Ethical international recruitment of health professionals:

Will codes of practice protect developing country health systems?

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Executive Summary

Many countries are using the strategy of international recruitment to make up for shortages of health professionals. This is often to the detriment of health systems in the poorest parts of the world. Codes of practice on ethical international recruitment – or similar instruments – are beginning to be introduced at both national and international levels to protect the health systems of vulnerable countries. It is too early to evaluate the actual impact of this strategy to influence international recruitment, so this study was designed to review the potential impact of existing instruments based on information available at the time. Eight national and international level codes of practice, or similar instruments, were identified for this review, which was carried out between July and December 2002.

While the findings showed that at the end of 2002 the instruments have generally been effectively disseminated and are in place, support systems, incentives and sanctions, and monitoring systems necessary for effective implementation and sustainability are currently weak or have not been planned. If such codes or instruments are to be used to protect developing country health systems, a number of lessons need to be learnt from these early experiences:

- The focus of protecting developing country health systems needs to be emphasised in instruments with multiple objectives.
- The process of implementing the instruments needs to be strengthened.
- Developing countries should improve the data they collect to enable them to expose unethical recruitment of their health professionals.
- Internal and external pressure needs to be increased to ensure the codes and instruments lead to ethical recruitment and help to protect developing country health systems.

Keywords: international recruitment, ethical codes, health professionals, developing country health systems

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Acknowledgements

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List of abbreviations

DOH	Department of Health
DOHC	Department of Health and Children
ICN	International Council of Nurses
ILO	International Labour Organization
INO	Irish Nurses Organisation
IR	International Recruitment
IRC	International Recruitment Co-ordinator
RCN	Royal College of Nursing
UNISON	The union for nurses, midwives and healthcare staff
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians
WDC	Workforce Development Confederations

1 Background to the Study

Many health systems in developing countries are facing crisis. A major contributor to this crisis is the shortage of staff, especially in the poorest countries and remotest areas. There is a world shortage of nurses [1] and other health professionals. Many countries that are able to are using international recruitment as a strategy to make up their shortfalls. Although international recruitment may be of benefit to the individual migrant, and to some extent to the family and home country, if they benefit from remittances, it exacerbates the problems already being faced by the health systems of some of the world's poorest countries. This problem of the impact of migration on developing country health systems was raised in the 1970s [2], but the pressure to take action quickly faded away.

So what is being done now to protect the health systems of these countries? Over the years a number of different strategies have been developed to enable countries to protect their skilled human capital. They have been used with varying degrees of success [3, 4]. One such strategy that has emerged since 1999 is the use of the voluntary code of practice – or similar instrument – on ethical international recruitment. These instruments may cover a number of different objectives: protecting individuals, in the recruitment process and from unscrupulous employers; ensuring individuals are properly prepared for and supported for the job (for nurses this usually means some kind of supervised practice); and (the subject of this paper) protecting source countries from aggressive recruitment of their health professionals.

Voluntary codes of practice have been used in many other areas to influence behaviour. However, the experiences of environmental lobbyists such as Greenpeace [5] and those concerned with working conditions in "sweatshops" in poor countries [6] raise questions about the effectiveness of these instruments, and indeed in some cases the advisability of using them at all. Establishing and implementing such instruments on a national scale is a major undertaking and requires substantial systems development. Some countries that are currently dependent on overseas sources of labour are also undergoing major structural reforms. The turbulence caused by structural change often puts fledgling or weak systems at risk. Given the scepticism about the use of codes of practice in other areas and the likely disruption caused by structural change, it is justified to question the potential effectiveness of such voluntary instruments in influencing the out-migration from source countries, especially low income countries, which have their own staffing shortages.

We assumed that most of the voluntary instruments would only recently have been introduced, so this study clearly had to be prospective, making an informed judgement about what is likely to happen, as opposed to an evaluation of their effectiveness so far[1].

[1] Since this study took place a partial review of a code of practice used in England has been reported in Buchan, J. (2003). Here to stay? International nurses in the UK. London: RCN.

2 Aim and Objectives

The following aim and more detailed objectives were developed for the study:

Aim

To describe the content and implementation of the instruments for international recruitment of health professionals, in order to establish their potential effectiveness and sustainability in protecting developing countries from staff shortage as a result of targeted recruitment.

Objectives

1. To develop a theoretical framework for reviewing the context, development process, content and implementation of codes, position statements and guides of practice for international recruitment of health personnel.
2. To collect data on existing or proposed systems for dissemination, support, monitoring and control of the instruments.
3. To analyse the instruments by comparing them to the model framework or system.
4. To assess the instruments based on the existence and strength of the strategy as compared with the model framework or system.

