CENTRE FOR MIGRATION STUDIES
UNIVERSITY OF GHANA

EFFECTS OF THE SINGLE SPINE SALARY STRUCTURE ON MIGRATION INTENTIONS OF HEALTH PROFESSIONALS IN THE ACCRA METROPOLIS

BY
JAMES HAYFORD BOADI
(10506572)

THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE MASTER OF ARTS IN MIGRATION STUDIES

JULY, 2015
DECLARATION

I, James Hayford Boadi, hereby declare that this dissertation is my own work, and all help relative to other people’s work has been duly acknowledged. This dissertation is the result of my own effort under the supervision of Dr. Mrs. Mary Setrana. Furthermore, I assert that it has neither been partially or wholly submitted at any other institution for the award of any degree.

SIGNATURE:…………………………………………….. DATE:……………………

JAMES HAYFORD BOADI
(STUDENT)

SIGNATURE:…………………………………………….. DATE:……………………

DR. MRS MARY SETRANA
(SUPERVISOR)
DEDICATION

I dedicate this dissertation to my lovely wife Mrs Agnes AssandohBoadi and my children James, Benard, John, Prince, Bernard Jnr, Jennifer, Grisilda and Aliena. Finally, I dedicate this work to my mother EfuaTakyiwaa and father Emmanuel AnsahAsare and to all my brothers and sisters.
ACKNOWLEDGEMENT

I wish to express my heartfelt gratitude first to the Almighty God for giving me the grace and wisdom to complete this dissertation. I am also grateful to my supervisor Dr. Mrs Mary Setrana for her unflinching support and guidance without which I could not have completed this dissertation successfully.

My sincere gratitude goes to all the lecturers at the Centre for Migration Studies for their selfless dedication to work especially to Dr. DelaliBadasu who is the Director of the Centre. I further acknowledge the cooperation of the Directorate of Ghana Immigration Service for the permission granted me to pursue this course.

Finally, I wish to appreciate the contribution of all my course mates and to Lawrence Simpi for his unflinching support. God bless you all.
ABSTRACT

Emigration of health professionals in Ghana has been a serious challenge to all successive governments and stakeholders in the health sector. In attempt to battle this emigration canker, governments have introduced policies and measures including the following; Additional Duty Hours Allowance (ADHA), Health Sector Salary Scheme (HSSS), Deprived Area Incentives as well as Vehicle Ownership Scheme. In the year 2010, the Single Spine Salary Structure (SSSS) was introduced to cushion all public sector workers especially health professionals. However all these measures and policies appear not to solve the problem for which it was introduced. The aim of this study therefore is to examine how the introduction of the current wage dispensation (SSSS) is impacting on the migration intentions of health professionals in Accra metropolis. Data was gathered through the administration of 90 questionnaires, involving 74 nurses and 16 doctors and in-depth interviews conducted with 4 nurses, 3 doctors and 3 hospital administrators. Analysis of the sex composition of the health professionals shows that a little over 74% of the health professionals were females. The ages of the health professionals ranged from 28 years to 65 years. In respect of migration intentions, this study shows that 70% had intended to migrate within the next ten years. The result further shows that the United Kingdom, United States and Canada are the preferred destinations of the health professionals. More than half (52.1%) of the health professionals intend to emigrate within the next five years. Reasons cited for migrating from the country included financial considerations and the desire for higher learning or skills and to experience life abroad. Finally, it was realized that despite the fact that some health professionals are better off under the SSSS, most of them however declared their intentions to migrate irrespective of the impact of the single spine pay policy on their salaries. This therefore implies that, the SSSS is insignificant to a large extent on the migration intentions of health professionals in the Accra metropolis. It is therefore recommend that more health training institutions should be built to absolve more doctors and nurses. Again a further increase in salaries and allowances as well as better conditions of service should be ensured to motivate them to stay and work in the country.
LIST OF FIGURES

Figure 4.1: Distribution of the respondents by profession...........................................32
Figure 4.2: Sex distribution of the respondents............................................................33
Figure 4.3: Age distribution of the respondents...........................................................34
Figure 4.4: Distribution of number of children ever born............................................37
Figure 4.5: Distribution of the intention to emigrate....................................................39
Figure 4.6: Distribution of Length of stay at the preferred destination…………………42
Figure 4.7: Comparison of Nurses and Doctors on the basis of the reasons they intend
to emigrate..................................................................................................................45
Figure 4.8: Preferred Destination..................................................................................49
LIST OF TABLES

Table 1.1: Number of out-migrating Ghanaian doctors and pharmacists……………..5

Table 1.2: Health Care Personnel In Ghana, France, UK AND US, 2010………………..7

Table 4.1: Age distribution of the Respondents...........................................................35

Table 4.2: Distribution of Highest Educational level of the respondents....................36

Table 4.3: Distribution of Marital status.................................................................36

Table 4.4: Cross tabulation of intention to migrate and marital status of the nurses..

Table 4.5: Cross tabulation of intention to migrate and marital status of the health professionals..........................................................47

Table 4.6: Cross tabulation of intention to migrate and Sex of the health professionals..........................................................47

Table 4.7: Cross tabulation of intention to migrate and Educational level of the health professionals..........................................................48

Table 4.8: Cross tabulation of Single spine salary structure and migration intention of the health professionals..........................................................52

Table 4.9: Suggestions from the health professionals (Multiple responses)……………53
<table>
<thead>
<tr>
<th>Abbr.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOM</td>
<td>International Organisation for Migration</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GUSS</td>
<td>Ghana Universal Salary Structure</td>
</tr>
<tr>
<td>SSSS</td>
<td>Single Spine Salary Structure</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>ADH</td>
<td>Additional Duty Hour Allowance</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immune Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Projects</td>
</tr>
<tr>
<td>AMA</td>
<td>Accra Metropolitan Assembly</td>
</tr>
</tbody>
</table>
# Table of Contents

DECLARATION.........................................................................................................................i
DEDICATION..........................................................................................................................ii
ACKNOWLEDGEMENT............................................................................................................iii
ABSTRACT..............................................................................................................................iv
LIST OF FIGURES......................................................................................................................v
LIST OF TABLES........................................................................................................................vi
LIST OF ABBREVIATIONS.........................................................................................................vii
TABLE OF CONTENT..............................................................................................................viii

## CHAPTER ONE

INTRODUCTION .......................................................................................................................1
1.1 Introduction.......................................................................................................................1
1.2 Problem statement............................................................................................................4
1.3 Research Questions .........................................................................................................8
1.4 Research Objectives .......................................................................................................8
1.5 Relevance of Study .........................................................................................................8
1.6 Organisation of the Study .............................................................................................9

## CHAPTER TWO

LITERATURE REVIEW ON MIGRATION OF HEALTH PROFESSIONALS ....10
2.1 Introduction ....................................................................................................................10
2.2 An Overview of Migration of Health Professionals: trends, costs and benefits ....10
2.3 The factors influencing migration of health professionals ........................................12
2.4 The health sector workforce and their working conditions in Ghana ......................14
2.5 Theories of migration ....................................................................................................16
  2.5.1 Neo-Classical Theory ..............................................................................................16
  2.5.2 Network theory ......................................................................................................18
  2.5.3 Push-Pull Framework ............................................................................................20
2.6 Summary ........................................................................................................................21
CHAPTER THREE ..................................................................................................... 22
RESEARCH METHODS ............................................................................................. 22
  3.2 Description of the study area ....................................................................... 22
  3.3 Research Design ......................................................................................... 24
  3.4 Population of the study ............................................................................... 25
  3.5 Data collection ............................................................................................. 27
      3.5.1 Primary Data collection Instruments .................................................. 27
      3.5.2 Secondary Data .................................................................................. 27
  3.6 Sampling and sample size ......................................................................... 25
  3.7 Data Analysis ............................................................................................... 28
  3.8 Ethical Considerations ................................................................................. 28

CHAPTER FOUR ........................................................................................................ 29
RESULT AND DISCUSSION ..................................................................................... 29
  4.1 Introduction .................................................................................................. 29
  4.2 Socio-demographic characteristics of the respondents ......................... 30
      4.2.1 Professional status and Sex of the health workers ......................... 30
      4.2.2 Sex of respondents ............................................................................... 31
      4.2.3 Ages of the Respondents .................................................................. 33
      4.2.4 Highest Educational Level of the Respondents .......................... 34
      4.2.5 Marital status ....................................................................................... 35
      4.2.6 Number of Children ever born ............................................................ 36
  4.3 Migration intentions of the Health Professionals for the next ten years .... 36
  4.4 Period of Intended Migration ................................................................. 38
  4.5 Length of stay at the intended destination ............................................... 39
  4.6 Reasons for intending to emigrate ............................................................. 40
  4.7 Relationship between some socio-demographic variables and intention to migrate abroad ................................................................. 44
      4.7.1 Marital status and Migration intention .............................................. 44
      4.7.2 Sex and Intention to migrate abroad ............................................... 45
      4.7.3 Educational level and migration intention ....................................... 46
  4.8 Preferred Destinations of the health professionals ................................. 46
  4.9 Single spine salary pay policy (SSSS) and migration intention ............. 48
  4.10 Suggestions by the nurses ........................................................................ 50
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER FIVE</td>
<td>52</td>
</tr>
<tr>
<td>SUMMARY, CONCLUSIONS AND RECOMMENDATIONS</td>
<td>52</td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>53</td>
</tr>
<tr>
<td>5.2 Summary of findings</td>
<td>53</td>
</tr>
<tr>
<td>5.3 Conclusions</td>
<td>55</td>
</tr>
<tr>
<td>5.4 Recommendations</td>
<td>56</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>62</td>
</tr>
<tr>
<td>QUESTIONAIRE FOR HEALTH PROFESSIONALS</td>
<td>62</td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>69</td>
</tr>
<tr>
<td>INDEPTH INTERVIEW WITH HOSPITAL ADMINISTRATORS</td>
<td>69</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

1.1 Introduction

According to the ILO, approximately half of the world’s migrants are economically active (ILO, 2010) and are actively working in countries other than their country of birth either legally or illegally. These labour movements are often attributed to the following factors:

the “pull” of changing demographics and labour market needs in many industrialized countries, [and] the “push” of population, unemployment and crisis pressures in less developed countries, and established inter-country networks based on family, culture and history (IOM, 2003:1).

