Vezzoli 2010, 2011; Czaika and de Haas 2013; Czaika and de Haas 2014b; and their migration decision making (Czaika 2012). For instance, the study of the careers of overseas health migrant personnel shows that the opened or closed character of legal procedures in the host countries matters, as it impacts on migrant trajectories (Mendy 2014).

Consequently, in the case of African migrant nurses in the UK institutional system, objective constraints that impact upon migrant trajectories mainly appear on two levels. First, because of the tightening of the immigration policies now based on a PBS, African nurses must first obtain a work permit to allow them to enter the UK in order to undertake the registration procedures. It is difficult for

African nurses to obtain a permit as almost all African countries are on the banned list. This procedure is a considerable barrier to African nurses finding employment in the UK, and one of the only ways to navigate it is if their country has signed a bilateral agreement with the UK (cf. Department of Health website 2014). The immigration procedures are also costly, long and stressful (interviews, 2014). Second, to work as a nurse in the UK African migrant nurses have to register with the NMC following the registration procedures (reformed in October 2014). As well as the length of time it takes to complete these procedures, currently on average a year, they are also costly and do not guarantee employment at completion (NMC 2011; interviews, 2014).

Before moving onto a discussion on the registration procedures this paper will examine the PBS and what its implication has been on the mobility of African nurses.

5.1 The points-based system and its implication for the mobility of African nurses

The implementation of the new policy of recruitment, inspired by the Code of Practice, took place in a context of great change in UK immigration policy. While discussions related to the international migration of overseas health personnel were taking place at national and international levels, the Labour Government that took office in 1997 launched a broader consultation on the reforms of immigration policies. As Murray (2011) showed, the concept of 'managed migration' that was predominantly launched during this period meant not only controlled migration but also looked at selecting workers based on the interests of the UK economy (Murray 2011:10). Considered as 'the most significant change to managed migration in the last 40 years' (Charles Clarke, Home Office, 2006), the consultation over the PBS policies was closed in November 2005 (Home Office 2006:5) after the health sector incorporated a number of key reforms, namely the official publication of the Code of Practice for overseas health personnel in 2004, the reform of medical studies which aimed to modernise medical careers and gave priority to national physicians in training and those from other EU countries (Buchan et al. 2009). The PBS policies and the Code of Practice had several similarities: they are both explained 'by general public concerns over economic and social consequences of migration' (Brau 2011:4) and have been characterised by their controversial aspects. In fact, the PBS is perceived as 'the latest development in the contested and polemical area of post-World War II British immigration policy, introduced in the context of problematic integration issues and the immigration policies' (Brau 2011:3), whereas the Code of Practice appeared as the result of a controversial debate on ethical issues relating to international recruitment. Both the PBS and the Code of Practice are the responses of politicians and policymakers to public demands in formulating immigration policy (Brau 2011:5) and the ethical issues in the international recruitment of health personnel from developing countries.

How have African nurses been affected by the change in immigration rules? First of all, the PBS policies exclusively concern non-EU migrants, as the original document mentions: 'The points-based system will be designed to set the criteria under which nationals of countries outside the EU (European Union) and EEA (European Economic Area) will apply to come or to remain in the UK to work, train or study' (Home Office 2006:10). In this strict sense, its concerns African nurses who basically come to the UK mainly for three purposes: 'work, train or study'.

The RCN has expressed 'grave concerns about change to the UK immigration policy' which it said 'will see nursing from staff from overseas being forced to leave Britain unless they are earning more than £35,000 per year' (2012:1). According to the RNC the policy restrictions impact negatively on overseas nurses because, before the reforms, the Post Study Work (PSW) position allowed graduates to work in

the UK for a two-year period following their study. This is now abolished. In addition, the increase in fees relating to immigration and nationality applications discourages most of the overseas nurses from coming to the UK or staying (RCN website 2014). Finally, these restrictions tend to reinforce the UK health personnel shortage.

Beyond these changes to the immigration rules, the registration procedures which give authorisation to practice nursing in the UK have also faced change, and following recommendations from the Code of Practice it has simplified the procedures in the interest of the overseas health professional (NMC 2011).

5.2   Overview of the registration procedures

As an administrative process, the registration procedures appear to be a long and constraining process for overseas nurses. The practice of nursing in the UK requires a number of obligations that all nurses must follow. Among these obligations the procedure of registration is the first step. Nurses who desire to practice in the UK must officially be registered with the NMC. The NMC is the main structure that regulates the nursing practices by delivering the license of nursing and renewing the authorisation of nursing. Some points of the procedure are common to all nurses regardless of their origin, however some are differentiated according to three categories: nurses trained in the UK, nurses trained in the EU and EEA countries, and non-EU/EEA nurses. All qualified nurses have the opportunity to register for one or more specialities after completion of the registration procedure (NMC 2011). Consequently they can work in the NHS, the private health care sector including private hospitals, nursing homes or in the community. Similarly, all nurses registered with the NMC have to practice in accordance with the rules and standards of NMC (NMC 2008). They have to renew their registration and the frequency of renewal depends on the origin of the qualified nurse: for instance, three years for those who have been trained in the UK and EU members, and annually for non-EU nurses (NMC 2011). During every renewal two standards set by the NMC must be met: (1) the continuing professional development (CDP) standard and (2) the practice standard. Meeting these standards mean that nurses can demonstrate that they have undertaken 35 hours of learning activity relevant to their practice and completed 450 hours of practice during the first three years prior to the renewal of registration. Whatever the terms of employment are, every nurse has to provide evidence of meeting these standards in order to maintain their registration as a nurse with the NMC.