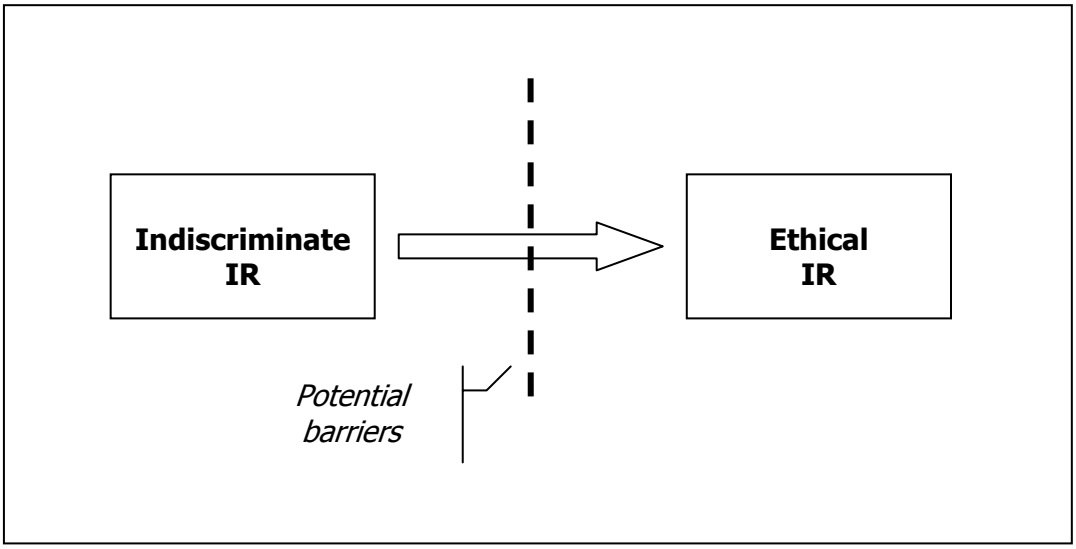
3 Methods

In order to carry out the study, a conceptual framework needed to be developed, since there was no existing framework that was thought to be suitable. This framework would offer a hypothetical approach for introducing and implementing an instrument to ensure that international recruitment becomes more ethical. Based on the model, a systems-based audit tool could be developed for comparing against the current systems being used to introduce instruments.

3.1 Conceptual framework

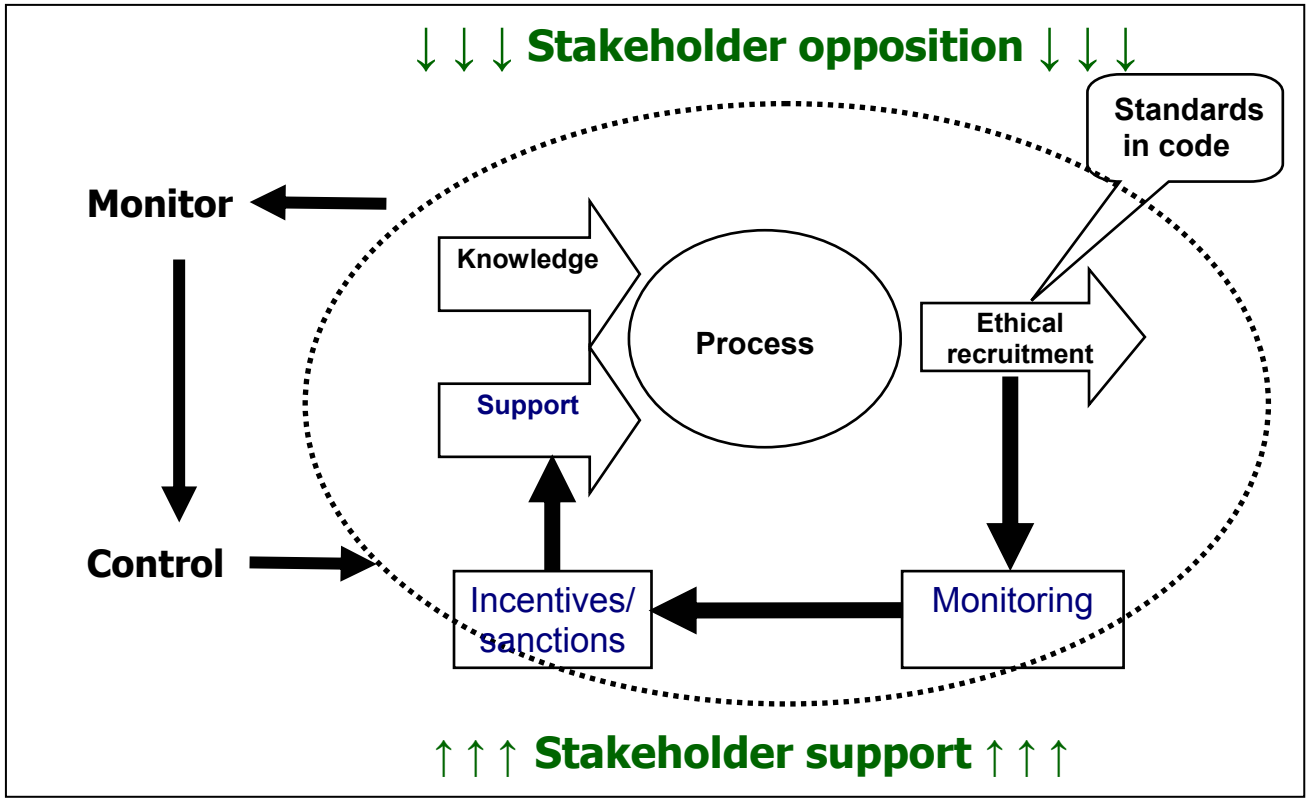
In the absence of a framework for examining the potential effectiveness of codes of practice or similar instruments, we drew on diffusion of innovation theory and implementation theories, stakeholder analysis and systems thinking to develop an appropriate model to guide our inquiry.

