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Staffing matters; funding counts – Pressure point: International recruitment

Is international recruitment a viable long-term solution for the NHS?

The Health Foundation

About this supplement

This supplement is produced to accompany the report *Staffing matters; funding counts: Workforce profile and trends in the English NHS.*

During the research to inform the report, six particular pressure points were identified for the workforce of the NHS in England. The pressure points were chosen based on feedback from a stakeholder roundtable, held in October 2015, and analysis of recent policy reports.

The pressure points are:

- the proposed changes to nurse bursaries
- international recruitment to fill vacancies
- the recruitment and retention of GPs
- the potential of physician associates
- the potential of nursing associates
- the use of temporary and agency workers.

These pressure points need to be addressed if the health service is to have access to the staff it needs to deliver high quality care.

In addition to the discussion in *Staffing matters; funding counts*, more detailed information and analysis about each of these pressure points is available as part of a series of supplements, from www.health.org.uk/publication/staffing-matters-funding-counts.

Please note: While the focus of this supplement is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

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Is international recruitment a viable long-term solution for the NHS?

International recruitment: The issue

The UK has been a long-term recruiter of internationally educated health professionals. As noted by NHS Employers, 'Recruitment from outside of the UK has made a valuable contribution in the NHS over recent years and forms an important part of the workforce supply strategy of NHS organisations'.[1]

The annual intake of doctors, nurses and other health professionals from other countries has ebbed and flowed over the years, but has remained a continuous and significant source of new recruits over the decades. About one in three doctors, and one in eight nurses in the UK was trained in another country. In particular, the inflow of nurses has increased in recent years, notably from European Union (EU) countries, in response to recruitment difficulties. The free mobility of doctors, nurses, midwives and some other categories of health professional across the countries of the EU has enabled this increased inflow, and austerity measures in the countries of Southern Europe have also been a driver. The recent vote for the UK to leave the EU is likely to affect this in the future, although it is too soon to be certain exactly what the impact will be.

While demand for international recruits has been increasing, other government policies have made it more difficult to recruit many types of health professional from outside the EU. Tightening of immigration requirements has meant that most categories of health professional have not been on the Shortage Occupation List (SOL) and it was therefore very difficult for UK employers to recruit these roles directly from non-EU countries. In addition, new proposals that migrant workers already in the UK would have to meet an annual earnings threshold of £35,000 to remain in the UK had raised concerns, as this would mean that many existing non-EU international nurses would have to leave the country.

These policy changes led to accusations of a lack of 'joined up government', and pressure from employers to ease the restrictions. The result was that nursing was temporarily placed back on the SOL late in 2015, for a six-month period, enabling UK employers to consider recruiting from non-EU countries. At the same time, the Migration Advisory Committee (MAC) was asked to report if nursing should remain long term on the SOL.

The MAC report in March 2016 recommended a longer but 'tapered' use of the SOL with an overall annual ceiling for nurses of 3,000-5,000 places in the first year, then decreasing year on year with nurses coming back off the SOL altogether by 2019: 'the point at which the Department of Health forecasts nursing demand and supply will return to equilibrium'.[2]

The MAC also expressed concerns about whether the health and care sectors will be sufficiently incentivised to tackle nursing shortages if the occupation is retained on the SOL, pointing to their 'poor track record' in addressing nursing shortages by other means (domestic training, improved retention etc).[2] It concluded that 'we do say this to the

employers, and, in this case, to the government. There is no good reason why the supply of nurses cannot be sourced domestically. The long-term solution to nursing supply is to offer people sufficient incentive and opportunity'.[2] A similar point was made by the Review Body report in March 2016 which noted that 'Whilst recruitment from overseas (via inclusion on the MAC SOL) provides a short-term stop gap, it is not a long-term solution'.[3]

The month after the MAC report on international nurses was published, NHS England announced a new initiative to recruit GPs from India, Australia and other countries: 'A major new international recruitment campaign to attract up to an extra 500 doctors from overseas' .[4]

Can, and should, there be a switch away from international recruitment?

International recruitment: The evidence

International recruitment is one option for employers looking to fill vacancies or expand their workforce. Other main policy options are to increase domestic training (which takes 3–4 years to be realised for nurses and a decade or more for doctors, and is relatively costly), improving retention (and 'return' of non-practising professionals), and reducing demand through productivity improvements.

Nursing has been the health profession with the greatest policy attention in England in recent years, in terms of shortages and associated efforts on international recruitment. An examination of trends in international flows of nurses, and the related policy context, provides evidence which questions if international recruitment will be 'off the table' as a policy option in the foreseeable future. As with the other aspects of health workforce policy examined in *Staffing matters; funding counts*,[*] the answer lies in examining the staffing–funding connection.

Data from the Nursing and Midwifery Council (NMC) showed that at March 2016, there were 673,000 nurses, midwives and health visitors on the UK register and reporting a UK address. Approximately 85,000 of these registrants had been trained outside the UK. This suggests that about 12.6% of UK nurses were from non-UK training sources.[5]

The majority – more than 60,000 – were non-EU, with more than 20,000 from the Philippines and more than 14,000 from India. However, there was a more recent swing to active recruitment from the EU, within an overall trend of growth reflecting domestic nursing shortages. The shift of international recruitment focus to countries of the EU reflected both the relative ease of the recruitment process from other EU countries, and also the 'push' factors that were making more nurses in the recession-hit countries of Southern Europe look abroad for jobs and career opportunities.