These push and pull factors are increasingly changing the status of many countries to either a sending or receiving country due to increasing labour migration across the globe. Migration is a means of livelihood strategy among many poor in deprived communities and developing countries (Quartey, 2009; Siddiquee, 2003). However, some empirical evidence indicates that migrating for the improvement of household wellbeing is not only limited to the poor and underprivileged in society particularly with regards to international labour migration due to the high cost involved (GIS AHSTIP data, 2014). In many West African countries, of which Ghana is no exception, anecdotal evidence suggest that there is one migrant in every ten households.

Data from the Ministry of Foreign Affairs in 2008 estimated that, Ghanaian migrants can be found in about 33 countries across the world (Quartey, 2009), and the majority of these migrants are economic migrants. Even though the leading destinations for the
majority of Ghanaian labour migrants are the West African countries; the most desired countries of destination for Ghanaians emigrants are the United States, the United Kingdom and Italy hosting 149,596 81,917 and 52,914 Ghanaians respectively (Setrana et al. 2014: 32). The choice of these destinations is as a result of the language proximity and colonial links (Anarfi, Awusabo-Asare et al. 2000). In terms of skilled labour migration, Ghana has the highest emigration rates for the highly skilled (46%) in Western Africa (OECD, 2005; Docquier and Marfouk, 2005), and medical profession are particularly affected by this skilled labour emigration phenomenon. It is estimated that more than 56% of doctors and 24% of nurses trained in Ghana are working abroad (Clemens and Pettersson, 2006).

Notwithstanding the fact that migration of skilled labour accrues social, economic and political benefits to both sending and receiving countries (Anarfi et al., 2005; Muzzucato et al., 2005), the adverse effects of the migration of health professionals to the sending countries cannot be under estimated (Dovlo, 2005) and some measures have been put in place to help curb this practice. The Organization for Economic Cooperation and Development has champion numerous initiatives, policy recommendations and others in this direction (OECD, 2007). In the same vain, the World Health Organisation in 2010 adopted a global code of practice on the international recruitment of health personnel with a focus on ethics and protecting less-developed sending countries in order not to ameliorate the already existing repercussions of the phenomenon (WHO, 2010).

Even though the primary beneficiary countries mostly in the global north have devised means of regulating the immigration of health professionals into their
countries as a benign gesture to the developing countries (Grignon et al, 2012), countries in the south have also been working hard to find lasting solution to this malignant form of migration. State governments are busy increasing their regulatory capacities to manage labour mobility to the mutual benefit of government, society and the migrant (IOM, 2003).

Ghana on her part has also adopted some measures to improve the working conditions of all public sector workers including those in the public health sector to ensure high level of retention of its work force not only in the country but in the public sector. In this vain, the country has witnessed a number of wage administration regimes and structures between 1999 and 2006, some of which include; the Prices and Incomes Board and the Price Water House Coopers Salary Structure and the Ghana Universal Salary Structure (GUSS) all of which were geared towards effective salary administration for the benefit of workers (Seniwoliba, 2014). The inability of these measures to achieve their objectives of ensuring a fair and adequate condition of service which is accepted by workers in the public service opened the way for preparation to adopt the Single Spine Salary Structure (SSSS) in 2007 (Seniwoliba, 2014) which aimed at motivating public service workers to improve service delivery and productivity. Its main purpose was to place public workers of same qualification and work schedule on equal salary level.

Prior to the introduction of the Single Spine Salary Structure (SSSS) for all public sector workers, specific mitigating measures were put in place for health professionals in the country as a way of curbing the mass exodus labour migrants especially those in the health profession. The Additional Hour Allowance (ADH) was introduced in
1998 by the Ministry of Health to compensate for the extended time that doctors, nurses and other clinicians have worked for (Antwi and Philips, 2011 cited in Teye et al., 2014). The Single Spine Salary Structure (SSSS) which came into force in 2010 saw some groups of public sector workers gaining a pay rise of up to 100% and having been in operation for four years, this study intends to examine the migration intentions of health professionals working in Accra after enjoying the SSSS system for the past five years.

1.2 Problem statement

The period between 1998-2003, witnessed worsened cases of infant and maternal mortality according to Ghana Demographic survey (2003) because of high emigration during this era. This national challenge drew the attention of few researchers (example Sanders et al. 2003; Anarfi et al. 2010; Seniwoliba, 2014; Teye et al. 2014) to investigate the implementation of these retention policies in Ghana and how they motivate and retain health workers. Sanders et al (2003) found in their studies that, Ghana, like many developing countries, lacks adequate resources to motivate and retain its health workers. Anarfi et al (2010) also identified that the migration of nurses and doctors from Ghana is a worrying trend, particularly, in terms of its consequences for the provision of health services to and for the well-being of many Ghanaians, including children. World Health Organisation (WHO) Report (2006) postulated that Africa alone harbours 46% of the global burden of diseases with very inadequate skilled (3%) man force to manage this alarming situation (WHO, 2006 cited in Crommett, 2008). For further clarification, the WHO estimated that globally, there was a shortage of more than 4.3 million health personnel and the hardest hit countries by this shortage are the Low-income countries. The disillusioned part of this
whole phenomenon is that, of the 57 countries with a critical shortage, 36 were sub-Saharan African countries (WHO, 2006).

In Ghana alone, the table below shows that between 1999 and 2004, migration of health professionals, that is doctors and pharmacists have been on the increase steadily. These are due to various factors of which wages are a very critical leading to the reduction in 2004. The Table 1.1 shows the distribution of the number of Ghanaian doctors and pharmacists who migrated from the country between 1999 and 2004.

Table 1.1: Number of Ghanaian doctors and pharmacists who migrated from Ghana between 1999 and 2004

<table>
<thead>
<tr>
<th>Profession</th>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
<td>2000</td>
</tr>
<tr>
<td>Doctors</td>
<td>72</td>
<td>52</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>49</td>
<td>24</td>
</tr>
</tbody>
</table>


Compared to what pertains at the global level, the migration of health professionals from Ghana is an equally worrying trend, in particular in terms of the consequences these shortages of health professionals have on adequate provision of health services to enhance the well-being of many Ghanaians, including children (Quartey et al, 2010).
A study by Nyonator and Dovlo, (2005) revealed that, malaria, tuberculosis, and HIV/AIDS featured conspicuously on the list of the World Health Organisation as the major health issues in Ghana. The magnitude of the record of the diseases brings to bear the weightiness of the issue under deliberation. Available statistics indicate that over 350,000 people are living with HIV/AIDS in Ghana, whilst over 79,000 people are living with tuberculosis, and over 3.5 million new cases of Malaria occur annually (The Global Fund, 2003). The period 1998-2003 witnessed a worsening of infant and maternal mortality cases, according to Ghana Demographic and Health Survey (2003), this occurred because the period was characterized by a rapid increase in the emigration of health professionals from the country, and this has called for attention of all relevant stakeholders to this practice. The presence of these health professionals is very paramount for the proper treatment of these diseases since they require continual attention and expertise (Kumar, 2007). However, the human resources available to deal with these health issues are severely depleted, causing many cases to be dealt with at home (The Global Fund, 2007). Similarly, service outputs in public and private health centres have declined due to lack of trained staff (Nyonator, and Dovlo, 2005).

Table 1.2 compares the number of health care personnel in Ghana, France, UK and US as at 2010. The data shows that compared to advanced countries such as France, UK and US, the number of doctors, nurses and midwives per 10,000 people is less. Meanwhile Ghana loses most of its trained health professionals to these advanced countries.

**Table 1.2: Health Care Personnel in Ghana, France, UK AND US, 2010**

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Doctors</th>
<th>No. of nurses and midwives</th>
<th>Percentage of births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>Midwives per 10,000 people</td>
<td>Attended by skilled birth attendant</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>37</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>23</td>
<td>128</td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>27</td>
<td>98</td>
<td></td>
</tr>
</tbody>
</table>


In Ghana efforts are been made to motivate health professionals to remain in the country through the introduction of SSSS. Among the importance of wages in the basic economic model of migration, there is inadequate evidence of the introduction of SSSS and its effects on migration intentions of health professionals since its inception. As such its effects on discouraging migration are still unclear in many of the migration literature.

While some scholars argue that increasing salaries of health workers is an expensive option for discouraging migration of health professionals, others argue that it is enough policy to bridge the increased migration of health professionals (Sabi W. 2014). As such the introduction of SSSS and its importance to improve retention of health professionals is still unclear. Not many studies have investigated the relationship between the SSSS and migration intention of health professionals. This study therefore seeks to examine the migration intentions of health professionals who have been on the Single Spine pay policy since its implementation in 2010 to ascertain its impact on their migration intentions.
1.3 Research Questions

The research questions are:

1. What are the socio-demographic characteristics of health professionals?
2. What are the motivational factors for the emigration of health professionals?
3. What is the impact of the Single Spine Salary Pay Policy on health professionals’ intention to emigrate?

1.4 Research Objectives

The main objective of the study is to examine the migration intentions of health professionals who have been on the Single Spine Salary Structure since its implementation in 2010.