Figure 1: Planned behaviour change resulting from codes of practice or similar instruments governing international recruitment (IR)



With the introduction of the instruments, the change being implemented is that of moving from a situation where international recruitment is carried out indiscriminately, to a situation where it is done ethically with regard to health systems in developing countries (see Figure 1). Inevitably there will be certain barriers to achieving this transformation. An early step in implementing change or innovation is to disseminate information [7] – in this case information that indiscriminate international recruitment may harm health systems in developing countries. This is represented in our systems-based model as the input *knowledge* (see Figure 2). Successful implementation usually requires some kind of support (see Beckhard 1969, quoted in Armstrong [8]). In this case support might involve helping managers to interpret the code or instrument in practical terms including companion documents or training. This is represented in our systems model as the second input, *support*.

Figure 2: Implementation model



"Ethical recruitment" is the intended output of the system. Specific *standards* for this output could be the particular countries specified by the instrument from which employers should not recruit people. For the system to work effectively an internal *monitoring and control* loop is required. Methods of monitoring adherence to the code are required. *Incentives or sanctions* are needed to encourage adherence (see Bandura 1986, quoted in Armstrong [8]), keeping in mind that adherence is voluntary. A wider external process of *monitoring and control* or auditing is needed to ensure that all employers are following the code [9] and to ensure that the new system is properly embedded in organisational processes, in other words Lewin's refreezing part of the change process [10]. Five elements or steps then were identified as needing to be in place for the ethical recruitment framework to be implemented effectively: knowledge dissemination, support, internal monitoring, incentives and sanctions, and overall monitoring. From a systems perspective, all these elements of the system need to be in place to transform indiscriminate international recruitment (IR) to ethical IR (Figure 1) and thus help protect vulnerable health systems in developing countries.

Stakeholder analysis will identify those individuals or groups who support ethical international recruitment and those who oppose it. The assumption is, using the Lewin's concept of force field analysis [10], that in order to put the code of practice in place the strength of the stakeholders in favour of its creation needs to be greater than that of opposing stakeholders. In order to sustain the use of the code, supportive stakeholders must remain the stronger group. If not directly involved in the operation of the system they will at least be interested parties in the external 'monitor and control' function. Opposing stakeholders may attempt to sabotage any part of the system, including hiding or doctoring monitoring information [6].

3.2 Search strategy

A few codes of practice or instruments had already been identified through earlier research [4]. Further instruments were identified through key informants and their national and international networks.

3.3 Data collection

From the model described in Figure 2 we developed questions for determining the likely effectiveness of codes of practice or instruments governing ethical recruitment:

- Who are the major stakeholders and what kind of influence do they have?
- What was the dissemination strategy and how effective was it in providing the necessary knowledge?
- What kind of support was given to managers to implement the code of practice or instrument?
- What procedures have been put in place to monitor adherence to the code of practice or instrument?
- What incentives or sanctions are in place to encourage adherence?
- What provision has been made for overall monitoring of the system?

The questions were sent in advance to form a framework for a telephone interview. For the few respondents unavailable by phone the questions were used in the form of a questionnaire sent by e-mail. The main data collection occurred between July and August 2002. Additional data was collected up to December 2002. In most cases informants were identified alongside the process of identifying the instruments themselves. They therefore tended to be people who had been involved in the development and implementation of the instruments.

3.4 Limitations

This was a small-scale study using only a limited number of respondents. Most were identified because of their involvement in either developing or implementing the instruments. The majority therefore tended to be biased towards promoting the use of these instruments, though by no means all of them were uncritical of their implementation.

We were concerned that the study may be perceived as being somewhat Anglo-centric, given the location of the researchers and their easier access to local information about wider pressures on staffing and about structural changes. However, the Department of Health (DOH) in England does seem to have led the way with its first code of practice for nurse recruitment in 1999 [11], with an expanded version in 2001 [12]. We also used an extensive international network of contacts to ensure that we had identified all currently available instruments.

The scope of some of the instruments analysed was very wide. Stakeholders may therefore be supportive of some statements in the instrument but not others. It was therefore sometimes difficult in the interviews to pin down the issues relating specifically to the protection of the health systems of poor developing countries, rather than those relating to other statements in the instruments.

4 Findings

4.1 The instruments to protect developing countries from unethical recruitment

Fifteen codes of practice or instruments[2] were identified, twelve of which included a statement about protecting developing country health systems. These are listed in Annex 1. They are all voluntary instruments; five were described as codes of practice, three as position statements and seven as guidelines. Four of the twelve were excluded because they had not been fully launched or no one was available for interview. This left eight [11-18] to be analysed (see Table 1). For each of the instruments analysed there were either one or two informants, except one, for which five informants were found.

