



Graduate School of Development Studies

**ROMANCING THE STONE:
Government's Policy for Retention and Return
Migration of Health Professionals in Ghana and its
Effects.**

A Research Paper presented by:

BENJAMIN KOBINA OSEI
(GHANA)

In partial fulfilment of the requirements for obtaining the degree of
MASTERS OF ARTS IN DEVELOPMENT STUDIES

Specialisation:
**Human Resource and Employment
(HRE)**

Members of the examining committee:

Dr. Freek Schiphorst (supervisor)

Dr. Karin A. Siegmann (reader)

The Hague, The Netherlands
November, Year

Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

Research papers are not made available for circulation outside of the Institute.

Inquiries:

Postal address: Institute of Social Studies
 P.O. Box 29776
 2502 LT The Hague
 The Netherlands

Location: Kortenaerkade 12
 2518 AX The Hague
 The Netherlands

Telephone: +31 70 426 0460

Fax: +31 70 426 0799

Table of Contents.	3
Acknowledgement.	5
List of Tables and Figures.	6
List of Acronyms.	7
Abstract.	9
Relevance to Development Studies.	11
Chapter 1.0 The Prologue.	12
1.1 Background.	12
1.2 Problem Statement.	15
1.3 Justification and Relevance.	18
1.4 Objectives of the Study.	18
1.5 Research Questions.	19
1.6 Methodology.	19
1.7 Definitions.	22
1.7.1 Retention, Turnover and Attrition.	22
1.7.2 Health Workers.	22
1.7.3 Migrants.	22
1.7.4 Incentives.	23
1.7.5 Enclave.	23
1.8 Practical Limitations to the Study.	24
1.9 Structure of the Report.	24
Chapter 2.0 Theories, Evidence and Practice.	25
2.1 Introduction.	25
2.2 Retention Theory.	25
2.3 Return Migration Theories.	27
2.4.1 Neoclassical and New Economic of Labour Theories.	27
2.4.2 The Structural Theory.	28
2.4.3 The Social Network Theory.	29
2.5 Return Motives and Readjustment Problems.	30
2.6 Analytical Framework.	31
Chapter 3.0 The Ghana Health Service And the Enclave Policy	33
3.1 Introduction.	33
3.2 The Ghana Health Service.	33
3.3 The Enclave Provisions.	34
3.4 Social and Economic Implications of the Enclave Policy.	35

Chapter 4.0	Voices from the field and Echoes from literature.	40
4.1	Introduction.	40
4.2	Retention Measures in the Ghana Health Service.	40
4.3	Why We Leave the Public Health Service.	41
4.4	Enclave Policy and Retention	42
4.5	Enclave Policy and Return Migration	47
Chapter 5.0	Policy Recommendations from respondents and Researchers footnotes	52
Chapter 6.0	Summary of Findings, Policy Recommendations and the Epilogue	57
6.1	Introduction.	57
6.2	Findings and Policy Recommendations.	57
6.2.1	Retention.	57
6.2.2	Return Migration	58
6.2.3	Policy Recommendations	59
6.3	The Epilogue.	61
References		62
Annexes		67

ACKNOWLEDGEMENT.

My studies at the Graduate School of Development Studies would not have been possible without financial support from the Ghana National Association of Teachers. I am particularly grateful to the National Officers and the General Secretary, Mrs. Irene Duncan Adanusa for the golden opportunity offered to me.

My lecturers and supervisors at the Graduate School for Development Studies, especially Freek Schiphorst and Karin Siegmann, need special mention for the support and encouragement given me throughout my period of study and conduct of the research. Their advice and directions have taken me this far. I, however, accept full responsibility for any shortcoming that might be associated with this final product.

This work is the outcome of a long search for what I wanted to know about health sector migration in Ghana. In my attempt to reach this destination, I have had support from many distinguished personalities in the fields of Health, Migration Studies, Policy Analysts, and Human Resource Management. I acknowledge in particular the invaluable support I received from the Director General of the Ghana Health Service; the Director of Human Resource Management at the Ministry of Health; the Director of Budget and Monitoring, Ministry of Finance and Economic Planning; the Deputy Financial Controller, Ministry of Health; the Rector of Ghana College of Physicians and Surgeons; Deputy Director, Verification, Authorisation and Indexing, Nurses and Midwifery Council; Trade Union Leaders in the health sector; and all physicians and nurses, both in Ghana and Britain, who provided information for the research. I am equally indebted to Mr. Kwesi Darkwa-Marfo, a Ghanaian student in the United Kingdom, who willingly accepted the responsibility and linked me up with Ghanaian physicians and nurses living and working in the United Kingdom.

I also like to acknowledge the contributions of all authors whose work has been used. Some of their arguments have been challenged with a view to adding to knowledge but not to discredit their work.

Finally, there are several others who, in one way or the other, have supported behind the scenes to produce this work. For special mention are Mrs Vida Harrison –Indome of Securities and Exchange, Ghana; Messrs. John Nyoagbe, Nicholas Akyire, M.V.V.K Demanya, Ernest Asamoah and Agyeman-Fokuo of the Ghana National Association of Teachers; Thomas Ango Bediako and Paul Osei-Mensah, former General Secretaries of the Ghana National Association of Teachers; Alexander Roosevelt Hortordze and Emmanuel Baisie of the Graduates School of Development Studies. They have been of tremendous help to me. I am grateful to them.

To my late parents Okyeame and Mrs Osei, all my children and siblings', I dedicate this work. They have been wonderful people in my life.

LIST OF TABLES AND FIGURES.

TABLES.

Table 1.0	Physicians and nurses' migration in selected countries by 2000.
Table 2.0	Health Indicators of Ghana, 1998 and 2003.
Table 2.1	Production of physicians and nurses in Ghana, 1990-2007.
Table 2.2	Stocks of physicians and nurses in Ghana, 1996-2008.
Table 2.3	'Brain Drain' in the Ghana Health Service, 1999-2006.
Table 2.4	Verifications of Certificates, 1998-2008.
Table 2.5	Trends in physician and nurse to population ratios.1998-2008.
Table 2.6	Intakes into Ghana College of physicians and nurses, 2004-2008.
Table 3.0	Categories and Number of Respondents.
Table 3.1	GOG Expenditure on the Ministry of Health, 2000-2006.
Table 3.2	Public Sector Wages as a percentage of GDP and the share of Health Sector, 2000-2007.
Table 3.3	The Public Health Sector Personnel Emoluments as a percentage of health sector Annual Budget, 2000-2006.

FIGURES.

FIG 1.0	Analytical Framework.
---------	-----------------------

LIST OF ACRONYMS.

ADHA	Additional Duty Hours Allowance.
AFRC	Armed Forces Revolutionary Council.
BGN	Brain Gain Network
CEPA	Centre for Economic Policy Analysis.
CIA	Central Intelligence Agency.
GATS.	General Agreement on Trade in Services
GBC .	Ghana Broadcasting Corporation
GDP.	Gross Domestic Product.
GOG.	Government of Ghana
GUSS.	Ghana Universal Salary Structure.
H.I.V	Human Immunodeficiency Virus
HIPC	Highly Indebted Poor Country.
HSS.	Health Service Salary Structure.
HSWU	Health Service Workers Union.
HR .	Human Resource.
ISODEC	International Social Development Centre.
IOM	International Organisation for Migration.
MDG	Millennium Development Goals.
MIDA	Migration for International Development Agency
MOH	Ministry of Health
MPI.	Migration Policy Institute.
NAGRAT.	National Association of Graduate Teachers
NELM.	New Economics of Labour Migration.
NCETA.	National Centre for Education and Training on Addiction
NPP.	New Patriotic Party.
PNDC.	Provisional National Defence Council.
POEA.	Philippines Overseas Employment Agency
POW.	Programme of Work.
SANSA	South Africa Network of Skills Abroad
TB	Tuberculosis
UK	United Kingdom.
USA.	United States of America.
USAID	United States Agency for International Development.

WHO. World Health Organisation

ABSTRACT

The Research examines the effects of an ‘enclave’ policy introduced by government in the public health sector in Ghana with an objective of reducing attrition and further induce return migration. In doing so, views of experts in public policy, trade union leaders, health sector professional administrators’, representatives of international organisations involved in migration, scholars from the academia, technocrats from the Ministries of Employment and Finance, health practitioners in the public and private sectors as well as returned and non-returned physicians and nurses were obtained through the use of semi-structured interviews.

The study reveals that the ‘enclave’ policy is effective in addressing some of the push factors which underlie health sector migration in Ghana. To a large extent, the policy has helped in retention in the public health sector. What is more, it has induced internal health sector migration from the private sector to the public sector. Statistical information provided by the Ministry of Health and the Nurses and Midwifery council showed that migration figures for physicians began decreasing from 117 in 2003 to 32 in 2007 whilst that of nurses decreased from 252 in 2003 to 92 in 2007. The turnover to migration for both categories for the same period was 410 and 1002 with attrition rates of 32.9% and 16.2% respectively. These rates are lower compared to the periods between 1995 and 2002 which was 42.6% for physicians and 25.5% for nurses. What accounts for this is not only improvement in the conditions of service of physicians and nurses in terms of pay increases, as well as an effective bonding system coupled with the establishment of the Ghana College of physicians and surgeons as part of the enclave provisions, but also international actions in the form of restrictive migration laws and ethical recruitment protocols between Ghana and Great Britain. Furthermore, the creation of European Union has limited the job market opportunities for non-European professionals including health personnel from developing countries.

Regrettably, the responses to the policy by migrants are not encouraging. Those who return are either retirees or people who want to establish themselves elsewhere in the private sector. Reasons assigned for this, among others, include placement problems on return, loss of social capital at home due to long absence and poor human resource management in the health sector.

Policy recommendations to address the retention and return migration include bilateral agreements with flexible tools that could incorporate a variety of provisions.

There could be a five year agreement in which migrant physicians and nurses would work in the United Kingdom for three years and in Ghana for two years, with all five years of employment paid for by the United Kingdom. For a successful project, the government should consider a policy that establishes a body that will be fully responsible for migration and return issues. Such a body could compile databases of Ghanaian professionals living abroad and make use of their networks to bring some of them home, even if it is for a short time service to the nation. The Philippines and South Africa have tried this to their advantages.

Furthermore it is recommended that government establishes a College of Nursing and Midwifery in Ghana to take care of the professional needs of nurses. The structure of courses should be designed in such a way that participants stay at their workplaces and attend the courses as being done for the physicians. Alternatively, the upgraded nursing certificate to Diploma could be used as entry qualification for a Bachelor degree in nursing at the University. This will be a good mechanism to retain nurses who may wish to migrate to study in Europe.

KEY WORDS

Migration, Enclave, Policy, Retention; Compensation, Return migration, Attrition, Networks, Incentives.

RELEVANCE TO DEVELOPMENT STUDIES

'Health is Wealth', and 'Brain Drain', prevents a nation from enjoying the potential of her human resources to the fullest. A country that loses her human capital to other countries through migration stands to lose the fight against poverty. Ghana has lost many physicians and nurses to migration and this has eroded the capacity of the health sector to provide quality health service to the citizenry. This research tries to find antidotes to some of the reasons behind the migration phenomenon and, by so doing, help Ghana regain the lost wealth needed for development.

Chapter 1

1.0 The prologue.

1.1 Background.

Skeldon, (2005: 2), notes that 'Human capital formation is considered to be of central importance to development and the ultimate reduction, even eradication, of poverty. Thus, any loss of the skilled through migration may be prejudicial to the achievement of development goals...' The achievement of good health for national development and growth depends not only on the availability of health infrastructure, but also sufficient quantities of well-trained health professionals. The absence of these does not only deprive a nation of her quality health care but also a capability deprivation that may hinder the functionings and wellbeing of individuals to reach their maximum potentials. The nation as a whole suffers when the health system grounds to a halt because of lack of health personnel, the diamonds (stones) whose value cannot be underestimated. A country that loses her human capital to other countries through international migration stands to lose the fight against poverty. This seems to be the plight of Ghana, a country that has set a target of being a middle income country by 2015.

The Migration Policy Institute (MPI,2004: 6), a Washington based think-tank dedicated to the study of international migration, noted that between 1995 and 2002, Ghana trained seven hundred and two (702) physicians and seven thousand, eight hundred and seventy-six (7,876) nurses of all grade. Attrition in the form of migration within the same period for physicians and nurses stood at four hundred and eighty - seven (487) and one thousand five hundred and fifty-three (1,553) respectively. Migration rates for the period were 69.4% for physicians and 19.7% for nurses. Furthermore, the estimated vacancy levels in the public health sector for 1998 were 42.6% for physicians and 25.5% for nurses. These figures rose to 47.3% for physicians and 57.0% for nurses in 2002 (MPI: 2004: 8). The population of Ghana between 1995 and 2002 was approximately 20.5 million. Physician and nurse to population ratios for the same period were 18,274 and 1,675 respectively. These high ratios meant heavy workload for those at post leading invariably to low service quality. As argued by Shobbrook and Fenton (2002: 534), increased workloads and low staffing levels could serve as some of the push factors in the migration matrix.

Ghana is not the only country in the sub-Saharan Africa which is plagued by the public health sector attrition (migration) disease. Public health sectors in countries such as Botswana, Uganda, and Tanzania have equally suffered from intense migration. But Comparison of Ghana's migration figures with these countries that are at similar level of economic development as that of Ghana, within the same period, portrays a relatively bad case for Ghana's developmental efforts. Table 1 below indicates the percentage levels of migration of physicians and nurses from these countries.

TABLE 1.0 Physicians and nurses' migration in selected countries in Africa by 2000.

COUNTRY	PHYSICIANS	NURSES
Ghana	56%	24%
Botswana	11%	2%
Uganda	43%	10%
Tanzania	52%	4%

Source: Clemens et al. (2006:12-13).

Table 1.0 above shows that Ghana's migration figures for the period are relatively higher. Physicians and nurses, like diamonds (stones), are not only precious but also valuable in meeting the health care needs of the citizenry. No amount of 'wooing' or 'romancing' them to stay and bring those who have migrated back home through policy initiatives would be too much for government and the people of Ghana.

Why do physicians and nurses leave the public health sector or migrate? Rutten, (2007: 21) argues that incentives to migrate typically involve a combination of push factors (unsatisfactory working or living conditions in the country of origin) and 'pull factors' (attractive working or living conditions, availability of positions and active recruitment in the country of destination) Dovlo and Nyonator (2001: 9), in a study on health sector migration in Ghana argued that, push factors for physicians and nurses' attrition in the form of migration include search for better remuneration and conditions of service (to seek greener pastures), search for better postgraduate training opportunities, lack of incentives for hard work in Ghana, frustration of juniors by their senior colleagues and delayed promotions.

In addition, Garbarino et al. (2007:31), contend that health personnel migrate to enable them enjoy the medical profession as they have been taught which largely refers to the ability to provide quality care which is often not possible in facilities in Ghana and many developing countries. They further note that pressures from extended family members which some cannot cope with and tacit encouragement from the same

quarters for health personnel to take up jobs abroad to enable them save sufficiently to build houses at home, contribute to retention problems in the public health sector (ibid.).