The research objectives are:

1. to describe the socio-demographic characteristics of health professionals in Accra metropolis
2. to outline the migration intentions of health professionals in the Accra metropolis
3. to ascertain the factors influencing migration intentions of health professionals
4. to investigate the relationship between the migration intentions and the SSSS.
5. to make policy recommendations based on the findings of the study to curb the migration of health professionals in Ghana.

1.5 Relevance of Study

International migration of health professionals has been researched into by a lot of scholars due to its devastating effect on the economies of third world countries. However, in the case of Accra metropolis specifically, not much has been done after the introduction of the Single Spine Pay Policy in 2010. Earlier research work has
been undertaken on this subject by (Dovlo, 2003), (Anarfi, 2010) and (Teye, et al 2014) but the first two were done before the introduction of the single spine pay policy and the last not on Accra metropolis specifically. Again, the fact that the problem of health professionals emigration still persists makes this study imperative. The study intends among others, to establish whether or not the increment in salaries of health professionals resulting from the introduction of the SSSS has imparted positively or negatively on the exodus of health professionals and on health delivery in the Accra metropolis.

Furthermore, the study intends to add to existing knowledge on migration of health workers from developing countries including Ghana and finally to inform policy makers, researchers, health professionals, government and all stakeholders of the seriousness of the negative impact of this social menace on the general socio economic development of Accra metropolis and the country as a whole.

1.6 Organisation of the Study

In order to address the objectives of this study, the dissertation is organised into five chapters. Chapter one gives an introduction to the study, identifies the problem of study, and highlights the objectives and research questions as well as the relevance of the study. Chapter two reviews relevant literature on the global, regional and national trends of health migration and critically examines the theories of migration. Chapter three follows with a discussion on the study area and the research approaches or methodologies used for the study. Chapter four is devoted to explaining the findings of the study. This chapter reveals the characteristics, factors and experiences of health professionals in the Accra Metropolis. The same chapter is discussed in relation with
the existing literature to know the extent to which the dissertation supports or deviates from the Ghanaian case. Chapter five summarises as well as concludes the dissertation and also makes some research and policy recommendations.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

Labour migration and mutual recognition of qualifications has enhanced opportunities for Ghanaians to work in Europe and this trend has increased in recent times. High living standards in developing countries is the incentive for Ghanaian Health Professionals to move abroad. This section analyses health professional’s intentions to migrate in spite of the implementation of the Single Spine Salary Structure in Ghana. It also analyses determinants of migration in general and the motivating factors that propels health professionals to migrate. The section also discusses some theories of migration most appropriate for explaining migration of health professionals. These theories are the Neoclassical, Network theory and the Push-Pull Frameworks.

2.2 An Overview of Migration of Health Professionals: trends, costs and benefits

Global statistics indicate that health professionals are the most migrating professionals when it comes to labour migration (Dovlo, 2005; Serour, 2009; Teye et al., 2014). Within the various regions, Sub-saharan Africa and Pacific Island are identified statistically as regions with more health professionals moving out with 13% each.
Latin America and the Caribbean Islands have 11% each while the Middle East and North Africa have 10% each (cited in Teye et al., 2014, page 254). These movements are generally due to wage differentials; search for quality life and for further training. These although may accrue remittances to origin countries, it is also obvious that shortages of health professionals are of great concern. This is also because the Sub-Saharan region has poor health provisions and delivery that is affecting the quality of life of its people. WHO (2006) estimates that about 3000 nurses and doctors from Sub-Saharan Africa are employed in developed countries. These also have negative consequences on the productivity of the sending country.

Some studies have identified the cost implications on the sending country by losing health professionals to receiving countries. Such lost include poor health care systems, few doctors having to take care of several people leading to poor health delivery due to pressure on them from the numerous patients (Stewart et al., 2007). Again, sending countries particularly in Africa loose financial investments which were saved in training these health professionals as they lose them to developed countries (Teye et al. 2014). Oyowe (1996) for instance identifies a loss of $184,000 to Africa when just one health professional migrates from Africa.

While some are losing on different factors, receiving countries also benefit from these lose. Receiving countries are able to fill in their vacancy of health professionals as they recruit from developing countries. The huge numbers employed reduce the workload on few people, unlike what happens in the developing countries, thereby leading to quality health care system and delivery. Also to the sending countries, they
benefit from the remittance transfers and brain gain when some of these health professionals come home with the quality and rich experiences gained from abroad (Robinson, 2007 and Teye et al. 2014).

2.3 Factors influencing migration of health professionals

Research on migration patterns of health professionals from developing countries to developed countries has dominated the migration discourse for some time now (Martineau, Decker, and Dundred, 2002; Buchan, Parkin, and Scholaski, 2003). Nevertheless, most of the studies have found that driving forces of migration in these areas are different.

It is realised that the main driving force moving health professionals from developing countries to developed countries are economic in nature (see example, Anarfi et al. 2010; IOM, 2010). Increased migration of health professionals has been on the agenda of many developing countries. As such, most of the source countries of migration are developing strategies to reduce the emigration or even to reverse the trend of migration.

In a study to consider how the rise of wages would impact health sector emigrants from African countries, Vujicic et al. (2004) found that the huge difference in wages in developing and developed countries does not prevent emigration of health professionals when there is increase of wages in African countries. Thus the wage is not a good policy enough as an instrument to change the migration behaviour of people and other measures should be considered (Vujicic et al. 2004).
In related studies, Antwi and Philips (2011) observed that in Ghana, the effect of wages on attrition is concentrated among early-career workers with no effects on older health workers. Also, the study found enough evidence that the impact of wages on attrition is strongest in urban areas, but no differences in impact by gender. The effect is concentrated among workers in occupations that tend to migrate (e.g. doctors and nurses). The study therefore concluded that wages affect attrition by reducing migration.

Vörk et al, (2004) opined that while among the old EU states, the main driving force for migration to the UK was unemployment at home country or motivation to get better training in the UK, in all the Central and Eastern European Countries (CEE) the main reason for emigrating is better wage abroad. The study concluded that migration pattern from the CEE countries to the West is more like the one from developing countries to developed countries and not like the migration between the old EU countries. In the United Kingdom, annual registrations of doctors from Ghana, South Africa and Zimbabwe represent around 1.1 per cent, 2.0 per cent, and 0.7 per cent respectively of the total number of doctors registering in the UK (Stilwell, 2003).

In Europe, studies have shown that EU’s strategy to cope with labour shortage in health sector is to recruit from other countries, including the new EU member states. Vörk et al, (2004) explains that Finland is actively recruiting health professionals especially Estonians, though their average share of Finish doctors to population is higher than in Estonia.
2.4 Health sector workforce and their working conditions in Ghana

Ghana has long been a major source of migrants in the health sector. Though the ratio of health care professionals to the population in Ghana is lower, yet many of the health professionals are leaving the country in search of opportunities abroad due to high quality training, low wages, and English proficiency. Quartey et al (2010) reports that health worker emigration from Ghana mostly involves two types of professionals in the health sector: doctors and nurses.

Whereas doctors find it easier to migrate to the USA, nurses find it more convenient to migrate to the UK because of the ease with which they are taken on by the health system. According to the UK Department for International Development (DFID, 2004) the number of nurses entering the UK health registers from Ghana has been increasing yearly in recent times. Quartey et al (2010) however noted that, the choice of destination depends on the recruitment process and more particularly the ease of registration with the country’s professional bodies hence more health professionals in the UK.

In a study conducted by Bhargava and Docquier (2008) to provide cross country data on physicians migration into OECD countries, the study found that between 1991-2004 three to four percent of Ghana’s physicians migrated annually, easily outpacing the African average. Early studies by Dovlo and Nyonator (2003) found that between 1985-1994, migration rates were even higher at 10 to 20 percent for graduates’ classes of the University of Ghana Medical School. Their study found UK as the destination country for most of these health professionals followed by the US.
In Africa, most of the health professionals move from Ghana to South Africa (Dovlo and Nyonator, 2003). This can be attributed to language as all of these countries are English speaking countries. However, data from Nurses and Midwives Council and administrative payroll indicates a decline in migration of health professionals after decades of extensive migration (Antwi and Philips, 2011). The Nurses and Midwives Council keeps statistics on the number of requests to verify the credentials of domestically trained nurses for international employment. Statistics from the council indicates that migration of nurses from Ghana was stabilised in the early 2000’s, dropped precipitously in 2006, and then levelled off at a reduced rate (Antwi and Philips, 2011). The recent decrease in migration of health professionals from Ghana is still blurred and therefore begs the question as to its causes.

Antwi and Philips (2011) reports that Ghanaian health workers migrating to the UK can double their earnings, even after adjusting for purchasing power differences yet there has been a steady decline in the migration of health professionals even though research has point to such wage gaps as the main cause of migration of skilled health workers to high-income countries.

The term single spine basically refers to the pay policy or principle where all public sector workers no matter their area of specialization and the public organization they belong to must be placed or linked to one common salary structure, typically like all nerves and organs of the body connected with the human spine. It is suggested that having employees with the required qualification, skills and abilities to perform their job well is only part of the equation and will not automatically result in improved job performance.
A fair and transparent employee reward system and other innovative strategies that include supportive working environments or positive work climate, job enrichment, educational opportunities, etc. are seen as some of the ways to transform the overall context in which employees deliver their work, enhance their motivation and consequently improve the overall performance of the organization. The SSSS policy seeks to ensure that the public sector remuneration structure is rational, equitable, transparent and sustainable. Essentially, the policy involves placement of all public sector employees listed in Article 190 of the 1992 Constitution on one unified salary structure known as Single Spine Salary Structure (SSSS).

2.5 Theories of migration

Since the early writings on migration by Ravenstein, (1889) based his “Laws of Migration” on empirical migration data, many other theories have evolved. In the session below, three theories of migration, namely Neo-classical, Network and Push-Pull theories of migration are critically examined to serve as the foundation for this study.