Table 1: Instruments for ethical international recruitment selected for analysis

Title of instrument	Author (s)	Date	Type	Informants
DOH Guidance on International Nursing recruitment	DOH England	Nov 1999	Code	2
DOH Code of practice for NHS employers involved in the recruitment of healthcare professionals	DOH England	October 2001	Code	5
DOHC Guidance for best practice on the recruitment of overseas nurses and midwives	DOHC Ireland	Jan 2001	Guide	1
ICN Position statement ethical nurse recruitment	ICN[1] (internat'l)	Jan 2001	State-ment	1
IHA/VOICES/RNHA Supervised practice programme for internationally qualified nurses Independent sector recommendations	IHA/VOICES /RNHA UK	Jan 2002	Guide	2
(WONCA) A code of practice for the international recruitment of health care professionals	WONCA (internat'l)	May 2002	Code	2 questionnaire responses
Royal College of Nursing guidance on nursing recruitment	RCN UK	July 2002	Guide	1
Commonwealth code of practice for international recruitment of health professionals (draft) & Companion document (draft)	CS (internat'l)	Sept 2002 (1st draft in May 2002)	Code & guide	1 & 1 questionnaire response

Note:
[1] The International Council of Nurses (ICN) represents 124 nursing associations; within Africa this mainly includes Anglophone countries, with a few Francophone ones.

[2] These were identified either from the titles of the instruments or from discussions with informants as "codes", "guides", or "statements".

4.2 The statements referring to protecting developing countries

The instruments focused mainly on improving migrant pay and conditions. None refers only to protecting developing country health systems. The wording or phrasing of the statements referring to protecting developing country health systems are similar, as presented in table 2.

Table 2: Statements relating to the protection of developing country health systems

Instrument	Statement
DOH England, 1999	*2.11 It is essential that all NHS employers ensure that they do not actively recruit from developing countries who are experiencing nursing shortages of their own. The only provisos to this policy are if:* *• nurses or midwives from these countries are seeking an opportunity for development, as part of a recognised programme which is approved by the relevant Governmental authorities in the country concerned* *• or if NHS employers consider unsolicited applications for advertised posts directly from international recruits.* *2.12 In view of current nursing shortages abroad, recruitment from the Republic of South Africa or any Caribbean country should not be considered by a NHS employer, unless the aforementioned criteria (in paragraph 2.11) are met. Neither should employers contract nurses or midwives from these countries via private recruitment agencies.*
DOH England, 2001	*Developing countries should not be targeted for recruitment of healthcare personnel unless the government of that country formally agrees via the DOH.*
DOHC Ireland, 2001	*Some developing countries are experiencing nursing and midwifery skills shortages of their own. It is recommended that Irish employers only actively recruit in countries where the national government supports the process. This approach is consistent with the concept of ethical recruitment.*
ICN, 2001	*The ICN acknowledges the adverse effect that international migration may have on health care quality in countries seriously depleted of their nursing workforce.*
IHA/VOICES/RNHA independent sector guide, 2002	*Independent sector employers will be aware of the sensitivities of targeting countries which cannot support large scale targeted nurse recruitment.*
WONCA, 2002	*Aim to discourage activities which could harm any countries' health care system* and *Receiving countries consider the effect of recruitment practices on lesser developed countries.*
RCN, 2002	*NHS employers should not target developing countries unless there is a government agreement or contact professional nursing association to determine if they can cope with targeted recruitment.*
Commonwealth Secretariat code, 2002	*The Code is intended to discourage the targeted recruitment of health professionals from countries which are themselves experiencing shortages.*

4.3 Stakeholder influences

The first of the instruments to be developed, the DOH NHS (England) guidance on international nursing recruitment of 1999, was initiated by the government following complaints from South Africa (through Nelson Mandela) and the Caribbean. As one informant stated, these countries "*accused countries, including the USA and Britain, of aggressive recruitment and stealing of staff with no return for the resources that the countries had spent on training them.*" The DOH NHS (England) guidance was developed by a working group, which included nursing officers with international recruitment experience, national recruitment personnel, representatives from the Department for International Development (UK), the MRC (UK) and some recruitment agencies. The updated NHS (England) code of practice of 2001 covering all professional groups was initiated by the NHS as the employer. The Department of Health and Children (DOHC) of Ireland, in its capacity as employer, initiated its own code of practice in 2001. Though some informal work had already been started by some groups in the independent sector, the pressure the UKCC[3] began putting on the independent sector triggered the development of the IHA/RNHA/VOICES guide of 2001.

The Royal College of Nursing (RCN), ICN and World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) instruments were developed at the instigation of the membership of these organisations. The Commonwealth Secretariat's code was also developed at the instigation of the member countries, following discussions in several meetings of health ministers, though negotiation of the actual content was sometimes difficult given that both source and receiving countries are members.

Several trade unions (the RCN and UNISON [the union for nurses, midwives and healthcare staff] in England and the INO [Irish Nurses Organisation] in Ireland) were able to apply some pressure or provide some input to the instruments developed by employers, though the emphasis of their influence was mainly regarding pay and conditions and exploitation in the process of recruitment, rather than protecting developing country health care systems. The media were used as a strategy for applying pressure. UNISON and the RCN then went on to produce their own instruments.