Eastwood et al. (2005:1895), on the other hand, note that national policies and international agreements such as the General Agreement on Trades in Services (GATS) could also influence migration of health personnel. In their view ‘The World Bank in the past had proposed that health services are another area in which developing countries could become major exporters by temporarily sending their health personnel abroad’ (ibid.).

The ‘pull’ and ‘push’ factors constitute enormous challenge to developing countries and, therefore, need to be addressed if public health sector migration could be reduced to avoid depletion of stock of critical health personnel such as physicians and nurses. Which policy instruments are available to sending countries and particularly Ghana in addressing the migration canker?

The Fifty-Seventh World Health Assembly of the United Nations held in May 2004, saw international migration of health personnel a challenge for health systems in developing countries and by resolution WHA57.19 urged all member states to:

1. Develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems
2. Frame and implement policies and strategies that could enhance effective retention of health personnel including, but not limited to, strengthening of human resources for health planning management,
3. Review salaries and implement incentive schemes.
4. Use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration .
5. Establish mechanisms to mitigate the adverse impact on developing countries of loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular, human resources development, in countries of origin.

Before resolution WHA57.19 was adopted, Ghana government had already initiated plans to address the disturbing migration trends. In 1998, the ruling government, PNDC, introduced Additional Duty Allowance (ADHA) for direct patient care for physicians and nurses as an incentive to retain them and also stem the tides of migration. Ironically, this attempt coincided with the enactment of the United

Kingdom National Health Service (NHS) Plan which included recruitment of foreign health care workers. Part of the plan consisted of a website set up to recruit nurses from other countries (www.nursinguk.nhs.uk). (MPI 2004: 13). Records available indicate that in 1999, a year after the publication, 72 physicians and 215 nurses left the country.

By 2002, the operation of the ADHA scheme had run into problems and this necessitated that government suspended it, creating disenchantments in the health sector. Health sector trade unions were at arms with government over the withdrawal and this usually culminated in industrial actions. In 2004, the New Patriotic Party (NPP) declared the public health sector as an ‘enclave’ and allowed its management to introduce a wide range of incentives in the sector which eventually led to the hiving-off of public health sector workers from the public sector pay structure and providing them with two separate consolidated salary structures in 2007. One pay structure was for physicians and the other for nurses and paramedical staff. By all indications, these salary structures were more ‘juicy’ than what obtained in the public sector. This decision did not go down well with other public sector workers especially teachers. There were newspaper reports of wages and salary demands on government championed by the National Association of Graduate Teachers (NAGRAT) which more often than not ended in industrial actions which disturbed industrial peace in the public sector.

The details of the enclave provisions and the industrial unrest associated with its implementation are discussed in chapter 3.

1.2 PROBLEM STATEMENT.

Despite Government’s bold attempt to motivate health sector employees, especially physicians and nurses to stay and induce those who have migrated to return, the situation seems not to have improved. Dovlo and Nyongator (2001: 6) give an indication that between 1969 and 1997, Ghana Medical Schools trained 1,380 physicians. Eastwood et al. (2005: 1893) report that as late as 2003 the United Kingdom issued work permit to 850 Ghanaian health professionals. The World Health Organisation (WHO) disclosed that in 2004 there were 3,240 physicians and 15,797 nurses in Ghana. Baah (2007), citing the Controller and Accountant General’s Department, reveals that by 2006, there were 1400 physicians and 13,960 nurses of all

types at post in Ghana. The differences between the 2004 and 2006 stocks of physicians and nurses based on these data sources are 1,840 and 1,737 respectively. This type of 'brain drain' happened within the period when the health sector had been declared an 'enclave' and incentives provided to induce retention and return migration.

Furthermore, an interview with the chairman of the Ghanaian Physicians Association in the United States on June 28, 2008, revealed that there are currently 120 practising physicians living and working in the United States. This number does not, however, include physicians who for one reason or the other, have changed jobs. The large outflow of health workers especially physicians and nurses has had and continues to have a dire consequence on health delivery in Ghana. The public health sector is currently characterised by work overload that has affected the quality of services rendered to the public.' Empirically, there are several hospitals and clinics in the deprived rural areas without core health personnel even though many of the incentives provided through 'enclaving' are geared towards rural health workers. Shortage of staff has eroded the capacity of local health systems to function effectively and equitably in the production and delivery of health services to the poorest members of the Ghanaian societies' (Robinson, 2007: 4). Arguably, the access deficit to staff at the national level amounts to 66%. That means that for every 100 population, 66 Ghanaians are not able to access a health professional. This figure is much higher than that of Thailand which is also a developing country with access deficit of 1% in 2007 (Rosa et al. 2007: 5). With obsolete equipment and heavy workloads in public hospitals and clinics, the remaining health personnel may be tempted to leave and join the migration wagon, a situation which will not auger well for the people of Ghana whose health status had shown a down-turn by 2003 compared with that of 1998. Table 2.0 below, gives an indication of the health status of Ghana for 1998 and 2003

TABLE 2.0 Health Indicators of Ghana, 1998 and 2003.

INDICATOR	1998	2003
Infant mortality rate (per 1000 live births)	77	64
Under 5 mortality (Per 1000 live births)	155	111
Neonatal Mortality (per 1000 live births)	44	43
Post-neonatal mortality (per 1000 live births)	33	21
Crude Birth Rate(per 1000)	47	33
Crude Death Rate (per 1000)	17	10
Life expectancy at birth (in years)	54	58
Total Fertility Rate	6.4	4.4
Maternal Mortality(per 100,000)	540	540

Source: GDHS.1993, 1998 & 2003, Ghana Statistical Service, 2007 & MOH/RCH annual reports 1996-2003.

A cursory look at the indicators shows that infant mortality, under 5 mortality, and neonatal mortality rates have increased. When these are viewed against the backdrop of the Millennium Development Goals which include reduction in the rate of infant and child mortality by two-thirds by 2015; cutting the rate of maternal mortality by three-quarters by 2015; attaining universal access to reproductive health services by 2015; reducing HIV infection rates by 25% by 2015 and decreasing TB and malaria mortality by 50% by 2015 (ISODEC, 2006: 19) one can legitimately conclude that Ghana has a long way to go in meeting these goals in the absence of sizeable numbers of physicians and nurses.

This scenario is not a positive one when viewed against the backdrop that the country has started a National Health Insurance Scheme and free medical care for pregnant women as a fulfilment of the Millennium Development Goals (MDG), the success of which depends on the availability of physicians and nurses besides other paramedical staff. Has the 'enclave' policy helped to stem the tide of migration and brought return migration? Are there other strategies Ghana government could adopt to improve on retention and return migration in the public health sector? These are the issues the research attempts to answer.

1.3 RELEVANCE AND JUSTIFICATION.

Rutten (2007: 24) argues that outflows of medical personnel to developed countries constitute a human capital loss of educated and experienced personnel with negative spill-over effects on those who remain. Martineau et al. in Rutten (2007: 24) estimated that Ghana spends US\$60 on cost of training her health personnel whilst The Health Services Workers Union of the Ghana Trades Union Congress also notes with concern that between 1998 and 2003, Britain saved \$117 million by recruiting Ghanaian physicians while Ghana lost \$63 million worth of investment in her health professionals. Additionally, within the same period, the per capita health spending was \$1,668 in Britain and \$11 in Ghana (HSWU, 2006: 2). The loss of health professionals contributes to a general decline in average incomes as physicians and nurses generate skilled health system jobs beyond their own (Badu-Akorsa, 2006: 17). For these reasons, there is an urgent need to look for pragmatic policy options in dealing with outflow of medical personnel and its economic and social cost. This is what this research sets out to do.

Apart from the financial justification for the research, out-migration from Ghana's health sector has received considerable attention, whereas retention and return has not. This study explores this area and adds to existing knowledge for policy initiatives.

Finally, in the field of Development Studies and particularly in Human Resources and Employment, the study provides additional tools in addressing retention in a 'migration prone' sector such as the health sector in Ghana and the principles applied to other public sector institutions such as Education which is equally under stress due to manpower shortages arising from attrition.

1.4 OBJECTIVES OF THE STUDY.

The research, which is exploratory, examines the effects of the 'enclave' policy as an instrument for addressing the retention and return of physicians and nurses in the health sector in Ghana.

It specifically:

- Evaluates the effectiveness of the policy as an instrument for ensuring retention and return migration of physicians and nurses in the public health sector.
- Explores other policy options that could be used to encourage retention, return migration.

1.5 RESEARCH QUESTIONS

- (1) How effective has the ‘enclave’ policy been in addressing retention in the public health sector in Ghana?
- (2) To what extent has the ‘enclave’ policy induced return migration in the public health sector?
- (3) Which other policy options could be explored by the government of Ghana in addressing retention and return migration in the public health sector?

1.6 METHODOLOGY

The study uses both primary and secondary data. The primary data consists of semi-structured interview responses from policy experts, health management professionals’, returnee migrants’, scholars from the academia, representatives of international organizations which deal with migration, migrants’ living in the United Kingdom and physicians’ and nurses’ from the public and private sectors’. Semi-structured interviews were used because they encouraged two-way communication. It also allowed the researcher not only to receive answers to the questions asked but also the reasons for the answers.

A total number of 54 respondents were slated for the interviews but 2 of the migrant physicians whose telephone numbers were made available to the researcher, did not participate. One had travelled to Ghana on holidays and the other simply did not want to talk about his experiences abroad. The response rate was therefore 96%. Table 3.0 below indicates the category and numbers of respondents. The positions and personalities interviewed are attached as annexure 1.

Table 3.0 Category and Number of Respondents

GENERAL RESPONDENTS			KEY INFORMANTS					
Retained Physicians./nurses		Migrants	Returnees	International Organizations involved in migration	Academia	Public Health Management	Unions	Policy Experts
Public	Private							
10	10	8	10	2	2	4	3	3

Source: Own Construction, 2008

The experts on policy, finance, migration and health sector trade union leaders were purposively sampled because the researcher found them appropriate for the study. Snowballing was used to select returned and non-returned physicians and nurses. The reason for using the method was that, the researcher could not know any of the returnees in person. The initial contacts for the returnees were the medical superintendents of the districts used for the study whilst the initial participant for the non-returned was contacted through a personal friend living and working in the United Kingdom. The choice of snowballing as a method for selection of respondents has an inherent difficulty. Atkinson and Flint (2001: 1) note that because elements are not randomly drawn, but dependent on the subjective choices of the respondents first accessed, most snowball samples are biased and do not, therefore, allow researchers to make claims to generality from a particular sample. Secondly, snowball samples will be biased towards the inclusion of individuals with inter-relationships and, therefore, will over-emphasize cohesiveness in social networks and will miss ‘isolates’ who are not connected to any network that the researcher has tapped into. In addition to selection bias, there is also the issue of gatekeeper bias ‘Gatekeepers’ are sometimes reticent or protective toward those they cared for and sometimes hindered access for the researchers. These difficulties are likely to affect the quality of the responses. There was no way the researcher could check this and had to do with respondents identified.

Physicians and nurses operating in Ghana either in the private or public sector were randomly chosen through the lotto method except that the study area for this category of health staff differed. The lotto method was used because it was found to be the least expensive way of selecting researcher’s respondents and also guaranteed the inclusion of the people the researcher needed despite the fact that there was the possibility that the sampling population might not have the required information. (Kumar, 2005: 178). This problem was avoided through the use of alternative

questioning techniques which provided opportunity to cross check information earlier received.

The private health practitioners were chosen from Ho Municipal in the Volta and Kumasi Metropolitan in the Ashanti Regions respectively. These study areas harbour large numbers of private hospitals and clinics. Physicians and nurses in the public sector were chosen from Agona and Amasaman districts in the Central and Greater Accra Regions respectively. These districts were chosen because they form part of the deprived districts and also fall under the category where physicians and nurses are expected to enjoy most of the incentives outlined in the enclave policy. The four Regions, Volta, Ashanti, Central and Greater Accra Regions were chosen for the study because they were among the Regions with the highest number of health facilities in Ghana by 2006. In addition, these Regions have excellent road networks which made travelling easier for the researcher to contact respondents.

The non-returned migrants were interviewed through the use of telephone because the researcher could not travel to Britain to interact with them due to lack of funds and time. Great Britain was chosen because the country harbours the majority of Ghanaian physicians and nurses. A study conducted by Buchan et al. (2005: 10) on behalf of International Council of Nurses reveals that out of 3,087 nurses who verified their certificates from Ghana Nurses and Midwives Council between 1998 and 2003, 2,468 verified for Great Britain. It is explained that Ghanaian nurses preferred UK as a destination because it does not require the nurses to sit pre-entry examination and only requires an adaptation once registration and qualifications in Ghana have been verified and accepted (ibid.).

Respondents from health management, physicians and nurses in the public sector were requested to assess the enclave provisions and suggest what government could do to retain physicians and nurses whilst inducing return migration. Migrants were asked to share their experiences abroad and what is required to bring them home. Respondents from the academia, international organizations for migration, policy experts and trade union leaders were asked to assess the effectiveness of the enclave policy in addressing retention and migration return in the public health sector.

Secondary data for the research included articles and publications on health sector migration from textbooks, websites, Health Service Policy documents on incentives to motivate and attract health sector workers', Health Sector expenditure and share of personnel emoluments in the public sector as a percentage of GDP from 2000 to

2008, and data on output from nursing training institutions and medical schools from 2000-2008. This period was chosen for the study because it marks an era when the health sector saw enormous improvement in the working conditions, especially in salaries and allowances. The data will be analysed qualitatively and quantitatively and Excel programme was used for the final output tables and figures.

1.7 DEFINITIONS

1.7.1 Retention, Turnover and Attrition.

Retention describes an organisation's ability to keep employees in their positions for as long a time as possible. Employee turnover on the other hand, refers to the voluntary separation from an organisation by an individual who receives compensation from that particular organisation. Gurney, (1990: 12) in a graphic manner, argued that 'If an employee leaves, it is called 'turnover' and if the employee stays it is called 'retention.' By this definition, retention of physicians and nurses in the public health sector refers to the ability of the sector to keep its physicians and nurses for a long time without losing them to the private health sector , international migration or voluntarily resignation from the profession to take up other jobs which have no relations with health care delivery. Turnover and attrition, as discussed in this research, refer to migration.

1.7.2 Health Workers.

The World Health Organisation (WHO) defines health workers as 'all people engaged in actions whose primary intent is to enhance health'. Robinson, (2007: 4) In Ghana, the health sector includes government health services, private, traditional and non-governmental providers, civil society and community groups, all working to deliver health services. In dealing with turnover and attrition, attention will be on physicians and nurses in the public health sector.