2.5.1 Neo-Classical Theory

The Neo-classical theory according to Castle et al. (2014) is based on the assumption that tends towards equilibrium. As Raventein (1889) asserted that economic factors are the major cause of migration, migrants prefer to move to places where they will be fruitful and earn higher wage. This theory is considered as a development process, thus, areas where labour is in surplus supply and areas with scarce labour (Todaro 1969 and Lewis, 1954 as cited in Creswell et al., 2014).
The interplay of the distribution of demand and supply of labour has resulted in wage differentials, encouraging workers in low wage region (developing countries) to migrate to high wage but labour scarce regions (developed countries) causing labour shortage at place of origination (Harris and Todaro, 1970). Migration of highly skilled professionals is said to be an inevitable part of globalization (Pittman et al., 2007), since countries suffering from demographic dilemma are in high demand of labour to replace their aging workforce (Buchan and Sochalski, 2004).

Migrants are believed to be rational actors, who base their decision to migrate on cost benefit analysis, importantly, maximizing their income (Creswel et al., 2014). Booth (2002) highlighted some factors that were mentioned by the Global Advisory Group (GAG) for nurses and midwives as drivers of nurses and midwives migration. These were Underpayment, hazardous working conditions, lack of career development, as well as professional status and autonomy.

Studies by Anarfi et al. (2005) and UNDP (2005) have identified challenges such as unequal income and resource distribution, unemployment and violence as the main push factors causing people to migrate. This confirms why people will move from developing countries to seek better livelihoods in advanced countries.

Booth (2002) further argued that, there will still be sharp decline in new recruit so far as this reasons persist. IOM confirms this assertion that Africa has lost a great deal of its human capital to the developed counties, and still on-going at an alarming rate with
about 20,000 doctors, university lecturers, engineers and other professionals migrating each year since 1990 (see for instance Adamson, 2005).

In Ghana, highly skilled professionals like doctors, engineers, pharmacists, nurses, lectures and teachers migrate to countries with higher wage to seek better remuneration to improve their living standards (Anarfi, et al, 2000; Manuh, 2001; Sabi, 2014). Neoclassical theory best explains the problem of health professionals migration, though it has been criticized as focusing more on demand and supply of labour due to wage differentials, ignoring other social, family and political factors such as family reunification, pursuit of education, peer pressure, conditions of work, conflict, violence and so on.

2.5.2 Network theory

Massey et al. (1993: 448) defined network as:

Sets of interpersonal ties that connect migrants, former migrants, and non-migrants in origin and destination areas through bonds of kinship, friendship, and shared community of origin

According to Massey et al. (1993), they are a set of interpersonal ties that link migrants, and non-migrants in both origin and destination areas through bonds of kinship, friendship, and shared community origin. The network theory explains how migrants, being skilled professionals or unskilled, form and maintain social ties with other family and friends, and other migrants. They provide essential resources for members of the network, which is usually referred to as social capital. Social capital
includes personal relationships, family and household patterns, friendship and community ties and mutual help in economic and social matters (Assuman, 2014).

It binds both migrants and non-migrants together in a complex web of social role and interpersonal relationships (Castle et al. 2009). Social capital can further be explained as the ability of actors to obtain assistances by virtue of membership in the networks (Portes 1998:6). Chain migration (as referred to by early scholars) or network migration (as used in recent literature) occur due to networks (Price, 1963), migrants who are settled at destination serve as ‘bridgeheads’ for relations left behind at origin (Böcker, 1994) reducing the risks, material and psychological costs of subsequent migration.

Studies have shown that colonization, warfare, conquest, occupation and labour recruiters, as well as shared culture, language and geographical proximity counts in the initiation of migration (as cited in Castles et al, 2014). When there are pioneer migrants at destination, other factors like network and recruiters influence come to play for new migrants. They help new migrants by providing information, assisting their travel, assist in securing work and housing and helping them adapt to new environment. Migrants form groups at destinations which increase the likelihood of network migration (Castles et al., 2014).

Evidence is the study on Mexican migrants resident in the USA in the 1970s, according to the study, 90% of these migrant came through family and employers connections (Portes and Bach, 1985). Notwithstanding the critiques of network theory, as being adamant to external, structural factors and internal processes that
counteract the tendencies leading to increasing migration, it helps understand how health professional migration is on the increase. Employers and other pioneer migrants assist in their migration.

2.5.3 *Push-Pull Framework*

Moving away from the Neoclassical and Network theory which helps explain health professionals’ migration in part, the push-pull framework gives a more holistic explanation and therefore makes it the most appropriate framework for this study. The push-pull factors explain that whereas push factors drive migrants out of their countries of origin, pull factors are responsible for dictating where these migrants end up. Lee (1966) formulated migration in a push-pull framework on an individual level looking at both the supply and demand side of migration. Positive and negative factors at the origin and destination push and pull migrants towards migration. Nevertheless these are hindered by intervening factors, example migration laws are affected by personal factors, example how the migrant perceives the factors (Lee, 1966). This theory helps me to explain the factors that attract health professionals to work abroad or in Ghana and whether the introduction of the SSSS has any influence on their movement since 2010.

Studies (Dovlo, 2003; 2005; Anarfi et. al. 2010) have indicated that economic incentives provide both the biggest push and pull factors for potential migrants. Health professionals migrating to more developed countries often find that the same work they were doing at home is rewarded abroad with higher wages. They also find a greater safety net of welfare benefits should they be unable to work. Migrants are drawn to those countries where they can maximize benefits. As such, for the health
professionals, demand for labour in the developed countries coupled with the high wages and better conditions of service pull or attract them to move to the developed countries from the developing countries. In Ghana, this could be explained by the poor condition of services, low salary, work overload and lack of educational facilities for self-development among others pushes them away to areas with such facilities and conditions.

Developed countries like, UK, USA, Germany, Canada among others have designed their immigration policies to entice skilled labour from developing countries (Sabi, 2014). For instance, the American lottery is a way of attracting and scouting for the highly skilled. Portes et al (2007) confirmed that in 2003, about 360,498 work permits were issued to foreign nationals from different parts of the world by the US government. This act by the US is a way of bridging the labour market gap. Health professionals, like other skilled professionals usually would explore opportunities in other places outside their countries of origin to improve on their livelihoods. For most migrant health workers in Europe, nurses from the Philippines and doctors from Indian form the largest workforce (WHO, 2006).

It can be concluded that migration is selective and inversely linked to distance, but fuelled by the push pull factors even though the pull factors mostly are more important.

2.6 Summary

This section has sought to highlight and provide explanation on the general trends, patterns and factors of migration among health professionals. From the various
discussions, it is clear that while attractive factors in developed countries cause health professionals to migrate to developed countries, there are also driving forces back home pushing them to countries of destination. Wage differences among other factors are identified as one of the main factors pulling and pushing health professionals to developed countries.

CHAPTER THREE
RESEARCH METHODS

3.1 Introduction
This chapter is primarily concerned with how the study was designed and how data was collected and analysed in order to achieve the objectives of the study. Specifically, this chapter presents description of the study area, research design, population the sampling method and sample size, data collection and data analysis. It also presents some ethical considerations in respect of the study.

3.2 Description of the study area
The study was carried out in the Accra Metropolis. The Accra Metropolis is among the sixteen (16) Metropolitan, Municipal and District of the greater Accra region of Ghana. It shares common boundaries with La Dade Kotopon Municipal from the East and Ga West Municipal, Ga Central and Ga South Municipal Assembly from the west and finally with the Gulf of Guinea from the south. According to the 2010 Population
and Housing Census, Accra has a population of 4,010,054. This makes it the most populous city in Ghana (Accessed from www.ghanadistricts.com on 7/07/2015).

The Greater Accra region is the second most inhabited region after Ashanti region, which has an estimated population of 4,780,380. The city is the second largest Metropolitan conglomeration in Ghana by population and the eleventh largest metropolitan area in Africa, by the same standard. Being the national capital, Accra has several health facilities, both government and private (Accessed from www.ghanadistricts.com on 7/07/2015).

The Accra Metropolis was chosen partly because of time constraints and the area’s proximity to the researcher. In addition, studies have shown that the increased workload of health professionals in Accra coupled with unsatisfactory salaries and incentives has contributed to the emigration of health professionals in the Metropolis (Anarfi, Quartey and Agyei, 2010).

The health care facilities selected were Korlebu Teaching Hospital, University of Ghana hospital, the Police hospital and the Ridge hospital. The Korlebu Teaching hospital and Ridge hospital were selected because these hospitals operate as major referral hospitals in southern Ghana. The Police hospital was particularly selected because of its strategic operation as a major hospital that provides health care services not only to the country’s security personnel and their families but also to the general public. The University of Ghana hospital was selected because it provides health care services to the University of Ghana community and the general public.
In a recent publication, the AMA Metro Health Services identified a number of health care challenges facing Accra. According to the Accra Metropolitan Assembly (AMA) Metro Health Services, Accra faces the challenges of inadequate emergency care, infrastructure and equipment, and a lack of office and residential accommodations for health professionals. The Metro Health Services further identified physical challenges at the hospitals. The agency indicates that many units in the major hospitals in the city lack adequate number of beds and specialty services. In addition, AMA Metro Health Services highlighted the severely low number of experienced health professionals in the city and indicates that the doctor to patient ratio in the city is 1:12,000 and the nurse to patient ratio is 1:1,837 (Accessed from www.ghanadistricts.com on 7/07/2015). The huge workload coupled with limited resources to work with has pushed several health professionals out of the Metropolis.