Perhaps because of the bias in the selection of informants for this study, few *stakeholders in opposition* were identified. In England private recruitment agencies were invited to take part in developing the instrument as it related to the independent sector, though they declined the offer and for business reasons verbally opposed the use of the instrument.

4.4 Elements of the model in place

Based on the data collected from the interviews we made the judgement on whether or not each of the elements of the model was in place. In some cases an element might have been planned but was not in place at the time of the interviews. Some of the detailed findings are presented below by element. A more detailed presentation of findings by element is given in Annex 2 and a summary of this information is given below in Table 3.

[3] Now the Nursing and Midwifery Council

1. Knowledge dissemination

Seven of the eight instruments had clear dissemination strategies. The dissemination of the instrument was targeted at employers, unions, regulatory bodies, international development departments, with the document being sent by post or e-mail to the recruitment or human resource management department. Additional knowledge awareness strategies used by some included publicising in a journal, through the national media, during training courses and at conferences. In England the DOH and the RCN advertise their instruments for international recruitment on a helpline. Most instruments are also available from the organisation's website. A few did a formal launch in a conference format.

2. Support

Support for the implementation of the instruments was generally offered to employers but this often seemed passive rather than proactive. Some informants felt that support strategies had not yet been planned or developed as the instrument had only recently been introduced. They felt the focus of the support should be helping with the dissemination of knowledge. Passive approaches to providing support relied on the employer to contact the regional or central human resource person or providing written guidelines within the document or an additional, separate booklet. The Commonwealth Secretariat has included a separate companion document. This approach incorporates the support and dissemination process into one activity. In some cases, especially for those instruments dealing with the supervision of new recruits, there is substantial detail within the document that would provide support to users. Some respondents felt that the detail made the document self explanatory and therefore there was no need for further support. In a couple of cases specific officers have been allocated to support the implementation of the instruments. In England, where some employers found the 1999 DOH code both inflexible and difficult to use, a network of temporary regional international recruitment officers (IRC) was created. They worked from the Workforce Development Confederations (WDC) spread throughout the country. The IRCs provide support both with international recruitment in general – working with recruitment agencies – and for employers in following the ethical guidelines of the code. The DOH supports the process by posting on its website a list of countries from which NHS employers are not allowed to recruit. The DOHC in Ireland, a much smaller country, provides support centrally. In Ireland, and in some trusts in England, an international recruitment nurse officer has been created. These are locally created posts aiming to assist the employee and the other staff to integrate and to develop skills. It is unclear how much they can contribute to the DOHC's goal of protecting developing countries with nursing and midwifery skills shortages of their own.

3. Monitoring (internal)

Monitoring adherence to the instruments was generally seen as important in sustaining the implementation of the instruments. Most informants, however, gave no evidence of any specific plans to monitor adherence to instruments. Many informants in England perceived this monitoring role, including that of the independent sector, as being the responsibility of the national bodies. Informants who commented on international instruments perceived the monitoring role as that of national governments. However, for the 1999 code of practice in England the individual employers took on the monitoring role. For the 2001 DOH code of practice in England the IRCs have taken on the role of monitoring compliance; this was reported to have been effective, though it was carried out using informal means. The IRCs work closely with the human resource departments in hospitals and hear of instances of unethical targeted recruitment via these channels. In London this reporting system is well

established with regular meetings and reports from trusts. The RCN is able to monitor compliance with their code through their area representatives.

4. Incentives and Sanctions

A number of UK informants, including those from RCN and UNISON, felt that enforcement of the code in the NHS was not required. One informant felt employers simply needed assistance in understanding the code and how to apply it in their work setting. The incentive for the employer to follow the code was to improve the efficiency of international recruitment. However, some strategies for encouraging compliance were identified in England and Ireland. This was mainly through the provision of verbal warnings. For example, an NHS employer tried to recruit staff from South Africa (a country protected by the code) erroneously thinking that the nurses about to be recruited had approached the recruitment agency independently[4]. The IRC stopped the recruitment process following the threat of a warning from the national level, after it was discovered that the recruitment agency was breaking the code by targeting nurses in their own country.

In England the NHS has a list of recruitment agencies on their website identified as carrying out international recruitment in an ethical way. NHS employers are told only to use agencies on this list, thus encouraging ethical behaviour by the recruitment agencies.

5. Overall monitoring (external auditing)

External monitoring was also perceived as important; however, most informants said they did not have a strategy because they lacked the resources. One informant felt this was important even if a country to country agreement is in place. A lack of monitoring in the Philippines has resulted in experienced nurses leaving in excessive numbers. One person suggested that professional associations act as effective monitors, though another informant felt this could be inappropriate for countries where these associations are not sufficiently representative of the particular profession in question and therefore coverage would be incomplete. Ireland seems to have access to sufficient reliable monitoring information at national level, but no formal system is in place. Details of all new recruits are collected when applying for a post. The task force of the DOCH in Ireland that developed the instrument plans to review progress after one year, and presumably will review the effectiveness of the monitoring system. In England the National Nurses and Midwifery council registers all new recruits. However, details of the process of recruitment are not recorded. It is therefore not known if the international recruits from developing countries were targeted by recruitment agencies or if the recruits approached the agencies independently. The national IRC in England has developed a formal reporting system to check compliance across the country, though this was not yet fully functioning, and at the time her post was only temporary[5]. There are no systems associated with any of the instruments to monitor the impact of targeted recruitment in developing countries. A number of informants suggested this role should be carried out at government level or by an international body such as the WHO.