5.2.1 Description of the registration procedures

The procedure of registration is composed of three sections related respectively to the UK graduate, applicants from EU/EEA member states, and applicants from the non-EU Area (NMC 2008).

5.2.1.1   The EU/EEA member states

Applicants who are trained and have qualified as a nurse in the UK need to complete and return an application form and pay the established fee, currently £100 (NMC 2014b). The qualified nurse receives a pack after sending the course completion details from the Higher Education Institute (HEI). He or she sends to the NMC a declaration of good health and good character. This declaration is required of all nurses irrespective of where they come from. Once this information is received by the NMC, it takes two to ten days for the UK-graduated nurse to receive a statement of entry. For nurses trained in the EU it depends on the country of qualification. Details are provided on the NMC website about what the equivalent qualification is for each EU/EEA country (NMC 2011). Language requirements are not

obligatory but the NMC 'strongly' advises nurses from the EU/EEA to have 'sufficient knowledge of English in order to practice professionally' (NMC 2011:6). For both UK and EU/EEA nurses the procedure is relatively quick and imposes fewer demands than those made of non-EU nurses.

5.2.1.2   Overseas applicants

The application process for non-EU applicants is composed of two steps: the pre-registration stage and the registration procedures. The registration procedures have undergone changes, particularly with the introduction of the International English Language Testing System (IELTS). The biggest change has been the introduction of the Overseas Nursing Programme (ONP). The whole application process is now longer and more restricted and takes, on average, a year to complete (NMC 2014a). This paper will now briefly outline the previous application process for registration before moving on to presenting the changes, which are currently being implemented.

5.2.1.3   The pre-registration procedure

To enter the register all overseas nurses are pre-required to meet the following four requirements, with no exception granted:

1. To demonstrate a language competency that shows they can communicate clearly and effectively and speak English fluently. This is demonstrated by the completion of an academic version of the IELTS test, with the candidate achieving an overall average score of seven (out of the possible nine) and at least seven in each of the academic areas of the test – listening, reading, writing, and speaking. The IELTS test is valid for two years (NMC 2011); if his/her application takes longer than this the applicant must retake this test.

2. At the time of application the practice requirements supposes that the applicant has been practicing as a registered nurse for at least 12 months after qualifying. If the applicant has been qualified for longer than this, s/he must also have practiced for at least 450 hours in the previous three years. The longer version of the ONP is required if the applicant has not practiced in longer than the five year period preceding their application with the NMC (NMC 2011).

3. The current registration or license of practice delivered in the country in which the nurse is qualified or has been practicing is required.

4. The education requirements suppose that the overseas nurses must successfully complete at least 10 years of school education before starting a post-secondary education nursing training programme, leading to registration in their home country as a first-level registered nurse.

After meeting the pre-requirements, the overseas nurses receive from the NMC an application pack for the first stage of the registration process.

5.2.1.4   The registration procedure

The registration process involves four stages. First, the overseas nurses complete the NMC application form and provide supporting information. In addition, they attend a face-to-face identity check at the NMC offices in London. Second, they pay an administration fee of £140, and return a fully completed application form with the proof of IELTS, and send official documents. In the second stage the application pack is sent when the NMC has finished assessing the information from stage one. The applicant has six months to return the following documents: a fully completed application form, two employment references, an original transcript of training provided by their training institution, and a completed original licensing authority from all the countries in which the applicant has practiced. Third, when the first two stages of the application are successful the applicants will have to complete an educational and/or clinical practice placement before they can be entered onto the register.

The overseas nurses have to undertake the ONP, which is run by selected universities in the UK. The ONP enables the assessment of the nurse's ability to practice in the UK health care environment and was developed to be comparable to the requirements made of UK-trained nurses. The programme is made up of two elements: first, 20 days protected learning and a period of supervised practice in the UK and second, a period of supervised practice, which can be for any period up to three months. All applicants undertake at least three months supervised practice placement before registering with the NMC. The NMC provides details of the duration of supervised practice in the decision letter that is sent to the applicant at the end of the stage two. The applicants have two years after the date of issue of the decision letter to complete the ONP. The application is closed if the applicant does not complete the ONP during the two years (NMC 2011:22). A maximum one-year extension can be offered. The final step is an identity check. On successful completion of the ONP, the NMC sends the applicant a final confirmation letter and asks him/her to complete a self-declaration of good character form and pay a fee of £133. Once this is done the overseas nurse must bring to the NMC the original documents of the copies supplied at stage one. Finally, the applicants name is entered on to the NMC register as a nurse and is provided with a personal identification number (PIN), which only happens once the applicant has attended an identity appointment and satisfied the requirements of the check. The entire procedure can take more than a year.