### 3.3 Research Design

Generally, there are two main research approaches in the social sciences. These are the quantitative approach and the qualitative approach (Denzin and Lincoln, 2011; Richards &Munsters, 2010). Whilst the quantitative approach emphasises the use of numerical data, the qualitative approach focuses on insider perspectives of particular social phenomenon (Shkedi, 2005; Babbie& Mouton, 2001).

This study adopted both quantitative and qualitative methods of data collection also known as triangulation or mixed method. Qualitative research method helps in discovering the general pattern of behaviour, experiences, perceptions, emotions and beliefs of respondents in a study (Clarke, 2009; Winchester, 2005; Patton, 1990). Quantitative research method is useful for generalization and predictions (Bryman,
The rationale for choosing this strategy is that, both approaches have their relative strengths and weaknesses and thus in this study, the weaknesses of one will be complemented by the relative strengths of the other (Babbie, 2008). Furthermore, a combination of the two methods will broaden the dimension of the study, the two methods (quantitative and qualitative) will complement each other, and assure validity of the findings (Teye, 2012; Bryman, 2012; Tashakkori and Teddlie, 2010; Desai and Potter, 2006).

One of the major challenges of the mixed method is that it has the tendency of widening the scope of a study than initially planned. Also, the mixed methods approach results in resource constraints and difficulty in integrating findings of a study (Owuengbuezie and Leech, 2005; Bryman, 2007). Notwithstanding the challenges associated with the mixed method triangulation method is proven to be the best research method (Teye, 2012).

3.4 Population of the study

Population is defined as the specific unit being sampled by the researcher for instance, geographical location and temporal boundaries of populations (Neuman, 2003). In this study, the population under study were medical doctors, nurses and administrators of the Korlebu Teaching hospital, Ridge hospital, Police hospital and the University of Ghana hospital.

3.5 Sampling and sample size

The study used different sampling procedures, as indicated earlier; four hospitals were purposively selected based on their status as major referral hospitals and strategic
operations to a section of the population. In selecting the individual respondents, the simple random sampling technique was used in selecting health professionals in each of the selected hospitals in Accra. Simple random sampling technique grants each member of the population an equal chance of being selected and guarantees the selection of a representative sample (Kothari, 2004). In using the simple random technique, the list of all the nurses and doctors who were employed before 2010 in each of the selected hospitals was obtained from the hospitals’ administration. By using random numbers the required number of respondents was selected from each of selected hospitals. In all, 100 health professionals were sampled; 25 from each of the selected hospitals. However, more nurses than doctors were sampled because of the higher number of nurses relative to doctors in each of the hospital. The response rate was as high as 90 per cent.

Participants for the in-depth interview were sampled using the purposive sampling technique. This technique was useful because of the need to collect information that would help explain patterns in the questionnaire data. Hammiche and Maiza (2006) indicate that one major advantage of purposive sampling technique is that it allows the researcher to collect data from individuals who are willing to be part of the study. In order to obtain detail information about the reasons health professionals intend to migrate in spite of the introduction of the single spine salary structure, 5 (five) experts consisting of doctors, nurses and hospital administrators were sampled purposively.
3.6 Data collection

The study used both primary data and secondary data. Primary data was gathered by administering questionnaires to collect quantitative data whilst in-depth interviews were conducted to collect qualitative data.

3.6.1 Primary Data collection Instruments

A structured questionnaire which consists of both closed and open ended questions and an in-depth interview guide were used in collecting primary data. The questionnaire was used to collect data on the socio-demographic characteristics of the sampled health professionals. The questionnaire also consists of questions that were targeted at collecting data on the migration intentions as well as recommendations from the respondents. The questionnaire was given to the respondents to fill since they could all read and write.

The in-depth interview guide was used to obtain information from the participants on their migration intentions and why they intend to migrate in spite of the introduction of the single spine salary structure.

Whilst the sampled medical doctors and nurses were asked to fill the questionnaires, the administrators who are responsible for the day to day running of the hospital were interviewed to obtain explanations for patterns in the questionnaire data as well as factors that contribute to the emigration of health professionals in the country.

3.6.2 Secondary Data

Kotler and Armstrong (2006) argue that secondary data provides great opportunity for student researchers to save money and time. In this study, the secondary sources of
data were published articles, government agency reports and statistical figures collected by state agencies such as the Ghana Health Service. The researcher used secondary data during the review of related literature and also in discussing the results of the report.

3.7 Data Analysis

Both quantitative and qualitative data were analysed using the appropriate data analyses tools. The questionnaire data were analysed quantitatively using the SPSS software. The SPSS statistical software was used to enter the questionnaire data and to provide descriptive statistics such as mean, median and mode. Also, chi-square test of association was used to examine the relationship between the socio-demographic characteristics of the health professionals and their migration intentions. Audio voices of interviewees were transcribed and then organised into reasonable themes manually. The qualitative analysis was in the form of narratives that reflect the opinion and experiences of the participants who were interviewed. Find attached in the appendix the socio-demographic background of the interviewed respondents.

3.8 Ethical Considerations

The consent of the hospital superintendents and the Matrons in charge of the selected hospitals was sought before the study commenced. Permission from heads of the various units in the selected hospitals was also obtained. The purpose of the study was explained to the respondents. Also, the respondents were assured of confidentiality and voluntary participation in the study. In addition, in order to hide the identity of respondents, pseudonyms have been used in the report.
3.9 Limitations of the Study

Constraints are inevitable in every research work. In this particular work, the first challenge faced was with respect to time. The sample size could have been enlarged but this was not possible due to limited time for this study. In addition, the busy schedule of the health professionals was another obstacle to contend with. The various hospitals were visited several times before the questionnaires were finally retrieved. These inconveniences delayed the data collection process. Finally, few of those interviewed did not permit the researcher to record their voices for fear of victimisation, despite the assurance of confidentiality.

Despite all these challenges, the researcher was able to manage the situation to conclude the data collection processes, as well as the entire study within time allotted.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the findings of the study based on the objectives outlined in Chapter One. It presents summary statistics on the socio-demographic variables such as sex, ethnicity, religion, marital status, age, professional status and highest educational levels. Also, some of the findings of the study are presented in the form of graphs or charts whereas others are in the form of frequency distribution tables. Furthermore, the chapter presents the results and interpretation of chi-square tests of association. While these quantitative analyses present a general overview of the migrations of health professionals, the researcher uses the qualitative interviews to provide deeper understanding of these general statistics. The results are discussed by
comparing them with the findings of similar studies in the literature as explained within the context of some perspectives. The chapter also presents specific quotes from the participants who were interviewed.

4.2 Socio-demographic characteristics of the respondents

This section presents results on the Socio-demographic characteristics of the health professionals surveyed. The variables include age, marital status, sex, number of children ever born and highest educational level of the respondents.

4.2.1 Professional status and Sex of the health workers

The result shows that majority (82.2%) of the health professionals were nurses whilst 17.8 percent were doctors as shown in Figure 4.1.

Figure 4.1: Distribution of the respondents by profession
4.2.2 Sex of respondents

The sex composition of the health workers shows that an overwhelming majority (85 %) of the nurses are females. In terms of the doctors, the result shows that 80 % of the doctors are males. The findings support studies by Anarfi, and others, (2010) that have also shown that the nursing profession in the country is dominated by females.

Source: Field work, 2015
It is believed that females are naturally predisposed to providing better care than males (Bartfay, Bartfay, Clow and Wu, 2010). However, in recent times the demand for male nurses in Europe and the United States of America has encouraged males from developing countries to train as nurses so they can take advantage of the opportunity by migrating to the countries that need their services (Dovlo, 2005). The result is presented in Figure 4.2.

**Figure 4.2: Sex Distribution of the respondents**

Source: Field work, 2015
4.2.3 Ages of the Respondents

The ages of the respondents ranged from 28 years to 65 years. The minimum age of the doctors was 29 years whereas that of the nurses was 28 years. However, the maximum age of the doctors was 65 years whereas that of the nurses was 58 years.

**Figure 4.3: Age distribution of the respondents**

Source: Field work, 2015

The result shows that 20 % of the health professionals were less than 30 years compared to 48 % who were aged from 30 years to 45 years. The table also indicates that 30 % were aged from 46 to 60 years. However, only 2 % were above 60 years.
old. Generally, the result shows that more than half (67.8 %) of the health professionals were aged from 28 years to 45 years. These health professionals could be described as young and energetic health workers who should be retained in the country to provide health care services for Ghanaians living in the Accra metropolis. The health professionals who were aged above 60 years were retirees who were working on contract as specialist doctors. A cross tabulation of age and profession shows that nearly 69 % of the doctors were less than 46 years old compared to 68 % for the nurses.

Table 4.1: Age distribution of the respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses</td>
</tr>
<tr>
<td>Less than 30 years</td>
<td>11(14.9 %)</td>
</tr>
<tr>
<td>30-45 years</td>
<td>39(52.7 %)</td>
</tr>
<tr>
<td>46-60 years</td>
<td>24(32.4 %)</td>
</tr>
<tr>
<td>Above 60 years</td>
<td>0 (0.0 %)</td>
</tr>
<tr>
<td>Total</td>
<td>74 (100.0 %)</td>
</tr>
</tbody>
</table>

Source: Field work, 2015

4.2.4 Highest Educational Level of the Respondents

The Table 4.2 shows that most (41 %) of the health professionals had diploma certificates particularly in Nursing whilst 40 % of them had Bachelor Degrees in Nursing or Medicine.
Table 4.2: Distribution of Highest Educational level of the respondents

<table>
<thead>
<tr>
<th>Highest Educational level</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses</td>
</tr>
<tr>
<td>Certificate in Nursing</td>
<td>10(13.5%)</td>
</tr>
<tr>
<td>Diploma in Nursing</td>
<td>37(50.0%)</td>
</tr>
<tr>
<td>Degree in Nursing</td>
<td>22(29.7%)</td>
</tr>
<tr>
<td>Bachelor of Medicine</td>
<td>-</td>
</tr>
<tr>
<td>Bachelor of Surgery (Specialist)</td>
<td>-</td>
</tr>
<tr>
<td>Post graduate Degree</td>
<td>5(6.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>74(100.0%)</td>
</tr>
</tbody>
</table>

Source: Field work, 2015

4.2.5 Marital status

In terms of marital status, less than half (42.2%) of the respondents were currently married whereas about 47% had never been married. The result is summarised in Table 4.3.