[4] This is permitted (see Table 2)

[5] At the time of the study, as part of a wider structural change entitled 'Shifting the balance', the Workforce Development Confederations which housed the IRCs were being restructured, with possible implications for staffing structures.

Table 3: Systems-based analysis of instruments: elements present or planned

	DoH '99 England	DoH '01 England	DoHC '01 Ireland	ICN '01	IHA etc '01	WONCA '02	Common-wealth	RCN '02
Knowledge Dissemination	✓	✓	✓	✓	✓	P	P	P
Support to managers	✓	✓	✓	✓	×	×	P	P
Monitoring adherence (internal)	✓	✓	✓	×	×	×	×	P
Incentives/ sanctions	×	✓	×	×	×	×	×	×
Monitoring & control of overall system (external auditing)	×	P	P	P	×	×	×	×

Key: ✓= system in place, P= system planned but not in place, × = no plans

4.5 Additional findings

New issues emerging from the findings

In addition to answers to the main questions of the study, a number of important themes emerged: collaboration, sustainability, alternative uses for the instruments, and the impact of the study itself.

1. Collaboration

Many different groups of people collaborated on the development of the instruments. This process may increase awareness of the impact of indiscriminate international recruitment and create a commitment to address the problem. Some sharing in the development of instruments occurred. For example, the Commonwealth Secretariat drew on the experience of the NHS when developing their code of practice. Such exchanges may have increased the solidarity of stakeholders with similar aims. The partnerships developed are potentially an important resource and were referred to in a few cases as potentially being the team to externally monitor and review the instrument.

2. Sustainability

The sustainability of the codes of practice and other instruments was a concern at the outset of the study. There was some evidence from England that the employers had

embedded the international recruitment systems into existing personnel systems, thus increasing the likelihood of their sustainability.

3. Alternative uses for the instruments

Although the main purpose of the instruments is to guide actual recruitment, they were also being used for lobbying purposes. For example, the American Nursing Association used the ICN position statement to lobby for improvement in ethical international recruitment. With a slightly different aim in mind it was reported that in Canada the nursing association successfully used the ICN instrument to change legislation to prevent untrained migrants from working in high security areas.

4. Study influence

Finally, it emerged that the study itself may have influenced thinking about the effective implementation of instruments. A number of the informants said they had not thought about the need for a system for overall monitoring, but on reflection recognised the importance of this element.

5 Discussion

The model for introducing and implementing instruments to promote ethical international recruitment was developed in the absence of an existing model which would enable us to carry out a systems-based audit. No clear shortcomings of the model were exposed during the study. Working on the assumption that the model is adequate, the findings of the audit are discussed and several recommendations are put forward for improving the use of codes of practice or similar instruments..

Knowledge dissemination, the first element in the model, was the main strategy used to implement the instruments. Dissemination was mainly by sending the documents to employers rather than actively guiding people in the workplace or in training sessions. A possible explanation for the focus on dissemination of knowledge rather than other elements in the model lies in the fact that this is the logical first step in the process, and the instruments are generally new. Another reason suggested by the findings of this study is that the intended function for the majority of these instruments was to provide some form of guidance to employers. The employers initiated the development of most instruments in response to cases of unethical recruitment which affected individuals or the health systems from which they came. Public sector informants said that monitoring was done with the intention of identifying problems caused by lack of knowledge and then assisting the employer with recruitment issues. For example, those responsible for monitoring could sit on a panel with employers when deciding how to work with recruitment agencies, and which ones to work with. The public sector informants favoured this supportive or persuasive method of improving ethical recruitment rather than applying sanctions and incentives. Indeed, it was generally perceived that sanctions were not required to change behaviour. As one informant said, information about the negative impact of indiscriminate international recruitment, along with guidance on which countries they could recruit from, would be sufficient. Consequently, a more complex system involving monitoring, incentives and sanctions was not perceived by some to be necessary or appropriate.

However, there are likely to be barriers to achieving the deceptively simple objective of ethical international recruitment to protect developing country health systems. The fact that since the introduction of the first ethical guidelines by the DoH (England) in 1999 the outflow from sub-Saharan Africa to the UK has increased significantly [19] and in the case of South Africa this figure has more than quadrupled [20] is bound to raise some concerns. From the current routinely gathered statistics it is not possible to identify whether people have been actively recruited or have made individual applications, but nevertheless the losses to developing countries' health systems appear to be on the increase. What needs to be appreciated are the powerful interests at stake: employers desperate to relieve their staffing shortages; recruitment agencies with strong business incentives; and health professionals with the opportunity of increasing their earnings substantially, for example from £77 a month as a specialist nurse in India to £1,250 working on a general medical ward in the UK [21].