1.7.3 Migrant

According to Bach (2003:2), a migrant is ‘a person who is to be engaged, is engaged or has been engaged in remunerated activity in a state of which he or she is not a national’. This review focuses on physicians and nurses, who for various reasons, have left the public health sector to the private sector or left the shores of Ghana to be engaged in remunerative activities elsewhere on the globe.

1.7.4 INCENTIVES

World Health Report 2000 defines incentive as ‘a particular form of payment that is intended to achieve some specific change in behaviour. In this work, incentives will refer to the financial and non financial provisions outlined in the ‘enclave’ policy.

1.7.5 ENCLAVE

The term enclave has been used in various ways in the development literature. Cardoso and Faletto (1969) used enclaves to explain industrial development and capitalist expansion in Latin America in the dawn of the 20th century, during one of the world’s earliest globalization waves. Enclave stood for inserting production controlled by external agents with heavy capital investments and highly specialized technology and marketing systems in a local economy, where domestic producers lost significance. While there is no agreement on an operational definition of enclave or their inherent development, The World Bank identifies an enclave as a project or an economy enclosed within another structure. It is an autonomous entity that is significantly different from its surroundings.(World Bank, 2004: 4) In this research, enclave refers to the public health sector in Ghana which has been carved out of the public service institutions and its management granted a measure of autonomy to depart from civil service pay and employment policies (Nduom, 2007: 2)

1.8 PRACTICAL LIMITATIONS

The research suffers from limited geographical coverage in terms of Regions. It was conducted in four out of ten regions-Greater Accra, Central, Ashanti and Volta Regions. This situation is due to the time allocated for the collection of data and the cost involved in travelling to all the ten regions. The nurse respondents were mostly female whilst the physicians were predominantly males. This did not allow for blend of ideas in each case based upon gender. At best the study is skewed towards male dominance at the physician level whilst it is skewed towards female dominance at the nurse level. All the experts and policy makers and analysts interviewed were males.

Also, the limitation of finance, distance and time necessitated the use of the telephone to solicit information from physicians and nurses living and working in the United Kingdom. This prevented the researcher from meeting the UK respondents and interacting with them face-to-face.

1.9 STRUCTURE OF THE REPORT

Chapter one, the prologue, dealt with the background of the enclave policy. It also looked at the objectives; the problem statement; relevance; the research questions; kinds of information and their sources; techniques used in selecting respondents; and limitations associated with the research. It also defined some of the key-words used in the study. Chapter two will be devoted to theories, evidence and practices associated with retention and return migration. Chapter three deals with the Ghana Health Service and the ‘enclave’ policy provisions’. It also deals with the rumpus the policy brought to the public sector in general whilst assessing its socio-economic ramifications. Chapter four examines the voices from the field and echoes from literature whilst Chapter five deals exclusively with policy recommendations from the field with footnotes from the researcher. The concluding chapter will be devoted to summary of the findings and policy recommendations as well as the epilogue.

Chapter 2

2.0 Theories, Evidence and Practice.

2.1 *Introduction.*

Chapter 1 identified the research problem and proposed three questions that have to be answered using both primary and secondary data. To place the study in its proper focus, this chapter examines retention and return migration theories. It also deals with return motives and readjustment problems returnees' face as well as providing an analytic framework for retention and return migration in the public health sector.

2.2 **RETENTION THEORY.**

Polit and Hungler (1999: 123) define nurse retention as 'the extent to which nurses' stay in their present jobs. Intent to stay is the nurse's perception of the possibility of leaving or staying in the present job'. Multiple variables directly affect retention and intent to stay. Independent variables affect the dependent variables directly or have an indirect effect through their intervening variables. For example, job satisfaction and individual characteristics are two main independent variables. Job satisfaction has direct positive effect on intent to stay and on job retention: the more satisfied the nurses are with their jobs, the more likely they will stay in their jobs. Lee and Drasgow (nd: 3) support these views when they argued that 'job dissatisfaction begins a cascade of events that include thoughts of quitting, intentions to search for an alternative, and forming an intention to quit or stay, which can cumulate into actual attrition.' Factors influencing staff retention include job satisfaction, autonomy, organisational and individual characteristics. What Polit and Hungler said about retention could apply to all employees including physicians.

Ellenbecker (2003: 306) groups job satisfaction into intrinsic and extrinsic characteristics and argued that intrinsic characteristics include autonomy and independence and group cohesion with peers and superiors. Extrinsic characteristics include stress and workload, autonomy and control of work hours and work activities, salaries and benefits and perception of the probability of finding an acceptable employment alternative' elsewhere. Organisational characteristics include type of governance and the organisations commitment to professional values whilst individual characteristics include age, tenure, family income, marital status, race, job position, kinship relationship and gender (Alexander et al. 1998:426 and Shader et al. 2001: 211).

In a study conducted in the United States to identify why nurses changed their work environment, it was found out that dissatisfaction of employment situation rather than the profession itself underpinned the phenomenon. Creating conducive work environment is, therefore, a sine-qua-non for retaining nurses. Retention strategies should take into account the needs and constraints within the health care environment (Fletcher, 2001: 234). In addition, NCETA (2005: 3) holds the view that supporting workers capacity to balance work with family life and providing new employees with realistic work expectation with regard to promotion opportunities, professional development opportunities and career mobility, could lead to employee retention.

Pullan and Lorbergs (2001: 19-20) in a suggestion as how to deal with shortage of nurses in Ontario, Canada, identified key retention factors such as offering of education and clinical opportunities and development of implementation strategies that incorporated the goals and objectives of the organisation into the needs of the individual nurses. Furthermore, retaining nurses in their positions or within the organisation required extreme orientation and education programmes (ibid.)

Whilst agreeing with the various views expressed by these writers on the retention drivers, one cannot lose sight of the fact that internal organisational systems and procedures when properly applied could help in keeping employees at post for a specific number of years. One of such procedures is the use of bonding systems. Teachers in Ghana are bonded for 5 years after the initial training after which they could apply for study leave with full pay to enter tertiary institutions to advance their career opportunities. On completion of their courses of study at the tertiary level, the beneficiaries are bonded again for a period covering the duration of the course plus one year. What this means is that if the duration of the course is 4 years, beneficiaries are bonded for 5 years. Though some people are able to redeem their bonds by paying the penalty, majority are not able to do so and as a result stay at post for the duration and even beyond.

It is also worthy of note that one dimension of retention or attrition is the awareness that job opportunities exists elsewhere that provides better incentives and working conditions. Employees being rational will choose employment opportunities where their human capital will be properly rewarded. It is in the light of this that one cannot separate employees' conditions of service from the national economy. Countries with strong economies suffer less migration whilst those with weaker economies lose their human capital to strong economies. An Adjunct to this is the type

of migration laws that are in place. In countries where there are restrictions on who could travel and to where, employees tend to stay no matter the cost. Ghana has lost some of her professionals because of poor economy and uncoordinated migration laws. The coming into being of the Ecowas Treaty in 1975 opened the flood gates for Ghanaian professionals to migrate to Nigeria in huge numbers to enjoy that countries oil boom. This view is supported by Hagopian et al. ((2005:1756)) when they argued that migration is a result of an equation consisting of economic and technical factors.

2.3 RETURN MIGRATION THEORIES.

‘Return migration is affected by multifarious factors that have made it a multifaceted and heterogeneous phenomena leading to several definitional approaches’ (Cassarino,2004: 253). Return migration theories tend to reflect the inverse of migration theories and have, therefore, followed the path of neoclassical, new economics of labour migration, structural, and network theories.

2.3.1 NEOCLASSICAL AND NEW ECONOMICS OF LABOUR MIGRATION THEORIES.

In the view of neoclassical economics, return migration is the outcome of failed dreams. It happens when migrants are not able to realize their expected benefits for migrating or when they realize that their human capital is not rewarded (Cassarino 2004: 255).

The new economic theory of labor migration (NELM), on the other hand, views return migration as a ‘calculated strategy defined at the level of the migrants’ household and resulting from the achievement of goals or target for migrating’. Migrants return home satisfied that their toils have not been in vain. (Cassarino 2004: 255). This is in opposition to the neo-classical economic theory.

Despite their seemingly contrasting positions, the two theories should be seen as being complementary in their approaches. Migrants who have not realized their dreams will stay on and persevere till their dreams are met. Furthermore, both theories give insightful slant to reasons why people move out of their countries and come back home. As rightly put, ‘Migrants have clearly defined projects or strategies before,

during and after their migration experiences and whether they are faced with market failures at home or with the need to compensate for wage differentials between their countries of origin and their areas of destination, plan and try to respond to market uncertainties' (Cassarino 2004: 255).

What the two theories suffer from is their shortcomings in their analytical approaches. They seem to dwell on financial and economic factors mostly without examining the actors themselves and their motivation for return. 'People may migrate to acquire skills which would be used in latter years in the home country' (Cassarino, 2004: 255). Many professionals in Ghana who travelled outside have come home with new skills and established their own businesses. The theories also fail to explain 'when' and 'why' the decision to return home takes place and virtually loses out when it comes to issues dealing with the social and political environment of the migrant. Migrants usually plan what they want to get from migration and the length of time they will like to stay outside. Many professionals have accepted contract work outside Ghana and have come back home after the contract period. Economic and political migrants have returned as a result of considerable improvement in Ghana's economic and human rights performances.

2.3.2 THE STRUCTURAL THEORY.

The structural theory postulates that return migration is based on institutional and social factors in countries of origin. Simply put 'Returnees' success or failure is analyzed by correlating the 'reality' of the home economy and society with the expectation of the returnee'. Improvement in the economy and political situations in the country of origin serve as incentive to return (Cassarino, 2004:257). For example, many Ghanaian professionals and businessmen fled the country during the AFRC/PNDC eras. Many of such people returned when Ghana reverted to Constitutional rule in 1992. Indeed, many of such migrants have returned to contest for political positions under the New Patriotic Party (NPP) administration. Typical examples of this are Dr. Arthur Kennedy who contested for the Presidential slot for the NPP at their congress held in Koforidua in 2007 and Mr. J.H Mensah, a leading member of the NPP. Furthermore, there have been several instances when migrants from Ghana have returned to establish themselves in the private sector of the economy because they want to participate in economic activities of the country. Many vehicle

spare parts stores located in Aboso-Okai in Accra are owned by people who migrated and came back.

Cerase (1974: 253), in his contribution to the structural theory debate, builds typologies of return based on time spent abroad and the degree of acculturation in the host society to determine the return type. His four main return characteristics are 'the Return of Failure'; 'Return of Conservatism'; 'Return of Motivation or innovation' and 'Return of Retirement'. (See also IOM, 2001: 22)

The 'Return of Failure' refers to migration return which is based on the failure of migrants to overcome the 'traumatic shock' upon arrival and who are not able to adapt to the new environment and quickly return to their home countries before their integration starts. 'Return of Conservatism', arguably refers to 'migrants' who migrate to pursue specific objectives after which they return to their country. 'Return of Motivation' or 'Innovation' typology refers to 'those who stay in the host society long enough to start referring to its value systems but who eventually return home. These migrants are those who bring back new ideas and values and are ready to apply the skills they have acquired abroad in their home context' (IOM 2001: 22).

'Return of Retirement' deals with migrants who have terminated their working lives and gone back home to private lives. Some of these return migrants normally engage themselves in part time work to support their retirement at home whilst others become specialist consultants who are consulted on technical matters.

2.3.3 SOCIAL NETWORK THEORY.

There are two variants of the social network theory. Wang and Fan (2006: 941) argue that, 'return migration is more likely to occur where a network system is not in place.' The International Organisation of Migration (IOM 2001: 37) on the other hand, argues that 'the development of social networks and ties can be seen as instrumental not only for emigration but also for return (to find satisfactory employment, suitable housing etc) or the development of transnational activities (contribution to hometown association, maintenance of cultural links between home and receiving countries etc.)'.

IOM (2001: 37) posited that 'the stronger the social and symbolic ties of migrants to persons and/institutions in the country of origin, the higher the propensity to return, and the greater the chances for this return to effect social and economic

change'. Alternatively, 'the stronger the social and symbolic ties of migrants to persons or institutions in the immigration country, the lower the propensity to return' (ibid.).

Shaw (2007: 11) notes that a survey conducted in 1995 showed that 23.5 percent of Ghanaian migrants migrated because of relatives and friends and that 'Ghanaian Diaspora associations, such as Pentecostal churches, assist new migrants in the United States, the United Kingdom, Canada and other countries' to settle in (ibid.).

2.4 RETURN MOTIVES AND READJUSTMENTS PROBLEMS.

Ammassari and Black (2001: 16), postulate that 'return motives include a variety of economic, social and family-related, as well as political reasons'. In their view 'strong family ties, the wish to rejoin family and friends, homesickness, problems of adjustment in the host country, racial harassment, and the aim to enjoy an improved social status back home are significant reasons for return'. Other factors, according to them, included 'migrants' stage in the life-cycle, as age brings changing needs and preferences. Migrants may for instance wish to raise their children back in their home country. They may return to get married, to care for elderly parents, or to take on particular family related responsibilities' (ibid.).