Table 4.3: Distribution of Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses</td>
</tr>
<tr>
<td>Married</td>
<td>29</td>
</tr>
<tr>
<td>Never married</td>
<td>37</td>
</tr>
<tr>
<td>Ever married</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
</tr>
</tbody>
</table>

Source: Field work, 2015
The remaining 11% were ever married. Those who were ever married comprised respondents, who were divorced, widowed or separated.

4.2.6 Number of Children ever born

The number of children ever born ranged from one to five. However, only 22% of the respondents had three or more children. Furthermore, nearly twenty-eight percent (27.7%) did not have children whereas 32% had one child. The remaining eighteen percent (18%) had two children.

Figure 4.4: Distribution of number of children ever born

Source: Field work, 2015

4.3 Migration intentions of the Health Professionals for the next ten years

The emigration of health professionals in Ghana is often seen as a response to market disequilibrium between the forces of demand and supply of health professionals (Quartey, 2006). In effect emigration of highly skilled is a direct response to real
wage differences between receiving countries and source countries (Anarfi, Quartey and Agyei, 2010). The loss of health professionals from the health sector has been a major challenge to the government of Ghana especially when studies had shown that the emigration of health professionals is the result of poor working conditions in the health sector (see Quartey, 2007; Quartey 2006). The introduction of the Single spine salary was expected to reduce the rate of emigration expectations of nurses and doctors from Ghana. This study shows that a total of 63 out of the 90 health professionals representing 70% had intentions to migrate in the next ten years. They indicated in the affirmative that they intend to migrate out of Ghana if the opportunity presents itself. The remaining 30% indicated that they had no migration intentions for the next ten years. Those who have migration intentions comprised 53 nurses and 10 doctors (refer to Figure 4.5).

**Figure 4.5: Distribution of the intention to emigrate**

![Distribution of the intention to emigrate](image)

**Source:** Field work, 2015
Specifically, the result shows that about 72% of the nurses intend to migrate in the next ten years relative to 63% of the Doctors. In spite of the introduction of the single spine salary pay policy, some nurses and doctors in the country still harbour the intentions to emigrate. The reasons given by the nurses and doctors who intend to emigrate is presented in the following sub-section.

4.4 Period of Intended Migration

The health professionals were asked to indicate when they intend to migrate abroad. The result shows that more than half (52.1%) of the health professionals intended to emigrate within the next five years (Table 4.4). This includes those who intend to migrate abroad next year representing 5.5%, those who intend to emigrate next two or three years representing 7.7%, and those intend to emigrate in the next four or five years representing 38.9% of the health professionals sampled. However, nearly 6% indicated that they intend to migrate abroad in the six years.

The result further shows that 31% of the health professionals said they had not yet decided when they intend to emigrate. However, nearly 11% who had the intention to emigrate indicated that they could emigrate any time they get the required financial means. Based on the above results, it is evident that the desire to seek greener pastures abroad is rated high among these professionals. The government of Ghana therefore needs to look for ways to provide extra incentives and motivation to change the migration intention of its health professionals.
Table 4.4: Distribution of when to emigrate

<table>
<thead>
<tr>
<th>When to emigrate</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The next one year</td>
<td>5</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Next two years</td>
<td>4</td>
<td>4.4 %</td>
</tr>
<tr>
<td>Next three years</td>
<td>3</td>
<td>3.3 %</td>
</tr>
<tr>
<td>Next four years</td>
<td>10</td>
<td>11.1 %</td>
</tr>
<tr>
<td>Next five years</td>
<td>25</td>
<td>27.8 %</td>
</tr>
<tr>
<td>Next six years</td>
<td>5</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Anytime I get the money</td>
<td>10</td>
<td>11.1 %</td>
</tr>
<tr>
<td>Not yet decided</td>
<td>28</td>
<td>31.1 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

Source: Field work, 2013

4.5 Length of stay at the intended destination

The result shows that almost 37 % of the health professionals intended to stay at their preferred destinations for about 5-10 years. Again, 11 % intend to stay at the destination over a period of not more than 5 years whereas nearly 32 % intended to stay for a period of 15 years or more. This results highlight the negative effect health delivery in the country can have, that is, if appropriate steps are not taken to make these professionals rescind their intentions of long absence from the country.
4.6 Reasons for intending to emigrate

Studies have shown that one of the major reasons Ghanaian health professionals emigrate is poor working conditions in the country. Vujicic, Zurn, Diallo, Adams and Dal Poz (2004) found that purchase parity pay for nurses in Australia or Canada was fourteen times that of a Ghanaian nurse. In this study, the result shows that some of the health professionals intend to emigrate in the next ten years because of Financial
or Economic considerations, the desire to acquire higher skills, and the desire to experience life abroad.

The result shows that 38 out of 53 nurses (71.7 %) intend to migrate in the next ten years because of economic considerations. Comparatively more nurses than doctors intend to migrate because of economic reasons. Better salary and attractive incentives were mentioned as economic considerations for which some of the nurses and doctors intend to migrate abroad. One of the male respondents had this to say concerning intentions to migrate during an in-depth interview:

   Our salaries are nothing to write home about compared to what some of my colleagues in UK are earning. We work hard but the salary is not commensurate with the work we do given the work load we are subjected to. (John, Accra, June 2015).

In another interview, a female health professional expressed her reasons for intending to migrate abroad. She said:

   We thought the single spine has come to make things better for health professionals in the country but we are experiencing the exact opposite. Our leaders at the labour front are still negotiating with government to make things better but nothing seems to be working well for nurses and doctors. I doubt things will get better for us and that is the reason why I intend to emigrate abroad (Cynthia, Accra, June, 2015).

Indeed, these two quotations reveal that wages or salaries are very crucial factors pushing many health professionals to work outside Ghana. The wage factor is consistent with the neoclassical theory which posits that people move because of wage differentials between countries. In order to enjoy higher wages, health professionals are forced to migrate outside their home country.
The pursuit for better skills and higher education in the health profession is one of the reasons some of the nurses and doctors intend to emigrate. The result shows that more doctors intend to emigrate in order to improve upon their skills than the nurses. Anarfi, Quartey and Agyei (2010) found in their study that Ghanaian migrant health professionals who returned to Ghana indicate that their emigration was motivated by the desire to improve upon their skills in the delivery of health care services. Another health professional gave the following response to explain why he would want to migrate abroad:

In the highly advanced countries there are several opportunities for doctors to improve upon their skills. Here in Ghana, the workload does not allow doctors to make time to do further studies. Specialist doctors in particular need to be abreast with modern procedures and new ways of dealing with diseases using modern technology (Frank, Accra, June 2015).

Family consideration was mentioned as one of the reasons some of the respondents intend emigrating in the next ten years. Only one respondent intend migrating abroad mentioned family reunion as the reason behind her migration intention. This female respondent indicated that she has to join her husband abroad with their five year old child since they had both planned to spend the next ten years together abroad.

Interestingly, some of the respondents in particular indicated that their intention to emigrate is driven by the desire to experience life abroad. In this respect, nearly 6% of the respondents gave this indication. It is likely that these respondents are being influenced by what their family and friends abroad tell them about life abroad compared to life in Ghana. With regards to this findings, other literature have argued that social networks are major influence on potential migrants reasons for migrating. In Ghana, studies have identified that Ghanaians migrate to places where they already have networks (Kyei, 2013).
As a follow-up on the reasons, the respondents were asked to indicate whether they had relatives or friends abroad. The result shows that 30% of the respondents had relatives or friends abroad. The network theory suggests that family and friends abroad are likely to serve as channels for the perpetuation of migration (Massey, Arango, Hugo, Kouaoici, Pellegrino and Taylor, 1993). Also, Dustmann and Glitz (2005) argue that the existence of social ties or networks is likely to influence the decisions of migrants when they choose their destinations.

**Figure 4.7: Comparison of Nurses and Doctors on the basis of the reasons they intend to emigrate**

Source: Field work, 2015
4.7 Relationship between some socio-demographic variables and intention to migrate abroad

In order to ascertain the relationship between the socio-demographic variables of the respondents and their intention to emigrate, a chi-square test of association was done at a significance level of 5 %. The results are presented in the following subsections.

4.7.1 Marital status and Migration intention

There is evidence in literature that people who are not married are more likely to migrate as compared to those who are currently married. King et al, (2010) explain that people who are currently married are not likely to have the intention to migrate relative to people who are currently not married because the currently married may have to consider the effect of their absence on their spouse and children.

In this study the marital status of the health professionals was categorized into those who were married and those who were not married. In this respect, respondents who were ever married were also considered as not married. The cross tabulation presented in Table 4.4 shows that a little over 90 % of those who were not married had the intention to emigrate compared to 42 % of those who were married. Furthermore, the chi-square test of association at a significance level of 5 %, revealed that there is a significant association between marital status and the intention to migrate abroad ($\chi^2 = 18.996$, df = 1, p =0.000 < 0.05). This means that marital status has an influence on the intention of the health professionals to migrate abroad. The result further implies that health professionals who are married are less likely to have migration intention as compared to those who are never married.
Table 4.5: Intention to migrate and marital status of the health professionals

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Do you have intention to migrate in the next ten years?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Not married</td>
<td>5 (9.6 %)</td>
</tr>
<tr>
<td>Married</td>
<td>22 (57.9 %)</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

$\chi^2 = 18.996, df = 1, p = 0.000 < 0.05$

4.7.2 Sex and Intention to migrate abroad

Studies have shown that traditionally, men are more likely to emigrate compared to women (Adepoju, 2005). However, the numbers of women migrating independently is on the increase (Awumbila, et al. (2011). In this study, the cross tabulation in Table 4.6 shows that 20 (86.9 %) of the males had the intention to migrate abroad whilst 64.2 % of the females had the intention to migrate abroad.