The recent report by the MAC confirmed that there has been recent growth in active recruitment of nurses, both by NHS and non-NHS employers, and that international recruitment activity was most prominent in London and the South East of England. Most recently there has been the reported beginning of a switch back to recruitment of nurses from non-EU countries.[2] This has occurred in part because of tightened English language requirements for EU nurses, and in part because UK employers express a preference for

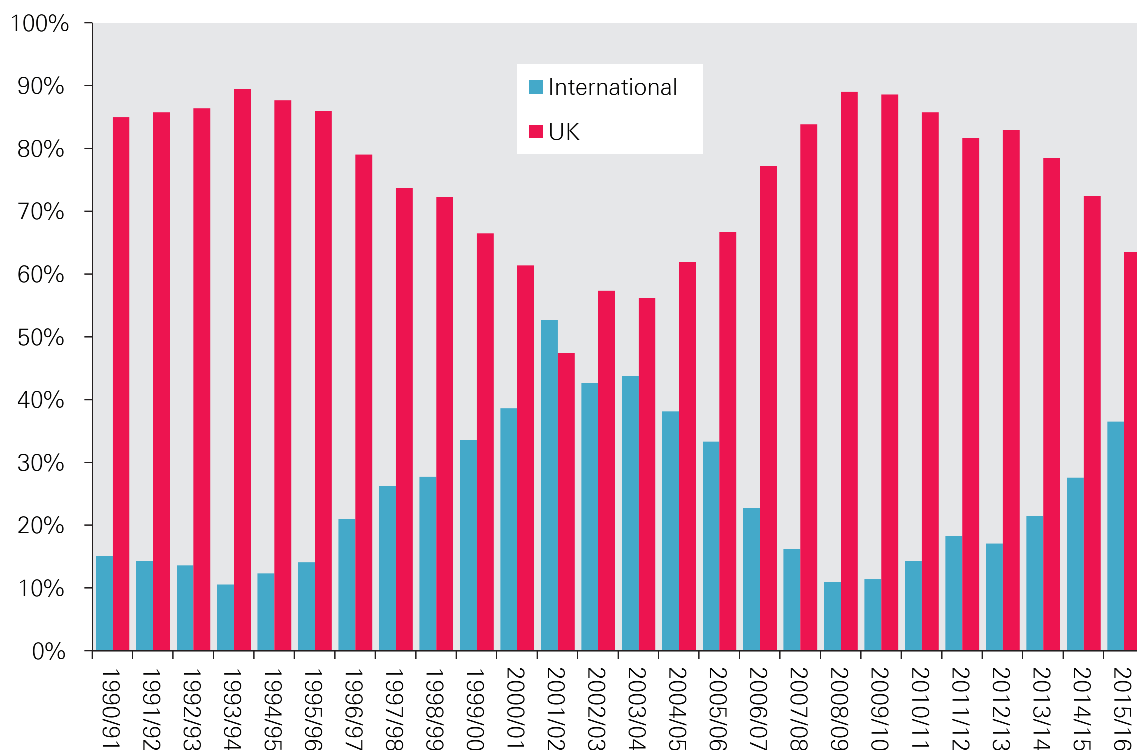
* See: www.health.org.uk/publication/staffing-matters-funding-counts.

non-EU nurses, who are reportedly often more experienced, and have lower turnover rates than EU nurses (because they are employed on immigration permits which restrict their internal mobility). The MAC report gave an example of one NHS trust in England that had recruited nurses in India in 2001–02, 78% of whom were still employed in the trust in 2015.[2]

While there is no standardised data publically available on turnover rates of EU nurses, one report in February 2015 analysed trust-level data and suggested that turnover of EU-recruited nurses was on average about twice the national average rate, and that some trusts had lost all or the vast majority of nurses recruited from EU countries within one year.[6] At least part of this high turnover is accounted for by rapid job moves by these nurses within the NHS.

To develop a better understanding of the level of reliance on international recruitment, it is important to compare the relative level of inflow from other countries (and the pattern of source countries) with the level of 'new' flows from education in the UK, as shown in figure IR1. This shows the percentage of nurses entering the UK register annually, from UK and international sources. It is one indicator of workforce 'self-sufficiency' – the higher the proportion of international nurses, the less self-sufficient was the UK in meeting its nursing requirements in that year. The level of reliance on international nurses has varied from a high of just over 50%, in 2001/02, to lower annual levels around 10%. Since 2008/09 the proportion of new admissions from international sources has increased year on year, reaching more than one in three in 2015/16.

Figure IR1: International and UK sources as a percentage of total new admissions to the UK nursing register, 1990/1–2014/15 (initial registrations)



Source: UKCC/NMC data, the authors.