In other spheres of activity critics have argued that codes of practice actually do more harm than good [5, 6]. The voluntary code is only a 'quick and cheap' strategy to change employment behaviour. At best the introduction of an instrument sends the message that something is being done to solve a problem; at worst the use of such instruments might be

a cynical exploitation of the general sense of goodwill we identified amongst our informants. At the least, "if voluntary agreements are to stand any chance of delivering at least some level of compliance there must be monitoring, verification and enforcement"[5]. Looking on the bright side it can be said that in the area of international recruitment of health professionals a good start has been made which should be built upon by improving existing systems and ensuring that new systems benefit from the experience of the 'early adopters' even if all the elements of the system are not yet in place.

5.1 Recommendations

On the assumption that the model developed for the systems-based audit is appropriate, we offer some suggestions for improving the process by which instruments to support ethical international recruitment are used.

1. To improve the effectiveness of the instruments we would argue that **the objective of protecting developing countries' health systems needs to be made clearer and more prominent.** It is currently overshadowed by other albeit important objectives such as protecting the employment rights of those who have already migrated or are in the process of so doing.

2. Secondly, as our inquiry has demonstrated, **the systems for implementing the use of the instruments need to be strengthened.** The challenge for national systems and global systems such as the Commonwealth Secretariat's code will be different. It is encouraging that some national systems relating to other objectives of some of the instruments – such as protecting migrants from exploitation by their employers – seem to be effective. Lessons could be learnt from the success in these areas and applied to the objective of ethical international recruitment. In England the IRCs seemed to be an effective form of support, and incentives were in place to ensure that employers used accredited recruitment agencies. Useful lessons could be learnt from the English experience. The application of the framework in Figure 2 as a systems-based audit tool would also help managers who wished to strengthen their systems. It is interesting to note that in some cases the interviews themselves, structured on the systems-based audit, provoked the informants to think of ways of strengthening their systems, in particular regarding overall monitoring.

3. For the international instruments some of the traditional sanctions and incentives are inappropriate as the relationships between key stakeholders are more like members of a club. Respectable membership of the 'club' is achieved by adherence to the values of the club. It was the exposure of countries not adhering to those values that led to the development of the Commonwealth Secretariat's code. Though they may not be able to exert a lot of pressure, **developing countries do have a responsibility to gather the best data they can on their losses of professionals** [3, 4, 19] to richer member states of the club. It is suggested that once collected, **this data could be used to expose those member states that are not adhering to the club values as made explicit by the code of practice**.

4. Stakeholders opposing constraints introduced by the codes of practice or other instruments on international recruitment are a powerful group. **Advocacy for ethical international recruitment is therefore a fourth area that needs to be strengthened.** The partnerships developed in the creation of the instruments, in the form of working groups, provide a good starting point. Professional associations in developing countries could be effective advocates, through their affiliations to their

international bodies, and supported by data collected on losses through migration. In some professions this is already happening. However, pressure also needs to come from a wider group of stakeholders in both source and recipient countries. Civil society organisations have been effective in their advocacy about environmental concerns, globalisation and world trade, but so far few have turned their attention to the loss of health professionals to some of the world's poorest countries. Potential candidates to support the cause need to be identified.

Conclusions

Using a systems-based audit, it is currently far from clear whether codes of practice – or other such instruments – on ethical international recruitment of health professionals will actually succeed in protecting developing countries' health systems. A start has been made and lessons are available to be learnt from the experiences of the early adopters, e.g. the model of support provided by the NHS (England). There are four key issues as indicated above:

- Where instruments serve a number of different needs, more focus on the ethical recruitment objective is needed.
- Implementation systems need to be thought through fully using a systems-based audit approach.
- Developing countries should improve the data they collect on international recruitment of their health professionals to empower them to expose unethical recruitment.
- A means of applying greater internal and external pressure to ensure the system is effective and sustainable needs to be found.

Unless these four issues can be adequately addressed, the instruments are unlikely to be effective in bringing about the necessary behaviour change in international recruitment. In fact, there is then the risk that stakeholders think that the instruments are adequately addressing the problem of unethical recruitment , when in fact they are not. In such cases it would probably be better not to introduce the instruments at all.

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Annex 1

Instruments on international recruitment of health professionals identified in the review, in order of publication

Name	Author (s)	Date pub-lished	Type of instrument
DOH. Guidance on International Nursing recruitment	DOH England	Nov 1999	Code
UNISON. Guide for nurses from overseas working in the UK	UNISON	Nov 1999	Guide
Statement from the Northern Nurses Federation. Recruitment of nurses from other countries	NNF	April 2001	Statement
Guidance for the provision of supervised practice for nurses and adaptation for midwifes in London	NHS London region	Sept 2001	Guide
DOH. Code of practice for NHS employers involved in the recruitment of healthcare professionals	DOH England	October 2001	Code
DOHC. Guidance for best practice on the recruitment of overseas nurses and midwives	DOHC Ireland	Jan 2001	Guide
ICN Position statement ethical nurse recruitment	ICN	Jan 2001	Statement
IHA/VOICES/RNHA. Supervised practice programme for internationally qualified nurses Independent sector recommendations	IHA/VOICES /RNHA UK	Jan 2002	Guide
Voluntary code on supervised clinical nursing practice/orientation and assessment of overseas nurses in the Dublin Academic Hospitals	Ireland	Jan 2002	Code
DOH. International recruitment of consultants and general practitioners for the NHS	DOH England	Feb 2002	Guide
WONCA. A code of practice for the international recruitment of health care professionals	WONCA	May 2002	Code
Royal College of Nursing. Guidance on nursing recruitment	RCN	July 2002	Guide
ICN. Career moves and migration: critical questions	ICN	July 2002	Guide
Commonwealth code of practice for international recruitment of health professionals (draft) & Companion document (draft)	CS	Sept 2002 (1st draft in May 2002)	Code & guide
Overseas Trained Doctor Recruitment Rural Doctors Network (RDN) Draft Policy	New South Wales	Oct 2002	Statement