Table 4.6: Sex of the health professionals and Intention to migrate

<table>
<thead>
<tr>
<th>Sex</th>
<th>Do you have intention to migrate in the next ten years?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Male</td>
<td>3 (13.1)</td>
</tr>
<tr>
<td>Female</td>
<td>24 (35.8)</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

$\chi^2 = 10.252, df = 1, p = 0.012 < 0.05$

The chi-square test shows that at a significance level of 5 % there is a significant association between the sex of a health professional and the intention to migrate abroad ($\chi^2 = 10.252, df = 1, p = 0.012 < 0.05$). This means that health professionals
who are males are more likely to have migration intentions as compared to their female counterparts.

4.7.3 Educational level and migration intention

The educational level of the health professionals was categorised into low education and high education. Health professionals who had certificates and diplomat certificates were categorised as persons with low educational levels whereas those with bachelor degrees and post graduate degrees were categorised as persons with high educational level. The cross tabulation shows that nearly 73% of the health professionals with low educational level have the intention to migrate in the next ten years whereas 52% of those with high educational levels have the intention to migrate within the same period. The chi-square test of association shows that there is no significant association between educational level of the health professionals and their intention to migrate abroad ($\chi^2 = 1.478, df = 1, p = 0.196 > 0.05$).

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Do you have intention to migrate in the next ten years?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Low</td>
<td>6(27.3)</td>
</tr>
<tr>
<td>High</td>
<td>32(48.4)</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
</tr>
</tbody>
</table>

$\chi^2 = 1.478, df = 1, p = 0.196 > 0.05$

4.8 Preferred Destinations of the health professionals

The most mentioned destinations were United States and UK (Figure 4.8). The result shows the UK, US and Canada are preferred destinations of the health professionals.
Of these destinations, the UK is the most preferred (37 %). Clearly, these countries are not only English speaking countries but also have the economic capability to pay very attractive salaries to health professionals (see Awusabo-Asare et al. (2000). This deduction is consistent with previous studies since it had been found that the migration of health professionals from sub-Saharan Africa is skewed towards the OECD countries (Kirigia et al, 2006).

**Figure 4.8: Preferred Destination**

![Bar chart showing preferred destinations](chart.png)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>9</td>
<td>14.3 %</td>
</tr>
<tr>
<td>Germany</td>
<td>4</td>
<td>6.4 %</td>
</tr>
<tr>
<td>Italy</td>
<td>10</td>
<td>15.9 %</td>
</tr>
<tr>
<td>UK</td>
<td>25</td>
<td>39.6 %</td>
</tr>
<tr>
<td>US</td>
<td>15</td>
<td>23.8 %</td>
</tr>
</tbody>
</table>

**Source: Researcher’s Field Work, 2013**

One of the health professionals had this to say in respect of the preferred destination:

I will want to go to UK. The pay is better as compared to Ghana. I have some friends in the UK and they told me that in the UK health professionals receive
attractive incentives. I also have some relatives there so accommodation will not be a problem for me and I can easily get a job to do (Janet, interviewed in June 2015).

Most of the interviewees indicated that they prefer the UK and the US because of the attractive wages and incentives that health professionals enjoy in those countries. The result is consistent with previous studies that have shown that the most preferred recipient countries of health professionals from sub-saharan Africa are OECD (Organisation for Economic Co-operation and Development ) countries (OECD Ad Hoc Group, 2003). Simons, Villeneuve and Hurst (2005) indicate that in the United Kingdom, some 8.34 percent of all nurses working there are migrants and that 21.2 percent of these migrant nurses are from sub-saharan Africa. Clearly it can be deduced that the United Kingdom is an attractive destination for migrant health professionals from Ghana.

4.9 Single Spine Salary Pay Policy (SSSS) and migration intention

The single spine pay policy in Ghana was introduced primarily to make the health public sector and the health sector particularly more attractive to health professionals. In this study, the health professionals were asked to compare their salaries and other benefits before and after the introduction of the single spine pay policy. Respondents were further asked to indicate whether they were better off before or after the single spine policy was introduced.

To ascertain the association between the single spine pay policy and migration intentions of the health professionals a chi-square test was done at a significance level of 5 %. The result shows that more than half (62.2 %) of the health professionals
indicated that they were better off under the previous pay policy whilst 37.8 % indicated that they were better off under the single spine pay policy.

One of the health professionals who indicated that she is better off under the single spine pay policy had this to say:

Prior to the introduction of the single spine pay policy, our salaries were far below what the doctors were earning. The difference was quite huge. But when we were put on the single spine our salaries went up by more than 20 %. In terms of absolute figures we are better off under the single spine.

Another health professional who disagreed that health professionals are better off under the single spine had this to say:

We still have a lot of unresolved issues in relation to our salaries. As for us as doctors I think we have not been treated fairly. We were told that no health professional will be worse off under the single spine but unfortunately doctors in this country have become worse off under the single spine. Our pension has been reduced and we are displeased with that. Some allowances that were taken from us ought to be restored. Prices of goods and services have gone up yet our single spine salaries have remained the same and there are no other incentives to cushion us against this harsh economic conditions.

In terms of migration intentions, 71 % of the health professionals who said they are better off under the single spine pay policy had the intention to migrate abroad whilst nearly 68 % of those who said they were better off under the previous pay policy had migration intentions. This implies that health professionals whether they are better off or not under any of the two salary structures have migration intentions. Consequently, the chi-square test of association shows that there is no significant association between the introduction of the single spine salary structure and the migration
intentions of the health professionals at a significance level of 5 % \( \chi^2 \) statistic = 3.723, df = 1, n = 90, p = 0.346 > 0.05. This result means that the introduction of the single spine salary structure does not influence the health professionals’ migration intentions. Stated differently, the single spine is not likely to reduce migration intentions of health professionals in the country.

**Table 4.8: Cross tabulation of Single spine salary structure and migration intention of the health professionals.**

<table>
<thead>
<tr>
<th>Comparing salaries before and after SSSS</th>
<th>Do you have intention to migrate in the next ten years?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Better off before SSSS</td>
<td>16 (39.3)</td>
</tr>
<tr>
<td>Better off under SSSS</td>
<td>11 (32.3)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

\( \chi^2 \) statistic = 3.723, df = 1, n = 16, p = 0.346 > 0.05

**4.10 Suggestions by the nurses**

Various suggestions in response to the question on what government should do to reduce the rate of emigration of health professionals in the country were given (Table 4.8). The table shows that the most mentioned suggestion was that government should pay health professionals attractive incentives to keep them in the country. Other health professionals were of the view that in order to reduce the number of health professionals who travel for further studies or upgrade their skills, there is the need for government to invest in the establishment of well-equipped specialist training facilities for health professionals in the country. Some of the health professionals also mentioned that the admission requirement for medical students in particular should be
more flexible so that more doctors can be trained to reduce their work load in hospitals in the Accra Metropolis and other cities.

**Table 4.9: Suggestions from the health professionals (Multiple responses)**

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government should pay attractive incentives to retain more health professionals in the country</td>
<td>80</td>
</tr>
<tr>
<td>Admission requirement for medical students should be more flexible to increase intake of medical students.</td>
<td>35</td>
</tr>
<tr>
<td>Government should invest in the establishment of well-equipped specialist training facilities for health professionals in the country</td>
<td>50</td>
</tr>
<tr>
<td>Government should improve upon health infrastructure in the country</td>
<td>60</td>
</tr>
</tbody>
</table>

*Source: Field work, 2015*

One of the administrators had this to say:

> Although the rate of emigration of health professionals has reduced marginally, we still need to do more to retain more of the health professionals in the country particularly the specialist doctors who are sought after in Europe. Apart from paying them attractive salaries, the government has to put in place a mechanism that will make it easier for the grievances of health professionals to be addressed promptly so they do not resort to strikes and then eventually decide to travel abroad to practice the profession.

Attractive salaries and good conditions of service were indicated as some of the provisions that would make health professionals stay at post. Also, the need to train more health professionals in order to reduce the work load on the few doctors and nurses in the country was mentioned during the in-depth interviews.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS
5.1 Introduction

In this study, the researcher sought to describe the socio-demographic characteristics of the health professionals sampled and to explore their migration intentions. The study also sought to examine the association between the socio-demographic characteristics and the migration intentions of the health professionals. Furthermore, the study sought to examine the relationship between the migration intentions of the health professionals and the introduction of the single spine pay policy. This chapter summarises the findings and presents the conclusions and recommendations.

5.2 Summary of findings

The result shows that majority (82.2 %) of the health professionals sampled were nurses. An analysis of the sex composition of the health professionals shows that a little over 74 % of the health professionals were females. The ages of the health professionals ranged from 28 years to 65 years with 20 % of them less than 30 years compared to 48 % who were aged from 30 years to 45 years. In terms of educational background, most (41 %) of the health professionals had diploma certificates particularly in Nursing whilst 40 % of them had Bachelor Degrees in Nursing or Medicine. The result further shows that less than half (42.2%) of the health professionals were married whereas 47 % were not married.