In addition, Ammassari and Black (ibid.) argue that 'there are various difficulties migrants face upon return'. They distinguished two perspectives from which the difficulties may be approached. 'On the one hand, the actual economic and social situation of returnees can be examined, looking at employment and housing, participation in associations, and so on. On the other hand, the migrants' own perceptions can be measured based on the degree of 'satisfaction' or 'dissatisfaction' with regard to their expectations nurtured vis-à-vis the home country upon return'. According to them, 'readjustment problems have been considered as an indicator of social change brought about by return migrants'. Additionally, 'the greater the conflict of re-adaptation due to the changed value structures of the return migrants, the greater the probability that they will provoke social change'. Conversely, 'the more traditional their value orientation upon return, the less likely they are to bring about innovation and social change'. (ibid)

In summary, employee retention or attrition rests with job satisfaction which is derived either extrinsically or intrinsically. Autonomy and organisational characteristics

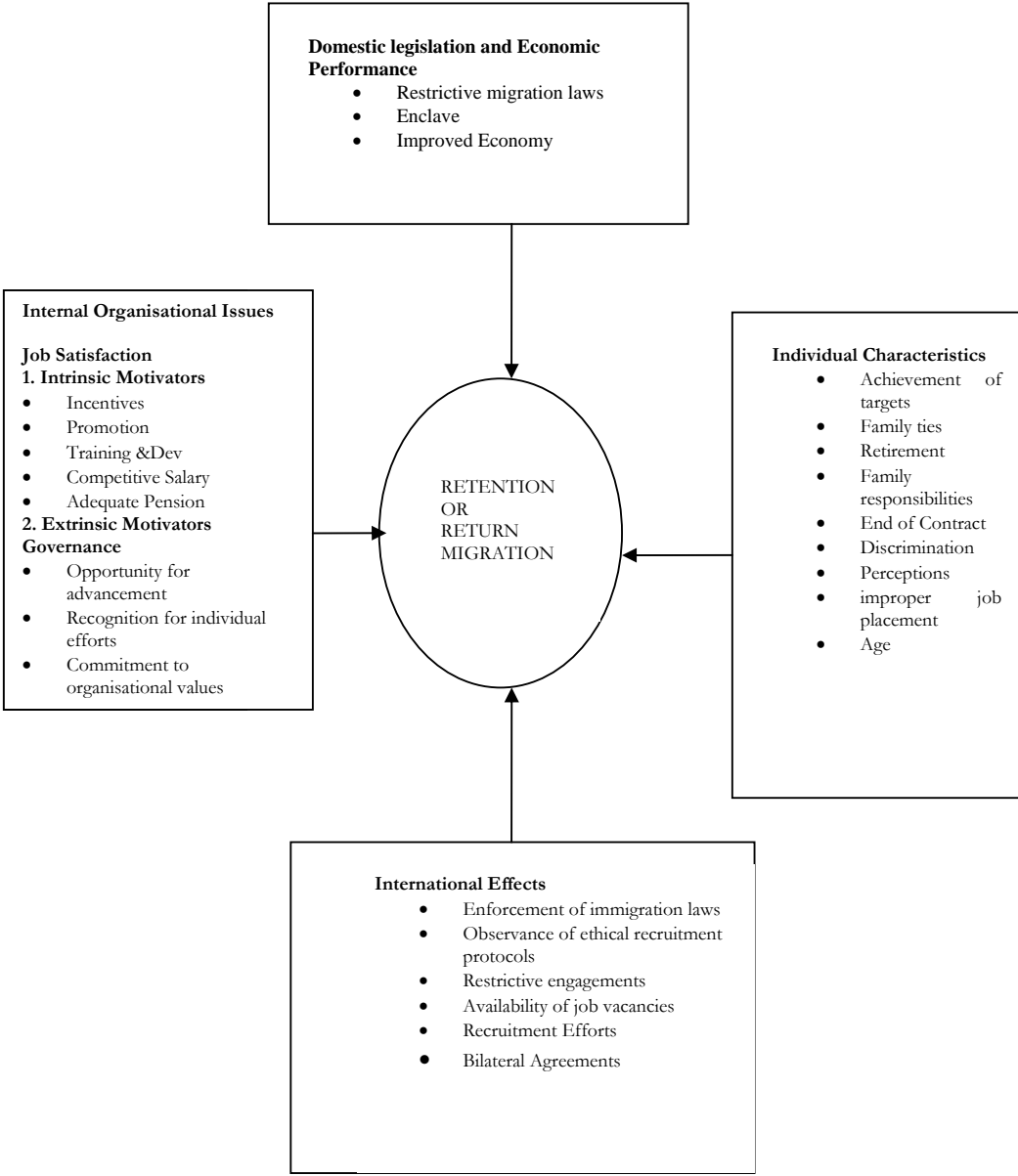
such as governance and the organisation's commitment to professional values also contribute to staff retention. Where these factors lack, employees will leave. Also important in the retention matrix are individual characteristics such as age, tenure, family income, marital status and job position. Improved national economy and effective national laws on migration and perception of the probability of finding an acceptable employment alternative' elsewhere also play significant roles in employee retention.

Return migration on the other hand, takes place because either migrant are not able to realise their human capital or that they have achieved their targets for travelling. They may also return as a result of not having access to networks in receiving countries that could serve as anchors on arrival. Return may also be attributed to the fact that migrants might have retired from active service in the receiving countries and wanted to return home to enjoy the fruits of their labour. Return motives include a variety of economic, social and family-related, as well as political reasons'.

2.5 ANALYTICAL FRAMEWORK.

From the literature surveyed retention and return migration of physicians and nurses in the health sector may not depend on introduction of incentives alone but other factors that go beyond the 'enclave' policy provisions, international action such as immigration restrictions and observance of ethical codes of conduct in recruitment, improvement in the national economy and personal motivation such as achievement of goals or targets, desire to come back home as a result of family responsibilities, are some of the factors that underlie return migration. Additionally, reduction in employee turnover in the health sector is contingent on job satisfaction and individual characteristics coupled with opportunities available for alternative employment. Figure1 below incorporates the assumptions for the analysis.

FIG. 1 ANALYTICAL FRAMEWORK FOR RETENTION AND RETURN
MIGRATION



Source: Own Construction

Chapter 3

3.0 The Ghana Health Service and the ‘Enclave’ Policy

3.1 Introduction

Chapter two examined some of the theories associated with retention and return migration as well as difficulties encountered by returnees when they do return. This chapter looks at the Ghana Health Service as a public service institution and discusses enclave policy.

3.2 THE GHANA HEALTH SERVICE

Article 190 (1) of Ghana’s 1992 constitution lists the Health Service as one of the Public Services in Ghana. It came into existence in 1996 by the promulgation of Act 525. Until then, the Ministry of Health through her agencies was responsible for health delivery in Ghana. With the establishment of the Health Service, the Ministry of Health concerns itself with policy formulation whilst the Health Service is responsible for implementation under the control of the Minister of Health through its governing council.

3.3 MANDATE OF THE HEALTH SERVICE

The Ghana Health Service website (www.ghanahealthservice.org) indicates that the Service has the mandate to provide and prudently manage comprehensive and accessible health services with special emphasis on primary health care at the Regional, District and Sub-District levels. The under-listed are the functions assigned to the Service by Act 525.

- Develop appropriate strategies and sets out technical guidelines to achieve national policy goals/objectives.
- Undertake management and administration of all resources within the Service.
- Promote healthy mode of living and good health habits by the people.
- Establish effective mechanism for disease surveillance, prevention and control.
- Determine charges for health services with the approval of the Minister of Health.
- Provide in-service training and continuing education for personnel.

- Perform any functions relevant to the promotion, protection and restoration of health

3.4 THE “ENCLAVE” POLICY PROVISIONS

The enclave policy grants the Health Service a measure of authority and autonomy to depart from Civil Service pay and employment policies because of its strategic importance in realising the tenets of Ghana’s Vision 2015 and the Millennium Development Goals. Specifically, the health sector has the responsibility of improving health care, enhancing the efficient utilisation of health resources, including human resource, improving the equity and access of the population to health care and increasing and coordinating the linkages between various sectors and communities contributing to health delivery in Ghana. The Ministry of Health’s programme of work (POW) for 1997-2000 was meant to achieve these goals and therefore had seven strategic objectives and five strategic interventions. The strategic objectives as documented by the Ministry of Health (2005: 13) include:

1. Improve access, quality and efficiency of primary health services.
2. Strengthen and re-orient secondary and tertiary service delivery to support primary health services
3. Develop and implement a programme to train adequate numbers of new health teams to provide defined services.
4. Improve capacity for policy development and analysis, resource allocation, performance monitoring and evaluation and regulation of service delivery and health professionals
5. Strengthen national support systems for human resources, logistics and supplies, financial management and health information
6. Promote private sector involvement in delivery of health services
7. Advocate for support for inter-sectoral action.

The interventions proposed in the programme of work as outlined in the document include:

- Decentralising management of health staff.
- Developing and implementing reward and incentive systems that recognise superior performance in under-served locations.

- Promoting collaboration between public sector health providers and private practitioners.
- Developing and implementing continuous professional development programmes.
- Training adequate numbers of competent professionals to serve in areas where their services are most needed.(MOH, 2005: 13)

In response to the second intervention, the Ministry of Health, over the last five years has instituted a wide range of measures under human resource policies and systems, to attract and retain health Service workers. The measures include:

- Payment of Additional Duty Allowance (ADHA) for direct patients care
- Provision of hire purchase saloon cars.
- A tax waiver for imported saloon cars.
- Provision of housing scheme for health workers.
- Continuing professional development including upgrading of nurses certificate to Diploma.
- Establishment of Ghana College of Physicians and Surgeons for post graduate training of physicians.
- Consolidated Salaries.
- Improved human resource management practices in recruitment, placement, re-deployment and promotions.
- Annual Best Nurse/Health worker Awards.
- Deprived area allowance for physicians and nurses.(MOH, 2007: 16)

3.5 SOCIAL AND ECONOMIC IMPLICATIONS OF THE POLICY

The purpose of the policy is to motivate health sector employees to stay and provide dedicated services to the people of Ghana but its implementation has produced unintended outcomes which are great challenges to the public health sector in particular and Ghana in general.

The freezing of the ADHA due to facility abuse brought a lot of labour unrest in the health sector itself. One of the deficiencies of the ADHA was that it excluded some categories of non-clinical support staff such as those working in the laboratories' with whom physicians and nurses worked closely at the facility level. Inversely other

categories of non-clinical support staff who worked at the managerial level accessed the facility without putting in extra effort. The Ghana Medical Association even though aware of the problems associated with the facility, went ahead on 2nd September, 2005 to declare a strike to back its demand for the de-freezing of the facility because it was affecting the income of its members. But for the timely intervention of the President of the Republic, the strike would have caused more harm. The Ghana Registered Nurses Association also called on its members on three occasions to embark on strike over the freezing of the ADHA in 2005. Anytime such industrial actions took place, the health system grounded to a halt with its attendant loss of lives at public clinics and hospitals. Such situations always brought the general public into sympathy and called on government to yield to the demands of the health sector workers at the expense of the national economy.

As a solution to the above problem, the government, in 2005, brought in a consultant to advise the Ministry of Health on what to do to resolve the compensation problems. The consultant conducted a job evaluation for the core health sector workers using 18 compensable factors and came up with two different salary structures, one for physicians and the other for nurses and other paramedical staff. The salary scales were referred to as HSS1 and HSS2. The new salary structure reflected a combination of the ADHA and enhanced pay values. The approval for the implementation of the two new salary structures was given in January, 2006. To all intent and purposes, the new salary structures were 'juicy' compared with the Ghana Universal Salary Structure (GUSS) which was the main instrument for compensation management for public sector workers. Hagopian et al. (2005: 1756) question how monetary incentives work in the health sector with the fact that physicians and nurses are generally civil servants with public salaries and the value of which jobs have been evaluated alongside others in the public sector. In their view, giving the migration potential of the sector, it would have been expedient but politically difficult. Raising the salaries for that single professional group significantly beyond other sectors of the labour force is a recipe for chaos. This position was vindicated with Ghana's situation.

Granting public health personnel with enhanced salaries opened the flood gate for series of industrial actions in the public sector. Many public sector employees especially teachers who constituted 80% of public sector workers saw the introduction of different salaries for health sector workers as a betrayal and at best, a callous decision

which only widened the income gap between the two sectors - Education and Health. Under the GUSS, teachers had a slight edge over nurses whilst other grades were comparable with those of physicians. The two institutions have similar entry requirements and the same number of years for training of nurses. Using the Hay model, Price Waterhouse conducted a job evaluation for the public sector institutions in 1995 and came up with a salary structure that recognized the value of individual jobs in the public sector. Positions in the health sector had their analogous positions in other sectors which by all indications looked equitable, fair and transparent. A departure from a 22 level salary structure to something that gave complete advantage to one group of workers, over others, was not what other public sector employees cherished. A cross mapping of grades to pay points carried out by Enchia (2006: 6) revealed that Junior House Officer in the health sector earned more than the nine most senior civil servants while a Staff Nurse earned more than all but the three most senior Police Officers, 20,000 civil servants and 91,000 Ghana Education Service Staff. This situation is worrisome and likely to impact negatively on productivity of other public servants. Currently, the Health Service ranks first in pay differential averaging 107.3 % (Ranging from 19.3% to 226.2%) above the over all Public Sector Median on consolidated pay (Enchia, 2007: 12).

Another feature of the two Health Sector pay structures HSS 1 for physicians and HSS2 for nurses and other paramedical staff was the internal inequity within the health sector itself. The wide disparity between the salary structure for physicians and the other paramedical staff including nurses worsened the situation with the nurses and other paramedical staff withdrawing their services several times as protest for inequities. A senior bureaucrat from the Ministry of Health, Nyonator, in an interview in Accra noted 'the continuous industrial action by health workers has contributed to the poor performance of health care delivery in the country. It has also contributed to the decline in utilization of services from health facilities' (11th April 2007, GBC Radio). How has the policy affected the public health sector and Ghana as a whole?

A Director at the Ministry of Finance and Economic Planning in an interview revealed: "It has not been easy managing health sector wage bills. It is characterised by constant budget overruns which are financed through re-alignments and suspension of some government projects". This position was collaborated by the Director General when he said , 'personnel emoluments of the sector takes between 10% and 15% of Ghana's GDP on the average whilst absorbing more than 80% of health sector annual

budgets leaving very little money for Administration, Services and Investment’. The import of this is that the health sector is not able to provide the necessary logistics and expand health facilities to meet the health needs of Ghanaians. In the words of the Director General, ‘If all migrant physicians and nurses return today, it will be difficult to get money to pay their salaries.’

Whilst seeing the policy as a bold attempt to salvage the collapse of the health sector as a result of high attrition, it is unlikely that all the provisions will be perfectly implemented due to external circumstances and inadequate resources. How and where the Government of Ghana will raise money to meet the full cost which is to be charged against the consolidated fund is the main problem when viewed against the backdrop that 30%-40% of Ghana’s annual budgets are financed through donor support. For example the Health Sector Report for 2007-2011 commenting on difficult area incentive reported that “in 2004, €10.5 billion was paid to health workers in 55 districts from Highly Indebted Poor Country (HIPC) inflows. However, this incentive scheme was not implemented in 2005 due to difficulty in assessing funds from HIPC inflows, thus, raising doubt about the schemes’ sustainability”(MOH,2007:9). Most of the provisions are extrinsic motivators which call for expenditures on behalf of Government. A tax waiver for imported cars, for example, is a cost to Government, thus reducing the revenue that should have accrued to the state to be used in providing the remaining incentives. It is likely that the Ghana Health Service will not be in a position to meet the full implementation of the provisions of the policy. Many nurses, who have accepted postings to deprived areas, have not been paid their transport fares, let alone deprived area allowances. Records available indicate that since the inception of the policy 1,082 saloon cars have been distributed to health personnel with thousands of applications pending. The housing scheme has not seen the light of the day. The Ghana Medical Association has started a housing scheme for its members due to the delay in implementing government’s plan. The non-implementation of some of the provisions in the policy is likely to have negative impact on the performance of the workforce and produce grounds for people to work with their feet, work to rule, and in the extreme case, resort to industrial action.

Government could reduce the financial impact of some of the provisions by involving financial institutions in the provision of the services whilst guaranteeing for the beneficiaries. For example, employees who need vehicles could take loans from their bankers whilst government provided sovereign guarantees for them. By this

arrangement, many people can benefit from the policy. A similar thing could be done with the housing scheme. Tables 3.1, 3.2, and 3.3 in annexure 3 are the details of GOG Expenditure on Ministry of Health from 2000 to 2006; Public Sector Wages and Salaries as a percentage of GDP and the share of the Health Sector from 2000 to 2006 and personnel emoluments in the Health Sector as a percentage of annual budget from 2000 to 2006.