The peak levels of reliance on international nurses were seen between 2000 and 2004. This reflected a time of national policy led active international recruitment, when the NHS, notably in England, was recruiting doctors and nurses from a range of countries to meet NHS staffing growth targets. The Health Committee review of NHS Workforce Planning in 2007 quoted the then Director of Workforce at the Department of Health as saying: 'If I go back to 2001–2002 when we were tasked with these massive increases in the NHS workforce… we knew that we did not have enough input of nurses and doctors [from domestic sources] to deliver the capacity that was required to achieve the main objectives of improving access. Thus we set up the international recruitment programme. The growth in international recruitment between 1999 and 2005 was considerable.'[7]

There followed an equally rapid decline in international inflow over the period 2005–10. This was a result of a decrease in demand for international nurses, tightened immigration policies that applied to non-EU nurses, and more costly application requirements being implemented by the NMC for non-EU international nurses. The same Health Committee report stressed that 'the rapid expansion of the workforce after 1999 was achieved mainly through a combination of increased international recruitment and increased UK training capacity. However, international recruitment expanded so quickly that there was a shortage of opportunities for UK-trained staff once output increased after 2004. There was a clear lack of alignment between the two approaches to increasing staff numbers'.[7]

The same Health Committee recommended that the Department of Health 'must play a more effective role in overseeing active international recruitment by the NHS. In view of the boom and bust in international recruitment… the Department of Health needs to work more effectively with other departments, notably the Home Office, to ensure that international recruitment is fair and consistent' and to 'ensure that future international recruitment is both ethical and better managed, taking account of the number of clinicians qualifying in the UK'.[7] Very similar points have been made more recently by the reports of the National Audit Office (NAO) and the MAC.

It is notable that the inflow of international nurses in 2015/16 is almost back up to the proportionate contribution evident in the early 2000s. The size and relative contribution of the international health workforce in the UK means it cannot be ignored. The relative inflow from other countries has varied across time, and the mix of source countries has also changed, which points to the need for effective monitoring of flows in order to assess immediate and longer-term risks of high or changing reliance on inflows (or effect of outflows). Inflow from non-EU countries is more susceptible to control than that from the EU. The magnitude of the inflow also argues for coordinated national policy to ensure that any flows that do occur are assessed, and where feasible adjusted, to assist in achieving a better supply–demand balance.

International recruitment: Conclusions

International recruitment has been an ever-present component of the health workforce policy terrain over the lifetime of the NHS. Its prominence has fluctuated, and it has not been well aligned with domestic health workforce policies. But, it has remained an attractive option because it is a relatively quick, and inexpensive, fix for employers.

Training costs and time lag are not part of the international recruitment option – but must be considered in the domestic training option. When there is immediate pressure to recruit to fill vacancies, UK employers' thoughts turn abroad.

The UK is much more reliant on international doctors and nurses than most other OECD countries. About one in three doctors and one in eight nurses in the UK were trained in another country. The 'flow' data examined has highlighted that the total annual number of international nurses (EU and non-EU) entering the UK has varied across time – between 10% and 50% of annual totals.

This variation reflects the changing level of demand for nurses in the UK. As the MAC noted, if international recruitment was not an option, UK employers would be forced to become more effective in utilising the other policy options of domestic recruitment, retention and workforce productivity.

The suggestion by the MAC that there be a pre-determined annual cap for the number of nurses recruited internationally from non-EU countries could be used as a means of containing that inflow, and a 'tapered' cap would give employers more time to develop alternative approaches. EU flows, which cannot be controlled, may increase as a result, although the recent vote for the UK to leave the EU is likely to affect this.

There is a role for government in monitoring and moderating this process, and maintaining a consistent national approach. This mandate has not been fulfilled clearly in recent years, because of policy disconnect and mixed messages from different government departments. What is required is a nationally led approach which focuses on achieving overall health workforce sustainability, and which integrates any nationally led international recruitment approach in overall health workforce planning and policy.

This means focusing on improving health workforce sustainability, which requires coordinated domestic policies and approaches on health workforce intelligence and planning; adapting the current workforce; improving regional recruitment, retention, distribution, and productivity. These 'domestic' policies must be aligned with policies aimed at making any international recruitment efficient, through effective recruitment and integration of foreign-trained/born professionals.[8] Another priority should be 'ethical' international recruitment – meeting the requirements both of the Department of Health's own Code on international recruitment,[9] and the WHO global code,[10] to avoid active recruitment from designated low income countries. In particular, the Department of Health and other government departments will have to give heed to milestone set out in the Global strategy on human resources for health,[11] adopted by the UK and all other member states in May 2016, that 'By 2030, all countries will have made progress towards halving their dependency on foreign-trained health professionals…'. However, the recent trend, for nurses at least, is for growing dependency in England, rather than reduced dependency.

The simple answer to the question 'Is international recruitment a viable long term solution for the NHS?' is 'yes'. There is no shortage of qualified staff available to recruit in other countries, no lack of specialist recruitment agencies ready to facilitate the process, and, currently, no absence of UK employers anxious to recruit.

But the question should be re-framed as 'Can international recruitment be an integral element of a comprehensive approach to achieving long-term workforce sustainability?'.

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