In respect of migration intentions, this study shows that 70 % had migration intentions for the next ten years. The result further shows that the United Kingdom, United States and Canada are the preferred destinations of the health professionals. Of these destinations, the United Kingdom was the most mentioned preferred destination. When asked when they intend to migrate abroad, more than half (52.1 %) of the
health professionals intend to emigrate within the next five years. In terms of how long they intend to stay abroad, the result shows that most (36.8 %) of the health professionals intend to stay at their preferred destinations for about 5 to 10 years. This study shows that some of the health professionals intend to emigrate in the next ten years because of Financial or Economic considerations, the desire to acquire higher skills, and the desire to experience life abroad. Nearly 72 % of the health professionals intend to migrate abroad in the next ten years because of economic considerations.

The study examined the relationship between the socio-demographic characteristics of the health professionals and their intention to migrate abroad. A chi-square test of association at a significance level of 5 % between marital status and intention to migrate abroad showed that there is a significant association between marital status of the health professionals and their migration intention ($\chi^2 = 18.996, df = 1, p = 0.000 < 0.05$). The result means that health professionals who are not married are more likely to have the intention to migrate as compared to their colleagues who are married. Also, the study found a significant association between the sex of a health professional and the intention to migrate abroad ($\chi^2$ statistic = 10.252, df = 1, $p = 0.012 < 0.05$). Health professionals who are males are more likely to have migration intentions than their female colleagues. However, the result shows that there is no significant association between the educational level of the health professionals and their migration intention ($\chi^2 = 1.478, df = 1, p = 0.196 > 0.05$).

Again, the study examined the association between the single spine pay policy and the migration intentions of the health professionals. The chi-square test of association shows that there is no significant association between the introduction of the single
spine salary structure and the migration intention of the health professionals at a significance level of 5% \( \chi^2 \) statistic = 3.723, df = 1, n = 90, p = 0.346 > 0.05. This result means that the introduction of the single spine salary structure does not influence the health professionals’ migration intentions. Stated differently, the single spine is not likely to reduce migration intentions of health professionals in the country.

5.3 Conclusions

This study is consistent with the evidence that the nursing profession in Ghana is dominated by females. Health professionals in Ghana still have the intention to migrate mainly for economic reasons. It is therefore concluded the intention to migrate is indeed a direct response to real wage differences between Ghana and the intended destinations of the health professionals as indicated by Anarfi, Quartey and Agyei, (2010). Most of the health professionals prefer OECD countries namely the UK, US and Canada because of the attractive salary packages and opportunities for skill development in those countries.

Clearly the effect of the single spine pay policy on migration intentions of health professionals in Ghana is yet to be realised. Consequently, it is concluded that the emigration of Ghanaian health professionals is not likely to reduce in the next ten years. This is because the single spine pay policy is not meeting the expectations of Ghanaian health professionals. The migration intentions of the health professionals resonates with the neoclassical theory which stipulates that as long as economic factors such as better and attractive wages persist at destination countries rational
labour migrants will migrate to take advantage of the opportunities at the destination (Anarfi, Quartey and Agyei, 2010).

5.4 Recommendations

The study makes the following recommendations based on the findings:

1. Government should review salaries and incentives of health professionals so as to retain more of the health professionals in the country

2. Admission requirement of medical students should be made more flexible to increase the intake of medical students

3. Government should invest more in the establishment of Medical schools and Nurses training colleges so as to train more health professionals in the country.

4. Government should also invest more in the provision of health infrastructure in the country to make the work of health professionals easier

5. Scholarships and skill opportunities for further studies should be available locally to enable health professionals to build their capacities.

REFERENCES


**APPENDIX A**

**QUESTIONNAIRE FOR HEALTH PROFESSIONALS**

I am a post graduate (MA) student of the Centre for Migration Studies of University of Ghana, Legon. As part of my Academic work I am required to embark on a Field Research. The research topic is “The Effects of Single Spine Salary Structure on
I shall be grateful if you could take time out of your busy schedules and answer the questions below. You are assured that any information provided will be treated confidentially and used solely for academic purposes. Please provide the appropriate responses. Thank you for your co-operation.

SECTION A

SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Sex:
   1. Male ( )
   2. Female ( )

2. Date of birth ........................................

3. Age of last birthday .................................
   Don’t know ( )

4. What is your ethnic background?
   1. Ga ( )
   2. Ewe ( )
   3. Akan ( )
   4. Mole Dagbani ( )
   5. Non Ghanaian ( )
   6. Other (specify) ........................................

5. What is your religion?
   1. Catholic ( )
   2. Anglican ( )
   3. Methodist ( )
4. Presbyterian ( )
5. Pentecostal & Charismatic ( )
6. Muslim ( )
7. Traditionalist ( )
8. No religion ( )
9. Other religion (specify) ..............................................................

6. Educational/Professional status

1. Doctor of Medicine ( )
2. Post Doctorate certificate ( )
3. Post Doctorate Degree ( )
4. Specialist (specify) ..............................................................
5. Certificate in Nursing ( )
6. Diploma in Nursing ( )
7. Degree in Nursing ( )
8. Other qualification ..............................................................

7. What is your marital status?

1. Married ( )
2. Divorced ( )
3. Separated ( )
4. Never Married ( )
5. Widowed ( )
6. Consensual Union ( )

8. Number of children ever born
1. None (    )
2. One (    )
3. Two (    )
4. Three (    )
5. Four or more (    )

9. How long have you practiced as a Medical Doctor/Nurse/Administrator

Please underline what profession is applicable to you

1. Less than 5 (    )
2. 5 to 10 years (    )
3. 10 to 15 years (    )
4. 15 or more years (    )

10. How many years more do you have before going on (compulsory) retirement?

1. Between now and 5 years (    )
2. 5 to 10 years (    )
3. 10 to 15 years (    )
4. 15 or more years (    )

SECTION B:

MIGRATION INTENTION AND SSSS INTRODUCTION

11. Do you intend to migrate and work outside Ghana in the next 10 years?

1. Yes (    ) 2. No (    )
If no, then this section will not be applicable to you. Please go to Section C

12. Which country do you have the intention of migrating to?

…………………………………………………………………………………………………………………………………………………

13. Is there any special reason why you want to migrate to that country?

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

14. State any other factor(s) or working condition(s) that has imparted on your decision to migrate

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

15. When do you intend to embark on your trip?

1. Next one year [X] 2. Next two years [ ] 3. Next three years [ ]
4. Next four years [ ] 5. Next five years [ ] 6. Next six years [ ]
7. Not yet decided [ ] 8. Anytime I get the money [ ]

16. How are you funding your travel? Is somebody sponsoring you or is all by yourself?

…………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………

17. Are there relatives/friends at your intended destination?

1. Yes ( ) 2. No ( )
18. Are your family/friends influencing your decision to migrate?
   1. Yes ( )                 2. No ( )

19. Do you have the intention of returning to Ghana after some years of work?
   1. Yes ( )                 2. No ( )

20. If yes, how long do you intend to stay at your destination before returning to Ghana?
   1. Not more than 5 years ( )
   2. 5 to 10 years ( )
   3. 10 to 15 years ( )
   4. 15 years or more ( )

21. What measures should be undertaken by the government to reduce migration of health professionals?
   …………………………………………………………………………………
   …………………………………………………………………………………
   …………………………………………………………………………………
   …………………………………………………………………………………
   …………………………………………………………………………………

22. Is your current salary sufficient or satisfactory enough to motivate you to continue working in Ghana?
   1. Yes ( )                 2. No ( )

23. Do you enjoy other allowances?
   1. Yes ( )                 2. No ( )

24. If yes, mention them please
25. If no, how does it impart on your decision to migrate?

26. Do you enjoy the working conditions in the country?
   1. Yes (   )  2. No (   )

27. If no, what are some of the challenges you face as a professional?

28. Has the introduction of the SSSS improved your standard of living?
   1. Yes  2. No

SECTION C

REASONS FOR NOT MIGRATING

This section must be completed by professionals who said they do not have any intention of migrating in the next couple of years)

29. State the main reasons why you do not want to migrate.
30. Has the introduction of the SSSS, influence your decision not to migrate?
   1. Yes (   )  2. No (   )

31. Please explain your answer

32. What measures should the government undertake to reduce the emigration of health professionals from Ghana?

APPENDIX B

INDEPTH INTERVIEW WITH HOSPITAL ADMINISTRATORS

I am a post graduate (MA) student of the Centre for Migration Studies of University of Ghana, Legon. As part of my Academic work I am required to embark on a Field Research. The research topic is “The Effects of Single Spine Salary Structure on
Migration Intention of Health Professionals in the Accra Metropolis”. I shall be grateful if you could take time out of your busy schedules and answer the questions below. You are assured that any information provided will be treated confidentially and used solely for academic purposes. Please provide the appropriate responses. Thank you for your co-operation.

IDENTIFICATION

Number………………………………………….

Profession………………………………………..Position..............................................

Telephone number………………………………………………………………………………..

Email……………………………………………………………………………………………………

SECTION A: SOCIO-DEMOGRAPHIC BACKGROUND OF INTERVIEWEE

1. Age………………………………………………………………………………………………………

2. Sex………………………………………………………………………………………………………..

3. Highest level of education………………………………………………………………………

4. Marital Status…………………………………………………………………………………………

5. Religious Affiliation…………………………………………………………………………………

6. How many years have you worked here?

7. Do you have the challenge of health professionals resigning and leaving the shores of Ghana?

8. What reasons are assigned for their resignation?

9. Does their departure have any impact on health delivery of this hospital?

10. Since the operation of the SSSS in 2010, has the emigration trend reduced, stabilised or increased?
11. How has the single spine affected your salary? Has it brought any significant increment in your salaries?

12. What do you think the government can do to reduce the emigration of health professionals?