Chapter 4

4.0 VOICES FROM THE FIELD AND ECHOES FROM LITERATURE

4.1. Introduction

In the previous chapter, the Ghana Health Service and the enclave policy provisions were examined. The main thrust of this chapter is to find out the effects of the policy on public health sector retention and return of migrant physicians and nurses. In doing so, the study will give voices to returned and non-returned physicians and nurses; physicians and nurses who work in public and private health institutions in Ghana; professional health administrators, policy makers; health sector trade union leaders; representatives of international organisations dealing with migration, scholars from the academia and labour experts through the use of semi-structured interviews, an instrument that allowed the respondents not only to talk but also give reasons for what they said. What literature says about retention and return migration is also brought to bear on the discussion.

4.2 RETENTION MEASURES IN THE PUBLIC HEALTH SECTOR

A report by the Ministry of Health published in May, 2005 cited as ‘Quality Health Partners, Ministry of Health and the Ghana Health Service. Assessment of Current Human Resource Management Systems and Practices in the Ghana Health Service’ suggests that Regional and District Directorates of the Ghana Health Service have in place retention strategies in conformity with the enclave provisions as described in chapter 3. Regional staff retention efforts include well-furnished free accommodation, ensuring that specialists are available to mentor young doctors, prompt payment of ADHA, payment of salaries in advance of final setup of direct deposit via the central payroll system, training and payment of fuel cost for transport.

District level strategies for retention include financial incentives such as staff loans for residential accommodation, cash allowance for study leave, travelling and transport for official trips, settling telephone bills, buying basic items like cooking utensils and television, and soft loans for those not yet on salary, verbal encouragement, showing concern about the economic and personal wellbeing,

provision of working equipment, adequate and regular training of staff and good working relations with staff.

To what extent have these retention drivers worked? Majority of physicians and nurses interviewed revealed that the incentive packages are there only in name and on paper. According to them several health personnel are sometimes denied their refund of travelling expenses genuinely made in the performance of their official duties because of lack of funds. In addition, salaries of newly recruited physicians and nurses are delayed for not less than two years before they are paid. Such personnel have to depend on friends and family members till they receive their salaries. Explaining why this is so, a young physician respondent attributed the situation to inefficient human resource management in the health service. In response to this allegation, a Director in the Ministry of Finance and Economic Planning stated that budgets for personnel emoluments for health staff are often exceeded before the end of the year and that non-critical staff are recruited at the expense of the needed professionals. According to him, in 2004 GHS exhausted its recruitment budget in September but wanted to recruit more staff, and this was not possible. 'The process in the past had been that the MOH recruited without regard to the budgetary ceilings but currently the MOH and GHS are expected to subtract all recruitments from the maximum and monitor the balance' he said.

The Director General of the Ghana Health Service and the Human Resource Director of the Ministry of Health confirmed that the implementation of the retention strategies has become a daunting task due to its financial outlay. In addition, the public health sector is still beset with lots of challenges including inadequate staff numbers; inequitable distribution of workers at different levels of service delivery; low morale and motivation of health workforce; inadequate supportive/facilitative supervision; weak performance management systems; limited training capacity to meet increasing numbers into training institutions and high attrition of health workers.

4.3 'WHY WE LEAVE THE PUBLIC HEALTH SECTOR'

Advancing reasons why physicians and nurses in the public health sector leave or migrate, majority of the health personnel interviewed either as migrant or still at post in the public or private sector in Ghana and returnee migrants revealed that they do so as a result of, desire for further training abroad, poor remuneration and working

conditions, lack of career profiles, desire for improved standard of living, delayed promotions, inefficient human resource management, poor pensions and social security benefits, discrimination in the award of scholarships for overseas studies and lack of career path for physicians, lack of recognition for nurses by top management of the Health Service, marriage and childbearing, exposure and desire to change environment, and frustration among nurses. These push factors reflect the neoclassical thinking and emphasizes more on individual and job satisfaction characteristics playing down on structural and external factors such as perceived possibility and availability of job vacancies elsewhere in Europe and particularly, in the Great Britain.

The highest attrition in the health sector was recorded between 1998 and 2003. This was the period when globalisation and its consequent free movement of goods and people were at the highest. Great Britain had advertised job vacancies for physicians and nurses on a web site and because of the long historical ties between Ghana and that country coupled with language advantage, many physicians and nurses found the situation propitious to run away from the economic difficulty the country was facing around that time. International action equally contributed to the retention problems in the health sector and this should not be overlooked. Furthermore, there is a large community of Ghanaians living in the United Kingdom who provide initial accommodation to new entrants thus making it easier to cope with trauma associated with migration. The network theory becomes relevant when the issue of retention of physicians and nurses in the public health sector comes under the radar screen.

4.4 ENCLAVE POLICY AND RETENTION.

Public health sector management and health practitioners in both public and private sectors interviewed admitted that there is decrease in the number of physicians and nurses who leave the public health sector either to migrate to the private sector or leave the shores of Ghana or abandon the health profession all together in the recent past. Statistical information provided by the Ministry of Health and the Nurses and Midwifery Council attested to this. Migration figures for physicians began decreasing from 117 in 2003 to 30 in 2007 whilst that of nurses decreased from 252 in 2003 to 92 in 2007. In addition, production of physicians and nurses from 2003 to 2007 stood at 1,274 and 6,200 respectively. The turnover to migration for both categories for the same period was 410 and 1002 respectively whilst attrition rates stood at 32.9% and

16.2% respectively. These rates are lower compared with the periods between 1995 and 2002.

Verification is one of the requirements for recruitment into the NHS in the United Kingdom. The Ministry of Health and the Ghana Health Service regard the process as intention to leave the public health sector and travel to Great Britain. In addition to the reduction in migration figures, verification or authentication of certificates by nurses reduced between 2003 and 2008 compared with earlier periods. For example in 1998, 172 certificates were verified. By 2003, the verification figures had reached 923. Interestingly, by June 2008, the figures had decreased to 32. In similar vein, trends in physician to population and nurse to population ratios have improved considerably. In 2001 the physician population ratio was 1:20,036 whilst that of nurse to population was 1:1,728. By 2008, the ratios had improved to 1:9,624 for physicians and 1:1,163 for nurses. Tables 2.4 and 2.5 in annexure 2 show the verification of Certificates from 1998 to 2008, and trends in population ratios for physicians and nurses from 1998 to 2008.

What accounted for the improvement in retention? A majority of the respondents attributed the improvement in retention to enhanced salaries and the incentive schemes. The year 2007 was the year when health sector workers received appreciable level of increases in personnel emoluments. The number of vehicles supplied to physicians and nurses also saw an upward surge to 1,082 (MOH, 2008). Data available from the Ministry of Finance and Economic Planning on personnel emoluments for physicians and nurses for 2007 indicated that nurses received between 242% and 244% increases over their 2000 salary levels whilst that of the physicians ranged between 274% and 395% for the same period (MFEP, 2008). A Director at the Ministry of Health noted that ‘the current salaries of physicians in Ghana are higher than those obtained in most developing countries hence the retention’. This statement may be true but Ghanaian physicians and nurses are mostly found not in developing countries but in the developed ones where conditions of employment including salaries could not be compared in anyway with those approved for health personnel in Ghana. For example the salary of a newly recruited physician in Great Britain as at April, 2008 was £32,793 whilst that of the nurse was £13,617 (NHS, 2008). These figures can not be compared to Ghana’s figures of £5,111,253 for newly recruited physicians and £2,210,459 for a newly recruited nurse (MOFEP, 2008).The salary alone may not be the retention driver in the public health sector as an instrument to retain physicians and nurses as many

factors come into play when attrition factors are being considered. Difficulties in finding an acceptable employment alternative elsewhere, organisational characteristics such as good governance, commitment to professional values and effective internal organisational control systems, restrictive migration and immigration laws, improved national economy and individual characteristics such as age, tenure, family income, and marital status all play an important role in the attrition matrix. This position was corroborated by the Director General of the Ghana Health Service and a Deputy Director from the Nurses and Midwifery Council when they argued that,

‘the downward trend in migration of nurses in the health sector could not be attributed to improved salaries and working conditions alone but also other factors such as improvement in bonding system, bilateral agreements at the international level between Ghana and Great Britain not to poach nurses from Ghana, stringent recruitment laws in receiving countries especially the United States of America and upgrading of initial nursing training certificate to Diploma which takes three years to complete’.

A Director at the Ministry of Health also noted that the purchase of vehicles on hire-purchase by physicians and nurses was also an effective means of holding up beneficiaries for some time. According to him, it took about 12 years for beneficiaries to complete payment by which time they would have established themselves in the profession and not see the need to travel. The President of the Ghana Medical Association refuted this on the grounds that many physicians had their own vehicle before the introduction of the hire purchase arrangements. What is more, beneficiaries who were bent on leaving the service could have equally sold the vehicles and paid up the loans. The Ghana Registered Nurses association, however, saw the facility as a retention driver and commented that it has raised the social statuses of nurses who have benefitted from it.

To the President of the Ghana Medical Association, the retention of physicians should not be attributed to improvement in salaries alone but also to an arrangement put in place by the Ghana Medical Association for its members to acquire their own houses through monthly contribution of c500,000 (\$50) per member per month for a period of 12 years. This commitment has forced many of the physicians to buy shares from Epack as a means of investment for their projects. This statement is quite revealing and supports the researcher’s assumption that improvement in national economies and political situations could serve as impetus for retention. Ghana’s, economy has shown improvement in performance compared to the 1980’s. In the late

80's, economic growth rate in Ghana was negative forcing many skilled labour such as physicians, nurses and teachers to migrate to Nigeria and other parts of the world to look for greener pastures. The period also coincided with the rule of a military junta that had hatred for successful people especially those in the academia and business. The political situation exacerbated the mass exodus of professionals. Ghana introduced structural adjustment in 1981 to resuscitate the economy and by 2000, the GDP growth rate turned positive to 3.7. In 2001, the political situation changed. Under the New Patriotic Party, the economy has grown steadily from 3.7 in 2000 to 6.2 in 2006. This has opened the economy up for investments, especially, in the financial sector. Physicians have, therefore, taken advantage of the liberalised economy to participate in the financial market, leading to their retention. Improvement in the national economy therefore has also played a role in retention of physicians and nurses in Ghana.

Expressing his personal views on public health sector retention, the Director of Planning at the Ghana Health Service argued that external and internal factors are in tangent when it comes to factors that have contributed to retention of physicians and nurses. To him, 'health personnel left Ghana in the 1990s because they were needed in Europe. The situation has changed as a result of the creation of the European Union. European Union members recruit personnel from among themselves'. Garbarino et al. (2007: 31) support this argument when they wrote that 'tightened administrative labour market requirements in host countries; the difficulty in assessing post graduate studies abroad; difficulty in finding jobs as physicians and nurses forcing some nurses to work as ward assistants and physicians as nurses or taxi drivers and frustration are preventing mass exodus of health personnel from developing world to Europe'. This confirms researcher's assumption that international action could play effective role in retaining health personnel. When physicians find it difficult to get jobs in receiving countries and also find difficulty in obtaining visas they would be forced to stay. A nurse respondent indicated that even though she had the desire to travel, she could not get a visa because of the cost involved and the difficulty in securing it. Shaw (2007:37) notes that 'the number of nurses emigrating dropped by more than half by 2003, in part due to United Kingdom's prohibition of recruiting of African health professional by the National Health Service'.

In addition to the improvement in salaries, the Rector for the Ghana College of Physicians and Surgeons informs that the establishment of the College in 2003 has helped a great deal in the retention of physicians. According to him, the establishment

of the college was a strategic move by government to provide avenue for young physicians who use further training opportunities as reasons to migrate to stay. In his view, 'the physicians consulting room in the public sector is part of the training for higher professional degrees and Diplomas. Physicians do not need to leave their duty post to travel outside to get higher degrees'. He hinted that 'residency' training for membership ranged between 2 and 4 years with additional 1 year practice after membership. Fellowship, on the other hand, involved extensive practice in speciality for between 2 and 3 years and subspecialty training lasting between 2 and 3 years. 'The long years of training help in retention of physicians in Ghana.' In his view, 'But for the College, Ghana would have further lost 463 physicians to migration between 2004 and 2008 on the excuse that they were going outside for further training.' Table 2.6 in annexure 2 shows the intakes to the College from 2004 to 2008.

The Ghana Registered Nurses Association on the other hand noted that in addition to improved salaries, stringent administrative procedures put in place in the public health sector had contributed to improvement in retention. According to the union, before any nurse could have a certificate verified, clearance from the Director General was needed. In addition, nurses who completed their programmes of studies were bonded for five years, making it difficult to move out. Many of the bonded nurses are unable to pay the penalty and have to wait to complete the bond years within which period they get married and stay in the service. These revelations confirm the assertion of the researcher that bonding of employees as part of internal organisational systems and procedures could play significant role in the public health sector retention efforts.

Perhaps, perceptions held by physicians and nurses who are at post about their colleagues who have migrated cannot be swept under the carpet when explaining the seemingly reduction in the attrition of physicians and nurses in the public health sector. Those who migrate are regarded as unpatriotic, money-loving and undedicated who enter the health sector for its prospects for migration. According to some of the nurses interviewed, lack of patriotism among young health workers in the public sector is the outcome of a failed educational system. Many physicians and nurses have stayed because they do not want to be described with such disgraceful epithets confirming the researcher's assumption that employee perceptions about the migration phenomena could affect decisions either to migrate or not.

4.5 ENCLAVE POLICY AND RETURN MIGRATION

The Ghana Health Service has no register on the number of nurses and physicians who have returned. The Director of Planning in the Ghana Health Service revealed that there were no statistics on return migrants because they don't inform officials about their departures. This makes it difficult to know who travelled and who did not. However, the Director General held the view that migrants physicians were returning and these included some of his own medical school mates who for several years had stayed and worked in Britain and that those who may not take advantage of the situation may have reasons such as improper job placement on return (apart from Specialists and Surgeons who return with higher qualifications and enter the health service with their qualifications at higher levels, all others begin from where they left off), inability to fit into the economic system and loss of social capital at home as a result of long absence.

The President of the Ghana Medical Association held the view that it was too early to assess the actual impact of the policy on return migration. He, however, hinted that some few physicians had come down to test the waters and gone back to prepare and come to settle permanently later. He further hinted that those who have returned are those who have retired from active service and have come down as specialists and consultants working in teaching hospitals in Ghana. This type of return corresponds to the structural theory and its 'return of retirement' typology. Health migrants will return when they have retired from active employment in host countries and wants to come home to enjoy what they managed to accrue whilst working outside.