Note: the instruments included for detailed review are shaded.

Annex 2

Element review of the instruments for international recruitment, as perceived by respondents

Instrument name	DOH England 1999	DOH England 2001	DOHC Ireland 2001	ICN 2001	IHA/ RNHA VOICES UK 2002	WONCA 2002	COM. SEC 2002	RCN 2002
Internal driving force	Some Trust employers	Some Trust employers & DOH international recruitment co-ordinators (IRC)	Nursing officers from public hospitals	Members survey of overseas recruits	None	WONCA president & two South African members	Member health ministers health worker migration study	Regional & NHS Trust Stewards
External driving force	South African ministers, DFiD, GMC RCN	UNISON[1], RCN[2], GMC[3], NMC[4], private sector, WHO, DFID	National co-ordinator for clinical placements	ICN Nursing & policy director	DOH	Literature review, WHO, ARRWAG	England DOH IRC, ILO[6], UNISON	National RCN officer
Restraining forces	Recruitment agencies	Philippines overseas employment agency and recruitment agencies (POEA)	None	None	Recruitment agencies, small nursing homes, trade magazines	Poor infrastructure to drive the code	USA not in the Common-wealth	Recruitment agencies
Dissemina-tion strategy	Hard and e-mail copy to employers, unions, statuary boards, DFiD, donor countries	Launching conference, Working group sent to e-mail to unions, regulatory bodies, recruitment agencies, DFID, WHO, regional IRCs, employers	Hard and e-mail copies to HR managers, regulatory bodies, POEA, director of trade, social security, immigration, nursing and education and unions	E-mail & hard copies to member associations, WHO, ILO and NGOs, part of ICN development workshop	ETAG[5] Working group sent hard copies to member institutions Trade magazines advert	E-mail to WONCA conference attendees plan to send to medical associations and WONCA members	Plan e-mail and hard copy. No launch planned	Press launch, TV, newspapers, nursing press, hard/e-mail regional offices,

Instrument name	DOH England 1999	DOH England 2001	DOHC Ireland 2001	ICN 2001	IHA/ RNHA VOICES UK 2002	WONCA 2002	COM. SEC 2002	RCN 2002
Support strategy	Document includes guide, some had Overseas Nurse Co-ordinator (ONC), later regional IRC, national IRC	Regional IRC who visit NHS employers to instrument vetting recruitment agencies, meetings. Some ONCs Help line	Seminar, 11 public full time ONCs, NCCP Support groups	Trained to use and explain in workshop Instrument produced	Detailed instrument in document	No plan – expect WHO	Companion document CS will encourage MOH and professional organisations to support	Regional & NHS trust Stewards *Plan-new document*
Internal monitoring strategy	Appeared few Trusts	Some have ONC, Sheffield, Liverpool london	Overseas nurses co-ordinator	Bi-annual survey, plan conference Board review Expect MOH	Expect NCSC[8]	Expect governments to integrate into Human Resource systems		Regional Stewards & DOH
Incentive/ sanction strategy	None	Local need, improves efficiently, prevents DOH enquiry	Referral to trade, quality or employment department	Suggest MOH who accredit, tax benefits, close agencies	Suggest role of the WDC and NCSC inspectors	Expect WHO and respective governments	Suggest registering recruitment agencies, immigration legislation	Avoid tribunals
External auditors	Regional IRCs in London	National IRC (recruit nos, country of origin) WDC[7] plan, unions Suggest CHI[9] (Trust ratings)	NCCP (nos, country of origin) Plan yearly review, plan for new private & union sector auditors	Suggest MOH	Part of ETAG 2- monthly review meeting Suggest DOH	Expect WHO	Expect MOH in respective countries	Perceived as the DOH

Abbreviations:

1 UNISON = Union for nurses and midwives and healthcare staff
2 RCN = Royal College of Nursing
3 GMC = General Medical Council
4 NMC = Nursing and Midwifery Council for registration of all nurses, including international recruits

5 ETAG = Education & training advisory group are auditors who determine if a public/independent institutions can conduct supervised training
6 ILO = International Labour Organization
7 WDC = Workforce Development Confederations in England, of which a total of 24 exist
8 NCSC = National Care Standards Commission
9 CHI = Commission for Health Improvements in DOH England – the auditing body