6   Changes in the administration procedures

As mentioned in the NMC publication 'Changes to overseas registration. For applicants educated outside the EU and EEA' (2014b:1) 'the new process will replace the Overseas Nursing Programme (ONP) (…) with a more robust application process with a test of competence at its heart'. The test of competence and the practical exam (OSCE) are the two main reforms in the overseas application process. Like the ONP, the test of competence will be based on UK education and competence standards for pre-registration. It consists of two parts: a computer multiple choice exam, which will be accessible in many countries around the world. This enables applicants to prepare for the test in their own country before going to the UK. Nurses and midwives eligible for the test and who are living in the UK will be able to access the test there. The computer-based exam provider will deliver the test of competence on the behalf of the NMC (NMC 2014b:2). After the candidate successfully completes the computer-based test, the NMC assesses their education, training, registration and employment history to confirm whether s/he meets all eligibility requirements before the candidate is put forward for the nursing or midwifery OSCE. The final part is the OSCE, held in the UK, initially at a test centre at the University of Northampton. According to the NMC, this allows the candidate to plan their financial and domestic arrangements for travelling to the UK. Applicants are not required to have a sponsor or employer to complete the process and so will be less at risk from the exploitation and poor recruitment practices that have been reported in the past (NMC 2014b:4). As it is the first draft of the new changes, an in-depth analysis of the final document will be required, alongside that of nurse's employment conditions, in order to understand its real impact on overseas nurses.

However comments which were given by the overseas nurses[6] during interview showed that those who had experienced the registration procedures and the visa application after the implementation of the Code of Practice and the new immigration policy related to the PBS confirmed the restrictions of

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[6] We are aware that it is not enough to draw a conclusion. This part will be subject to further analysis in the second part of the research with more interviews.

the administrative procedures[7]. According to those interviewed, overseas migrant nurses really have to have a desire to come to the UK or have no choice but to accept all the difficulties related to the immigration and registrations procedures. The main comments surrounded how long and expensive they found the procedures. They had to save money before committing to migrating since, during the period of attending the ONP – a period called adaptation – they are required to support themselves financially and assume all the cost of registration. To meet the NMC pre-requirements, they need to contact former schools and translate documents. According to the Canadian nurse, with the recent tightening of immigration criteria, the English examination takes much more time because of the small number of places where the English test can be taken in the sending country, and factoring in the attendant risks of delay. Irrespective of which countries the non- EU nurses are from they frequently need to call the NMC service to learn about their case. From a brief analysis of the interview of overseas nurses two main factors are commonly found: the length of the registration procedure and its high cost in terms of financial investment. In this sense, they all mentioned the high level of indebtedness and the situation of financial vulnerability before they take a job (interview 2, 2014). They said overseas nurses needed to find themselves a place at a UK university to follow the adaptation programme. They all concluded that the process was emotionally and financially demanding. The continuation of these interviews will involve 45 African migrant nurses in the UK, a sample large enough to confirm or refute these initial findings.

7 Conclusion

This paper analysed three mains issues related to the UK international health recruitment policy. How did the UK's political choices during the 1980s and 1990s create an unprecedented controversy around the international recruitment of health overseas personnel? How did national and international pressures instigate the implementation of the Code of Practice and the restriction of immigration policies? Finally, how were the policy changes criticised for their violation of the rights of people to move and its negative consequences on the migrant nurses themselves? The analytical review of the literature on international migration of African health professionals showed, first of all, the sensitivity of the issue, largely because of the ethical implications and the British dilemma in terms of national health workforce policy. On this last point, to what extent can the UK authorities apply restrictive policies without being confronted with a shortage of health professionals, and to what extent can the implemented policies remain broadly flexible for contingencies? In this sense, and based on the PBS contents, a few points can be highlighted. Firstly, in the PBS document, the UK does not deny the important role of international recruitment. The political options defined in the PBS document are formulated in a way that gives enough flexibility for consideration of national health professional needs. This means that the health sector could be added to the shortage list, which would allow it to benefit from some of the exemptions which would allow the authorities to meet health needs. Secondly, as many authors show, there is a gap between the official discourses in terms of policy restrictions and the objective realities of international recruitment. To understand these issues, it is worthwhile to consider this from the perspective of political actors in order to see how authorities reconcile national needs in the context of shortages with the satisfaction of the national electorate.

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[7] This section is based on interviews with four overseas nurses who have been asked to describe and comment on their own procedures of registration and the visa application. Two of the nurses have been working as nurses in the UK since 2000 and 2002. The third is a Canadian nurse who decided to follow his friend, hired in Oxford, and who has been in the UK for a year and a half, in applying for a job as a nurse. The fourth has been in the UK for seven years.

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