The Rector of the College of Physicians and Surgeons was of the view that 'Ghanaians normally don't like staying outside. It is when their aspirations at home are not met that they decide to migrate'. In his view, 'return migration depended on demography. Whether migrants will return or not depended on the ages at which they migrated. Young men who migrate may not return easily. They are usually hooked up by the system. They take mortgages and start raising families. Their children attend high schools and colleges in Europe where they have to work and pay their fees. This category of migrants, according to him, will not leave and come to Ghana because conditions of employment, especially salaries, have improved in the health sector as a result of an enclave policy. In his view, even if they return, they will prefer working in the private sector because of humiliation they receive from officials when they attempt

to regularise their appointments after return. Those who succeed with regularisation do not receive salaries for several months through no fault of theirs. This situation is due to budget overruns in the health sector'. The statement by the Rector, in part, confirms the researcher's assumption that the age at which migrants leave determines their return outcomes. Similarly migrants, when they return, will like to be in the private sector to be entrepreneurs of their own rather than serving in the public health sector.

None of the returned physicians and nurses interviewed cited the enclave policy provisions as the motivation for return. Their reasons for return included 'family pressures, old age and desire to settle at home, becoming an entrepreneur in the private sector and realisation of dreams'. One respondent, however, claimed that she returned for patriotic reasons 'To serve my country after further training abroad'. The reasons assigned for return by the respondents are in tandem with the return typologies and motives advanced by Cerase (1974: 253) and Ammassari and Black (2001: 16) respectively. 'Migrants return either because they have retired, achieved their objectives for travelling or due to family influence'.

Physicians and nurses in private practice interviewed alluded to the fact that some of the migrant health personnel are no longer in medical practice in the receiving countries because they could not meet recruitment requirement. Some of them are driving taxis in Europe. Such people, according to the respondents, will be of no use to the health system in Ghana if they return unless they go back to school. According to a nurse 'even though migrant physicians and nurses in Britain are facing strong discrimination, they may not take advantage of the situation because of marriage and child bearing, enrolment in Universities, lost of children to European societies, afraid of being regarded as returned failures by colleagues at home and working under juniors who have stayed back under trying conditions and have climbed the professional ladder to the top'. Furthermore, 'migrant colleagues may not take advantage of the improved conditions of employment because of unmet goals gossip at the workplaces, good pension arrangements in Britain, naturalisation and payment of mortgages.'

Contrary to the believe that migrant health professionals are not responding to the enclave policy provisions, analysis of data on national stock of physicians and nurses for 2003 to 2007 and the stock from 2006 to 2008, show interesting scenario. From the data, the stock of physicians and nurses from 2003 to 2006 in the public sector was 1,400 and 13,960 respectively. These figures rose to 2,026 physicians and 16,904 nurses in 2007 showing differences of 626 and 1,632 respectively. Meanwhile,

physician output for 2007 was 214 whilst that of nurses was 1,312. Subtracting the outputs from the differences, there are 412 physicians and 320 nurses in the public sector who have to be accounted for. Similarly, the differences between the 2007 and 2008 stock of physicians and nurses are 260 and 2008 respectively. When the output from training institutions for the same period is subtracted, there remain 8 physicians and 216 nurses who are to be accounted for. Where are these physicians and nurses coming from?

The Director General of the Health Service explained that the excess numbers are mostly public health personnel who moved to the private sector because of better salaries in the early 80's and 90's. With the enclave policy provisions, conditions in the public health institutions have improved considerably hence the reversal of the trend. In his view, private hospitals and clinics would not be able to pay the salary levels that obtain in the public health sector. In addition, many of the physicians in private practice are moving back to the public sector to enable them enrol as participants of the College of physicians and surgeons since private hospitals do not form part of the learning experiences required for practicum.

That, physicians and nurses in the private sector were moving back to the public sector was also confirmed by the Ghana Private Medical Practitioners Association. According to the President 'Young physicians prefer being in the public sector on permanent basis and doing 'locum' in the private clinics. By so doing, they get more money than staying permanently in the private sector'. A young physician in a private hospital in Kumasi confirmed this when he said 'We all need progress in our lives. Private owners of hospitals are not prepared to spend money on our training for fear of losing us. The alternative for us is to go back to the public sector and work part-time here. By so doing, we can benefit from both sectors.' This situation confirms the researcher's assumption that improved working conditions at the workplace could serve as a retention driver and induce migration return. Tables 2.1, 2.2, and 2.3, in annexure 2 show the production of physicians and nurses from 1990 to 2007 and stock of physicians and nurses from 1996 to 2008.

Responses from public health sector managers, officials from the Ministry of Manpower, Youth and Employment and experts on migration revealed that apart from a 'Brain Gain' programme, a collaborative effort between the Ministry of Health and the International Organisation for Migration (IOM) on one hand and Migration for International Development Agency (MIDA) on the other, with sponsorship from the

Netherlands government, which had brought 66 physicians back home for short services, (IOM,2008) the government of Ghana has no specific programme to consciously induce return migration. The 'Brain Gain' project provides Ghanaian health professionals resident in Europe the opportunity to work on short-term basis in Ghana during their vacation periods. This was a pilot project which began in 2005 and ended in 2007 (MOH, 2007:17).

The Philippines is one of the countries that have developed potential models for return migration. In 1995 the country established the Philippines Overseas Employment Administration (POEA) to promote the return and reintegration of migrants. Under this arrangement, many privileges are granted to returnees including tax-free shopping for one year, loans for business capital at preferential rates and eligibility for subsidized scholarships. In addition, POEA is mandated to build networks between the migrants and the homeland and conduct psychological counselling services through a network of offices abroad to strengthen the maintenance of 'Filipino values'. The government has also created the Philippines Brain Gain Network (BGN) with the responsibility of keeping the human resource data base of experts, potential investors and partners overseas for business networking, joint collaboration and foreign investments (Kiragu et al., 2003:43-44).

South Africa, which has also suffered massive emigration from her public health sector, has found innovative ways to address the problem. In 1998, the country established the South African Network of Skills Abroad (SANSA) and charged it with the responsibility to convert brain drain into brain gain by matching local shortages of skills with national expertise residing overseas. Towards this goal, SANSA has established an extensive human resource database to facilitate knowledge sharing and networking. In addition, the South African government has negotiated bilateral and multilateral agreements with its major destination countries in order to curb the emigration of health professionals. The National Health Service of the United Kingdom has developed a code of practice for international recruitment under which the British authorities agree not to organise recruiting campaigns for health professionals in South Africa and 153 other countries (ibid.).

Respondents from the academia argued that migration of health personnel and any other professionals could not be stopped by merely introducing a policy that provides salary enhancement to employees. In their view, developing countries cannot raise salaries to the levels as obtains in the advanced countries. Furthermore, human

beings are rational and will definitely be attracted to areas where they can make the best for themselves. Migration, as part of globalisation, cannot be stopped. Government should rather demand from receiving countries the cost involved in the training of the personnel and use the money to expand and improve on health facilities. Under Kaldor-Hicks efficiency standard, 'a human resource transfer from a developing country to a developed country that improves the social welfare of the population of the developed country while imposing a welfare loss on the population of the developing country would be potentially Pareto efficient, so long as the developed country compensates the developing country for its loss', (Skeldon, 2005: 11). In the light of this and in accordance with the third resolution of the World Health Assembly in 2004, government should establish mechanisms to engage receiving countries to help with development of health institutions in Ghana as compensation for the lost human capital. This position was echoed at the World Health Assembly in 2004 and also emphasized at Abuja in December, 2004. 'In the longer term developed countries need to be encouraged to make commitment to training of their own health personnel, but in the meantime they could at least pay back developing countries for the training costs of their health professionals that they employ...' (ABUJA, 2004: 13). Eastwood reports that in 2005, Britain through DFID approved a 6-year £100 million programme of support to the health service in Malawi for better training and higher salaries for physicians, nurses and other health workers. This can be replicated to help the health sector in Ghana by other countries who have engaged health professionals from the country.

Chapter 5

5.0 POLICY RECOMMENDATIONS FROM KEY RESPONDENTS.

5.1 *Introduction*

In chapter 4 an attempt was made to present the views of respondents on public health sector retention and return migration in relation to the enclave policy and its implementation. This chapter conveys policy recommendations from the key respondents and the researcher's views on them.

5.2 POLICY RECOMMENDATIONS.

1. PUBLICITY AND CAMPAIGNS ON THE ENCLAVE POLICY

Government should consider publishing the enclave provisions in international papers and magazines and also mandate Foreign Missions to re-recruit Ghanaian and non-Ghanaian health professionals for the Ghanaian Health Sector and provide support to successful applicants with passage and other incentives to come to Ghana and work. Officials from the Ghana Health Service and the Ministry of Health must mount vigorous campaigns in receiving countries to 'woo' migrant physicians and nurses who are stranded in one way or the other. Such health personnel could be brought home, rehabilitated through in-service programmes and posted to deprived areas where there is acute shortage of health staff. (Ghana Registered Nurses Association, Director General of the Ghana Health Service and President of the Ghana Medical Association).

As much as the researcher agrees that the enclave policy provisions should be publicized widely, the use of foreign newspapers and magazines will not be the best option due to cost. A better alternative is to advertise the provisions on the web site of the Ministry of Health. Government could equally reach individual migrant physicians and nurses by circulars through the use of networks and Associations that exist in receiving countries.

2. IMPROVEMENT IN PUBLIC HEALTH FACILITIES

Government must improve upon facilities in public health institutions so that health personnel who return are not frustrated by the sight of obsolete equipments and supplies. (Migrant Physicians and Nurses)

Garbarino et al. (2001: 9) argued that 'health personnel migrate to enable them enjoy the medical profession as they have been taught which largely refers to the ability

to provide quality care which is often not possible in facilities in Ghana'. This suggestion from the migrants is a clear indication that some of them migrated because of frustration arising from inadequate supplies and the use of obsolete equipment. A physician respondent in Ghana alluded to this and argued that 'it is usually painful for a physician to see his or her patient die in his/her presence due to lack of equipments and essential drugs'. How this suggestion could be implemented is the challenge when viewed against the backdrop that, more than 80% of the health sector budget is used in paying salaries and allowances, leaving 20% for investment and services. Donor support to improve on health facilities in Ghana could be an alternative to attract health migrants who are now used to sophisticated health equipment in Europe.

3. DECENTRALISATION OF THE HEALTH SERVICE.

Health services should be decentralised to the district level to allow districts to train their own personnel and pay their salaries and entitlements with some support from the Central government. When this is done, districts with sufficient resources could motivate and attract personnel whilst the weak ones could be supported by the central government. Alternatively, government should decentralise personnel management authority with transparent promotion in the health sector to improve bureaucratic efficiency whilst re-organising salary administration to allow for extra remuneration if the number of physicians and nurses are less than the calculated or budgeted norm for the service point (Ghana Medical Association, Ghana Registered Nurses Association, Migrant physicians and Nurses)

This policy when adopted will create inequality in health delivery. The richer districts will be able to recruit more personnel whilst the deprived ones will suffer staff shortages. Decentralising personnel management to the district level carries the advantage of speedy resolution of manpower problems but it also has the potential of breeding corruption and duplication of functions.

4. REGIONAL HOSPITALS AS SPECIALIST HOSPITALS.

Regional Hospitals should be designated Specialist Hospitals and allowed to charge consultancy fees to raise money to pay for specialist services including salaries and allowances of consultants and nurses who operate in them. (Physicians resident in Ghana)

This recommendation when implemented will make money available for meeting the salaries and allowances of health personnel working there without relying on government grants. However, this recommendation has a potential for putting pressure

on the National Health Insurance Scheme. Premiums for the scheme vary depending on the socio economic status and the ability to pay. Designating Regional Hospitals as Specialist hospitals and allowing them to charge fees will mean that people with low premiums cannot access medical care from these hospitals. This will perpetuate inequalities in health delivery in Ghana.

5. PRIVATISATION OF SOME OF THE ENCLAVE PROVISIONS.

Some of the enclave provisions such as provision of cars and building of houses for health workers should be privatized whilst government provides sovereign guarantees for the beneficiaries. (Policy Experts, Labour Consultant, Ghana Medical Association)

This recommendation, when adopted, will not only relieve the government from the huge financial outlays associated with their supply but also help the private sector to grow and provide descent jobs to individuals. The construction industry is labour intensive and will be a fertile area to offer employment to the unemployed youth. Provision of cars to physicians and nurses by private companies will also stimulate competition among suppliers, and by so doing reduce their prices and offer quality service to the clients. What government needs to do is to provide the legal and financial frameworks for the programme.

6. TRAINING OF PHYSICIAN ASSISTANTS.

Government should consider reducing the number of medical students and rather train more physician assistants who will be capable to handle most of the work that physicians do at a lesser cost in terms of training. (Policy Experts).

This recommendation is not progressive. No one cuts his nose to spite his face. The mere fact that physicians are migrating does not mean that Ghana should train fewer physicians and produce more Physician Assistants who currently are not even listed on job structures in Ghana. One must not be tempted to believe that the presence of Physician Assistants in health delivery negates the functions of physicians. In Europe where physician assistantship operates, physicians are still being produced. A health system without sufficient qualified physicians to operate at the tertiary level is a dead system. At the current physician to population ratio of 1:9,624, (MOH, 2008) a

reduction in the production of physicians would be a disaster. Achieving the Millennium Development Goals in the health sector would be a mirage.

7. REMOVAL OF SCHOLARSHIPS FOR MEDICAL TRAINING.

Government should remove scholarships offered for medical training for all students and target these to only those bonded for specified periods after graduation. (Private Sector Nurses, Public Sector Nurses, Policy Analyst).

The difficulty with this recommendation is that when it is adopted medical training will be discriminatory because tuition at the tertiary level for all categories of students in Ghana is free. What is more, full medical school fees are likely to be beyond the reach of ordinary Ghanaians and a fee system may simply reinforce disparities in opportunity between the rich and the poor. Under such circumstances, wealthier graduates will not be under bond and will have a much earlier opportunity to specialize and migrate. (Dovlo and Nyonator, 2001: 12).

8. PRIVATE PARTICIPATION IN TRAINING OF NURSES

Government should allow private participation in the training of nurses to improve the supply situation as a remedy for work over-loads (The Ghana Registered Nurses Association, Nurses and Midwifery Council).

Private participation in the production of nurses is a suggestion in the right direction. This will increase the number of nurses who will be available for work to improve upon nurse-to-population ratio which currently stands at 1:1,163 (MOH, 2008). This suggestion, however, has the potential of producing mediocre nurses because of the type of applicants who might be accepted for the private programmes. The private entrepreneurs may only be interested in getting returns for their investments whilst not bothering about quality. The recommendation will work better if the Ministry of Health will inspect such training institutions and put surveillance on them to provide quality materials for the Health Service and accredit the graduants'.

9. ESTABLISHMENT OF COLLEGE OF NURSING AND MIDWIFERY.

Government should consider establishing a college of Nursing and Midwifery in Ghana to take care of professional needs of Nurses and Midwives as has been done for physicians and surgeons (The Ghana Registered Nurses Association)

Establishment of College for Nurses and Midwives is in the right direction. At the moment, nurses and midwives who want to improve upon their professional qualifications or specialize in their fields have to apply to the West Africa College of Nursing and Midwifery in Nigeria. As a college for all West African countries, vacancies are limited since entry is by quota. The establishment of Ghana College for Physicians and Surgeons for physicians has created some uneasiness among nurses and midwives. In the view of Ghana Registered Nurses Association, the establishment of the college for physicians and none for nurses show the level of respect the government has for nurses. Establishment of a College for nurses and midwives will not only dispel this notion but also help in improving the quality of nursing staff and their career advancement. This in turn will take care of one of the incentives to migrate.

10. BILATERAL AGREEMENTS

Government must intensify bilateral agreements with receiving countries to allow health personnel of Ghanaian nationality to practice for prescribed period in specialised areas in Ghana whilst they continue receiving their entitlements in the host countries.

This suggestion has been tried between the Netherlands government and the Ministry of Health through the instrumentality IOM. Through this collaborative effort, sixty-six (66) Ghanaian medical professionals have been brought down from the Netherlands to put into practice their experiences gained whilst working abroad. This, in a way, constitutes transfer of knowledge from a receiving country to Ghana. This could be replicated with other receiving countries to the advantage of Ghana.

Chapter 6

6.0 Summary of Findings, Policy Recommendations and Epilogue

6.1 Introduction

The preceding chapter analysed the information provided by the respondents and secondary data available for the study. This chapter deals with the summary of the researcher's findings as they related the research objectives, questions and analytical frame-work. It finally comes out with policy recommendations meant to address problems associated with retention, return migration and the enclave policy and draws a conclusion.

6.2 FINDINGS

The objective of the study is to examine the effects of the 'enclave' policy as an instrument for addressing retention and return migration of physicians and nurses in the health sector in Ghana. It specifically evaluates the effectiveness of the policy as an instrument for ensuring retention and return migration of physicians and nurses, and additionally explores other policy options that could be used to encourage retention, return migration and also reduce the negative impact of migration in the health sector.

6.2.1 RETENTION

Evidence from the research literature on retention and return migration, relevant secondary data and views of key respondents suggest that the enclave policy and its provisions have helped improved retention in the public health sector in Ghana. The policy addresses some of the economic and social reasons that health professionals give as the reasons why they migrate - improved salaries and opportunity to advance ones career through training.

The research showed that the decrease in the number of attrition in the health sector was not due to improvement in salaries and other incentives alone but also the bonding system put in place for nurses and the upgrading of their professional certificates to Diploma as well as the establishment of the Ghana College of Physicians and Surgeons for physicians to take care of their professional development. In addition, lack of job opportunities for nurses and physicians overseas and international action in the form of ethical recruitment protocol between Ghana and the Great

Britain as well as restrictive immigration laws in some host countries, have all contributed to the improved retention in the public health sector in Ghana. This situation confirms the theoretical point of view that when employees are satisfied with their jobs and there are no external attractions for better jobs elsewhere, they would be forced to stay. It also confirms the researcher's analytical tool which posited that international action, domestic policies and organisations' internal human resource management systems and practices such as bonding in the health sector could lead to improvement in retention.

6.2.2 RETURN MIGRATION

Analysis of return migration revealed that the enclave policy has had little effect on international migrants but rather affected employment in the private health sector. A considerable number of physicians and nurses, who hitherto had moved to the private sector, had suddenly moved to the public sector to take advantage of the enclave policy provisions. It was discovered that physicians in the private sector in particular could not take advantage of the establishment of the Ghana College of Physicians and Surgeons since their consulting rooms do not form part of the learning environment, hence their drift to public health institutions. It was also discovered that many clinics and hospitals in the private sector are unable to pay salaries to the tune of what obtains in the public sector and as a result have lost some of their physicians and nurses to the public sector.

The study revealed that return migrants are highly successful people who have made it overseas and have returned either as consultants or investors in the private sector. From theoretical point of view, return migrants are no failures. They are successful migrants who return home after they have achieved their targets. International migrants who have not returned stated several reasons for not having done so. These reasons can be categorized into two main blocks- those related to circumstances in Great Britain and those related to Ghana.

Those related to Great Britain include good pension arrangements, naturalisation, payment of mortgages, loss of children to European societies', enrolment in higher institutions, and marriages and child bearing and unmet goals. Those related to Ghana include job placements after return, inability to fit into the economic system, loss of social capital at home, fear of being regarded as returned failures by colleagues at

home, having to work under former juniors who have stayed back under trying conditions and have climbed the professional ladder to the top, and gossip at the workplaces. These are individual characteristics that affect return migration the solution of which rest with the individuals as espoused in the researchers analytical framework.

6.3 POLICY RECOMMENDATIONS

Health worker migration is an inescapable feature of the health sector. The policy response should, therefore, shift from a reactive agenda that focuses on stemming migration towards a more ambitious agenda of managed migration that brings some benefits to source countries. A central component of any such agenda is an enhanced recognition of the importance of improved working conditions that ensures better income and good pensions, systematic training programmes and comprehensive bilateral agreements.

The bonding of nurses for 5 years, the completion of which nurses could undergo the upgrading programme for another 2 years, has helped in retaining them in the service longer than what some of them would have wished. The same argument holds for physicians. Physicians are now required to serve for a minimum period of 2 years as housemen instead of 1 year. The newly established College for Physicians and Surgeons takes about 4 years to complete whilst participants remain at post in their places of work and attend lectures. Government should consider increasing the Bond years for physicians to 5 years since the cost of their training is higher than nurses.

It will be worthwhile as a policy for government to establish a College of Nursing and Midwifery in Ghana to take care of the professional needs of nurses. The structure of courses should be designed in such a way that participants stay at their workplaces and attend the courses as being done for the physicians. Alternatively, the upgraded nursing certificate to Diploma could be used as entry qualification for a Bachelor degree in nursing at the University. This will be a good mechanism to retain nurses who may wish to migrate to study in Europe.

In addition to the establishment of the College of Nursing and Midwifery, government should introduce Modular training programmes for Senior High School graduates who have requirements to enter Nursing Training Institutions but who because of lack of vacancies are staying at home and adding up to the unemployment figures. The

adoption of the modular process, however, means double in takes for the training institutions and additional work for the tutors and lecturers. This calls for additional expenditure on government in the areas of personnel emoluments and investments. Donor support is required if this brilliant idea could be experimented.

The World Health Assembly held in 2004 urged member states to use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration. There are a number of potential advantages with the use of this channel in addressing retention problem in the health sector. First they reduce the need to utilize commercial recruitment agencies that are behind the abuse associated with migration. Secondary, these agreements are flexible tools that can incorporate a variety of provisions. For a start, they can include best practice guidance related to induction, training etc. They could incorporate genuine partnership between the two countries which could tip the terms of trade more in favour of the sending country. For example, there could be a five year agreement in which migrant physicians and nurses would work in the United Kingdom for three years and in Ghana for two years, with all five years of employment paid for by the United Kingdom. In addition, government should strive to have agreements with receiving countries to agree to some formal means of repatriation of part of earnings of migrant physicians and nurses to earn some indirect returns from its investment in training.

For a successful project, the government should consider a policy that establishes a body that will be fully responsible for migration and return issues. Such a body could compile databases of Ghanaian professionals living abroad and make use of their networks to bring some of them home, even if it is for a short time service to the nation. The Philippines and South Africa have tried this to their advantages.

6.4 THE EPILOGUE

The loss of physicians and nurses to migration as in the case with Ghana may be a feature of globalized labour markets and it may be here to stay because the phenomena is influenced by many factors, some of which are amenable to strategic interventions such as those proposed in this study and the use of incentives. However, a greater understanding of the qualitative factors that influence migration is required if policy-makers are to make sense of the situation and devise strategies to recruit and retain physicians and nurses in Ghana. Empirical analysis shows that the enclave policy, to a large extent, has helped in the retention of physicians and nurses but not significantly when dealing with international migration.

Although the individual's motivation to migrate is of considerable importance, there are structural causes, too, that have to be taken into consideration at the national and international levels. The continuing disparities between richer and poorer countries mean that there will be significant wage disparity that acts as a factor pooling physicians and nurses towards destination countries. Overall economic revitalisation is, in the long term, what will make a difference to this picture, and that requires multinational cooperation that is supported by international agencies. The incentive typology as contained in the enclave policy emphasizes on job satisfaction to the neglect of other structural factors. Effective programmes for retention and return in the health sector must be based on effective human Resource Management in the health sector itself, international action and domestic legislation and policy instruments. The programmes should not lose sight of personal characteristics which either advance or inhibit retention and return migration as espoused in the analytical framework.

REFERENCES

- Abuja, (2004) “Health Workforce Challenges: Lessons from Country Experiences.”
High- Level Forum on the Health MDG. Abuja
- Alexander, J A, R Lichtenstein, and E.Ullman (1998). “A causal model of voluntary turnover among nursing personnel in long term psychiatry setting” Research in Nursing and Health 21 (5): 415-427.
- Atkinson , R and John Flint (2001) “The Quality of the Data”
<www.sru.soc.surrey.ac.uk/SRU33 > accessed on 21/04/08.
- Ammasari, S and Black R (2001) “Harnessing the Potential of Migration and Return to Promote Development: Applying Concepts to West Africa”. Sussex Centre for Migration Research. Sussex.
- Anarfi J, Kwankye S, Ofosu Mensah A, and Tiemoko R (2003). Globalisation and Poverty. Migration from and to Ghana :A Background Paper. Working Paper C4 Development Research Centre on Migration
<www.migrationdrc.org/publications/working_paper>accessed on 08/04/2008.
- Baah, Y. (2006) “Avoiding Further Turbulence on the Labour Scene”. Ghana Trades Union Congress Policy Bulletin. Vol.2 No 3 November 2006.
- Bach, S (2003) International Migration of Health Workers: Labour and Social Issues. International Labour Office. Geneva. July 2003.
- Badu–Arkosa, A. (2006) “Migration of Health Workers: Ghana as an index case for Developing Countries” (Unpublished). Accra.
- Buchan, J M Kingma and F.M. Lorenzo, (2003). “International nurse mobility. Trends and policy implications”. Issue Paper 5. The Global Nursing Initiative. International Council of Nurses Geneva: (Switzerland).

- Buchan, J. and Dovlo, D. (2004): “International recruitment of health workers to the UK”, A report for DFID 2004. London.
- Cassarino, Jean-Pierre. 2004):“Theorizing Return Migration: The Conceptual Approach to Return Migrants Revisited” in International Journal on Multicultural Societies (IJMS) Vol.6, No.2, 2004: 253-279 .UNESCO.
- Cerese, F.P (1974) “Expectations and reality: A case study of return migration from United State to Southern Italy” International Migration Review 8(2):245-62.
- Clemens, M. and G Pettersson,. (2006) “A new database of Health Professional Migration from Africa... Centre for Global Development”. Working Paper Number 95, August 2006 < www.cgdev.org > accessed on 21/05/2008.
- C I A-Central Intelligence Agency (2008) “The World Fact Book: Ghana” < www.cia.ghana >accessed on 21/04/08.
- Dovlo, D. and Nyongator ,F. (2001) “Migration by Graduates of the University of Ghana Medical School: A Preliminary Rapid Appraisal” Ministry of Health Ghana.Accra.
- Eastwood,B, R.Conroy, S.Naicker, and others (2005) “Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK” in Public Health Vol. 365 May 28, 2005<www.thelancet.com>accessed on 21/05/2008.
- Ellenbecker, CH (2003) “A theoretical model of job retention for home health care nurses”. Journal of Advanced Nursing 47(3)303-310.
- Enchia, V. (2006) “Development of a Comprehensive Payroll Structure. Pay Structure Report”. November 16, 2006. Ministry of Public Sector Reform. Accra.
- Enchia,V (2007) “Government of Ghana Public Sector Pay Reforms :Job Evaluation” Manual, July, 2007. Ministry of Public Sector Reform. Accra.
- Findley, Alan (2001) “From Brain Exchange to Brain Gain: Policy implications for the UK of recent trends in skilled migration from developing Countries”. International. Migration Papers. Paper 43. International Migration Branch. International Labour Office, Geneva

- Fletcher, C. E (2001) Hospital RN's Job Satisfaction. Journal of Nursing Administration. 35 (7/8): 336-341.
- Garbarino S, Tomas Lieven, Peter Quartey and Serneels Pieter (2007) "Ghana Qualitative Health Worker Study: Draft report of preliminary descriptive findings". Ministry of Health. Accra.
- GDHS-Ghana Demographic Health Survey (1993, 1998 & 2003), Ghana Statistical Service, 2007 & MOH/RCH Annual Reports 1996-2003. Accra.
- Government of Ghana (2006) Budget Statement, Accra. December 2006.
- Gurney, C.A (1990) "Determinants of intent to leave among nurses with doctoral degrees". Unpublished Doctoral Dissertation. Chicago: UMI Dissertation Service.
- Hagopian, A., Ofosu, Fatusi and others (2005): "The flight of physicians from West Africa: Views of African physicians and implications for policy". Social Science and Medicine. 61 (2005) 1750-1760.
- HSWU-Health Service Workers' Union of TUC (2006) "Health Care Workers are not for Sale". PPA Media. Accra.
- ISODEC-Integrated Social Development Centre. Ghana (2006) "Budget Ceiling and Health in Ghana" (June 2006). Accra.
- IOM-International Organisation for Migration (2001) "Harnessing the Potential of Migration and Return to Promote Development: Applying Concepts to West Africa" IOM Migration Research Series No. 5. International Organization for Migration. Geneva.
- Kiragu, K. and Rwekaza Mukandala (2005) "Unlocking the Human Potential for Public Sector Performance." World Public Sector Report 2005. United Nations Organisation. (2005) New York, ST/ESA/PAD/SER.E/63. Chapter 11.
- Kumar, R. (2005) Research Methodology: A step-by-step Guide for Beginners: Sage Publications. London.

- Lee, W.C and Fritz Drasgow (nd) “Predicting Employee Retention : An Examination of a Retention Likelihood Scale”. University of Illinois Centre for Human Resource Management. Working Paper # 45.Illinois.
- MPI-Migration Policy Institute (2006) “Country Profiles Ghana Searching for opportunities at Home and Abroad”. <www.migrationinformation.org > accessed on 29/09/08).
- MOH-Ministry of Health (2007) Human Resources Policies and Strategies for the Health Sector 2007-2011. Accra.
- MOH-Ministry of Health (2005) “Assessment of Current Human Resource Management Systems and Practices in the Ghana Health Service/Ministry of Health.Quality”. Health Partners. Accra. < www.ghanaghp.org > accessed on 21/05/08.
- National Health Service, UK (1998) “Recruitment of Physicians and Nurses” <www.nursinguk.nhs.uk > accessed on 29/09/08).
- NCETA (2005) Workforce Development Tips : Theory Into Practice Strategies. A Resource Kit for the Alcohol and Other Drug Field. Chapter 11. Flinders University,AdelaideAustralia<www.nceta.flinders.edu.au>accessed on 7/10/08).
- Nduom, Paa Kwasi (2007) “Pay Reform: How Far?” In Ministry of Public Sector Reform Journal. Vol.2. Accra.
- Polit, D. F and B P Hungler (1999) Nursing Research. Principles and Methods. 6th (ed) .Philadelphia, Lippincott.
- Pullan, S.E and K.A Lorbergs (2001) “Recruitment and Retention. A Successful Model in Forensic Psychiatric Nursing?” Journal of Psychosocial Nursing. 39(9):18-25.

- Quartey, P. (2006) "Migration and Development: Challenges and Opportunities for sending countries: Ghana Country Case Study". University of Ghana, Legon.
- Ghana- Republican Constitution of Ghana, (1992) Article 190 (1) Public Services of Ghana.
- Robinson, R. (2007): "The cost and benefits of health worker migration from East and Southern Africa (ESA): A literature review". Regional Network for Equity in Health in east and southern Africa (EQUINET) Equinet Discussion Paper 49. The North South Institute. Harare.
- Rutten, M. (2007) "The Economic Impact of Medical Migration: an Overview of the Literature" IIDE discussion paper 200708-3. August, 2007, JEL code F22,11. Erasmus University, Rotterdam and Netherlands Ministry of Finance.
- Shaw, W (2007): "Migration in Africa; A review of the Economic Literature on International Migration in 10 Countries" Development Prospects Group, The World Bank, Washington DC.20433.
- Shobbrook P. and K .Fenton (2002) "A strategy for improving nurse retention and recruitment levels". Professional Nurse. 17(9) 534-536.
- Skeldon, Ron (2005) "Globalisation, Skilled Migration and Poverty alleviation: Brain drains in context." Southern African Poverty Network (SARPN) <www.sarpn.org.za> accessed on 22/11/2007).
- Stilwell, B. Diallo, Zurn, P. Vujicic, and others (2004): Migration of health care-workers from developing countries: strategic approaches to its management. Bulletin of World Health Organisation; August 2004, 82 (8). Geneva.
- UNO-United Nations Organisation (2004) WHAT 57.19 International Migration of Health Personnel: a challenge for health systems in developing countries. The Fifty – seventh World Health Assembly. Geneva.
- Wang, W.W. and, C.C. Fan (2006) Success or failure: selectivity and reasons of return migration in Sichuan and Anhui, China. Environmental and Planning. A 2006, volume 38, pages 939-958.
- World Bank, (2004) "Enclave Projects: What are they and what can be done?" <www.iadb.org> accessed on 23/10/08.

ANNEXURE 1

List of Respondents with interview dates

DATE	ACTIVITIES
25/06/2008	Arrival in Ghana
27/06/2008	Meeting with General Secretary GNAT
30/06/2008	Arranging of meetings in Accra

JULY, 2008

DATE	ACTIVITIES
02/07/08	Data collection in the Ministry of Finance and Economic Planning
03/07/08	Interview with Director of Human Resources-GHS
03/07/08	Interview with Director of Planning, Ghana Health Service
	Interview with the Director PPME, Ministry of Employment
04/07/08	Interview with Director General of GHS
08/07/08	Interview with District Director of Health Service, Swedru
09/07/08	Interview with Nurses at Amasaman
15/07/08	Interview with President of Ghana Medical Association
	Interview with President of GRNA
	Interview with Head of Policy Analysis TUC
16/07/08	Interview with Executive Director of CEDPA.
	Interview with returned migrant physicians, in Agona District.
	Interview with returned migrant nurses in Agona District.
21/07/08	Interview with Nurses at Agona Swedru
22/07/08	Interview with physicians and nurses at the Central Regional Hospital
23/07/08	Migration Workshop at Nuguchi- Accra/ IOM
28/07/08	Interview with private hospital physicians and Nurses in Ho
29/07/08	Interview with private hospital physicians and nurses in Ho
30/07/08	Interview with physicians at Amasaman District hospital
31/07/08	Meeting with chief executive of Gamey and Gamey, Tema

AUGUST, 2008

DATE	ACTIVITY
04/08/08	Interview with Registrar, College of physicians, Accra
06/08/08	Interview with private hospital physicians and nurses in Kumasi
	Interview with private hospital physicians and nurses in Kumasi
11/08/08	Telephone Interviews with physicians in Great Britain
12/08/08	Telephone interviews with nurses in Great Britain
13/08/08	Interview with the General Secretary of GHWU
14/08/08	Interview with Deputy Director, Verification GNMC
18/08/08	Interview with Registrar, Medical and Dental Council
19/08/08	Interview with Rector, College of Physicians and Surgeons
20/08/08	Interview with President, Private Medical Practitioners Ass.
21/08/08	Interview with Deputy Financial Controller, Ministry of Health

ANNEXURE 2

Table 2.1 Production of physicians and nurses in Ghana 1990-2007

Category	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	2000
Doctors	86	85	96	91	79	8	121	93	79	96	
Nurses	711	795	678	839	677	706	629	768	609	536	928

2001	2002	2003	2004	2005	2006	2007
		158	216	220	214	252
486	357	899	1023	1169	1312	1797

Source : MPI (2005) and Ministry of Health, 2008

Table 2.2 Stocks of physicians and nurses in Ghana 1996-2008

CATEGORY	1996	1998	2000	2002	2004	2006	2007	2008
Physicians	1,154	1,132	1,015	964	3,240	1,400	2026	2,286
Nurses	14,932	15,046	13,742	11,325	15,797	13,960	16,904	18,912

Source GHS, 2008

Table 2.3 Brain Drain- 1999-2006

CATEGORY	1999	2000	2001	2002	2003	2004	2005	2006
PHYSICIANS	72	52	62	105	117	114	89	60
NURSES	215	207	235	246	252	292	209	157

Source, GHS, 2008

Table 2.4 Verifications of Certificates, 1998-2008

YEAR	VERIFICATION
1998	172
1999	328
2000	727
2001	923
2002	731
2003	923
2004	786
2005	686
2006	148
2007	109
2008, June	32

Source: Nurses and Midwives Council, 2008.

Table 2.5 Trends in physician and nurse to population ratios, 1998-2008

YEAR	PHYSICIANS	NURSES
1998	1:15,901	1:1,196
1999	1:18,551	1:1,395
2000	1:20,689	1:1,528
2001	1:20,036	1:1,728
2002	1:18,274	1:1,675
2003	1:16,759	1:1,649
2004	1:17,733	1:1,510
2005	1:17,929	1:1,508
2006	1:15,423	1:1,537
2007	1:13,683	1:1,458
2008	1:9,624	1:1,163

Source: Ghana Health Service, 2008

Table 2.6 Intakes into Ghana College of physicians and surgeons. 2004-2008

YEAR	NO OF RESIDENTS
2004	76
2005	45
2006	105
2007	154
2008	83
TOTAL	463

Source: Rector, College of physicians and Surgeons 2008.

ANNEXURE 3

Table 3.1 GOG expenditure on Ministry of Health, 2000-2006 (Amounts in billions of cedis)

Year	Item 1 (Emoluments)	Item 2 (Administration)	Item 3 (Services)	Item 4 (Investment)	Total
2000	213,024,337,287	30,513,117,065	74,046,847,730	48,994,963,170	
2001	359,876,116,130	34,432,771,639	35,259,013,113	15,004,239,405	
2002	563,898,389,857	51,445,569,081	33,642,544,268	13,287,716,107	
2003	792,301,735,350	39,770,745,109	81,289,641,374	1,791,473,366	
2004	980,947,546,633	30,853,141,791	84,760,061,278	12,585,085,289	
2005	1,380,984,888,786	50,739,025,414	110,096,432,083	2,074,897,758	
2006	2,296,371,289,554	70,682,019,979	109,533,286,719	117,894,358,909	
Total	6,587,404,343,597	308,436,390,078	528,627,826,565	211,632,734,004	7,636,101,294,244

Source: Ministry of Health, 2008

Table 3.2 Public Sector Wages as % of GDP and Health Sector Share, 2000-2007

YEAR	GDP (Nominal) in blns	Public Sector Wages %	Health Sector Share %
2000	2,715,200,000,000	7.2	7.8
2001	3,801,400,000,000	8.0	9.4
2002	4,776,400,000,000	8.7	11.8
2003	6,526,200,000,000	8.7	12.1
2004	7,980,370,000,000	8.7	12.3
2005	9,701,800,000,000	8.5	14.2
2006	11,490,320,000,000	9.9	20
2007	13,976,700,000,000	10.2	N/A

Source: Ministry of Finance and Economic Planning, 2008

Table 3.3 Public Health Sector personnel emoluments as a % of annual expenditure, 2000-2006

YEAR	PERCENTAGE
2000	58.1
2001	81
2002	85.1
2003	86.5
2004	88.4
2005	89.4
2006	88.5

Source: Own Construction, 2008

ANNEXURE 4

SEMI-STRUCTURED INTERVIEW QUESTIONS.

4.1 RESPONDENT: Director General

1. What are the main challenges for the public health sector in the area of human resource management?
2. How do you assess the trends of health sector migration now as compared to the periods before 1998
3. How do you explain the trend?
4. Government created the public health sector as an enclave in 1998. What are the main policy instruments and to what extent has it affected employment in the public health sector?
5. If the policy has not worked, what do you see as the main weaknesses and what do you suggest as what could have been done better?
6. What are the future plans in the sector to induce retention and return migration?
7. Countries like the Philippines and South Africa have developed systems and procedures to encourage brain gain through exchange programmes in the form of 'home-coming'. To what extent can this work in Ghana?
8. What do you suggest as an alternative to the enclave policy in addressing retention and return migration in the public health sector?

4.2 RESPONDENTS: Directors of Human Resource Management, MOH&GHS; Director of Planning GHS

1. How long have you been the Human Resource Director of the Ministry of Health?
2. What have been the main challenges of your office in the area of employment?
3. How do you assess migration trends in the public health sector now as compared to the period before 1998?
4. What accounts for the trends you are describing?
5. Why did Government create the public health sector as an enclave in 1998? Will you say the policy has had any positive effect? In which ways then?
6. Could there be a strategy better than the enclave in ensuring retention and return in the public health sector?
7. What are your future plans in solving human resources shortage in the public health sector?

4.3 RESPONDENTS: The Rector, College of Physicians and Surgeons

1. When and why was the College of Physicians and surgeons opened
2. How many physicians has the college trained since its inception?
3. Writers on public health sector migration have argued that the establishment of the college has created a bigger basket for health sector migration. What are your comments on this assertion?
4. In which ways do you ensure that graduates from the institution do not disappear immediately after training?

5. In your view what can government of Ghana do better to reduce attrition in the health sector?
6. Do you see the enclave policy an appropriate measure to induce return migration? Kindly explain your response.
7. Who should be blamed for the high attrition in the health sector- government, ministry of health, the economy, Ghana health service or the individual employees? Give reasons

4.4 RESPONDENT: Director, PPME, Ministry of Employment

1. Migration in the public health sector constitute brain drain to Ghana. Are there some policies in place to address the problem? If yes which are they?
2. The enclave policy was put in place to address the push factors that results in migration. To what extent does the policy also work in the area of return migration?
3. Is there any programme put in place to consciously motivate migrants to return?
4. What are some of the impediments that may prevent migrants from returning?
5. Could you suggest some policy measures that should be considered to reduce the effects of migration?

4.5 RESPONDENT Presidents of Health Sector Trade Unions

1. How do you assess the current employment situation in the health sector in terms of demand and supply conditions of employment and wages?
2. What are the main challenges in the health sector now compared with the situation 5 years ago?
3. What do you consider as the causes of migration of physicians and nurses in the health sector?
4. Why have some physicians and nurses not migrated?
5. How do you assess the effectiveness of the enclave policy as an instrument to address retention and return migration in the health sector?
6. Why do you think a physician or nurse migrant might not return to Ghana?
7. What could be done by Government and the Health Service to encourage return migration in the health sector?

4.5 RESPONDENTS: Retained Physicians and Nurse.

1. Many of your colleagues have migrated to look for greener pastures, why have you not joined them?
2. How do you assess your conditions of employment as a physician/nurse in Ghana now compared with situation before 1998?
3. What accounts for your response?
4. Do you have any intention to migrate? Why

5. Speaking generally about migration, what do you see as the main causes?
6. What have been the effects of migration on the health sector in general and you as an individual?
7. What can government do to retain physicians and nurses?

4.6 RESPONDENTS : Returned Migrants

1. Why did you migrate?
2. Will your reason apply to others?
3. Which was your receiving country and why that particular country?
4. How did you feel about it then?
5. Why did you return?
6. What are the main motives or reasons of migrant health workers deciding to return voluntarily?
7. What incentives are offered to encourage voluntary return migration? Are they considered effective? If no indicate why.
8. What should government do to retain health personnel and bring those who have left the public health service back

4.8 RESPONDENTS: Policy and Labour Experts

1. Government in 1998 created the public health sector as an enclave and introduced incentives to physicians and nurses to induce retention and return migration. What is your general assessment of the policy?
2. Which policy alternative could government explore to induce retention and return migration in the public health sector?
3. What do you consider as some of the social and economic costs of the policy?

4.7 RESPONDENT. Director of Budget and Monitoring, Ministry of Finance and Economic Planning

1. Government in 1998 created the public health sector as an enclave and introduced incentives to physicians and nurses to induce retention and return migration
2. What is your general assessment of the policy?
3. What has been the social and Economic impact of the policy and how has your ministry been able to deal with them?
4. In your personal view, are there alternative policies that could be adopted by the government to deal with retention and return migration in the public health sector? If yes what are they and do they solve the problem?

4.8 RESPONDENT: International Organisations Dealing with Migration.

1. No country can develop in the midst of mass exodus of her skilled personnel. As development organisation dealing with migration, what do you suggest as a remedy to Ghana's brain drain in the public health sector?
2. In 2004, government declared the public health sector as an enclave to induce retention and return migration. How do you assess the policy against its objectives?

3. What can the international community do to help Ghana solve her health sector migration?
4. What in your view could be bottlenecks in Ghana's attempt to bring migrant health personnel home through the use of incentives?

4.10 RESPONDENTS: The Academia

1. Globalisation has come to stay with its attendant free movement of people across national boundaries. Under a globalised world, do you see an future for Ghana in her attempt to retain health personnel through incentive regime? Give reasons.
2. Which alternative policies are likely to help the health sector in dealing with the brain drain?
3. What do you think the international community should do to help Ghana solve her brain drain problem?

4.11 RESPONDENTS: Migrants

1. Why did you migrate?
2. Why did you migrate to Great Britain?
3. How did you get appointment in Great Britain?
4. Have you achieved the purpose of migrating?
5. What are some of the problems you face as a migrant worker?
6. Do you have any intention of returning to the Ghana public health service? Give reasons for your response.
7. What will prevent you from returning to Ghana?
8. What can the government of Ghana do to encourage your return to the Ghana public health sector?