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Migration of Health Workers: The UK Perspective to 2006

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SUMMARY

The UK has a population of 56 million, and most healthcare is delivered through the National Health Service (NHS). The NHS employs more than one million staff.

In the late 1990s shortages of skilled staff were a main obstacle to improving services in the NHS. The response by government was to "grow" the NHS workforce. There are four main policy options to "grow" the workforce- increase home based training; improve retention rates of current staff (to reduce need to recruit additional staff); improve "return" of staff currently not practising; and internationally recruit health professionals.

International recruitment was used to achieve rapid growth in the NHS workforce. It was facilitated by fast tracking work permits for health professionals, by targeting recruits in specified countries, using specialist recruitment agencies, and by co-ordinating local level recruitment within the NHS.

NHS international recruitment was also underpinned by a Code of Practice. One key point of the Code is that developing countries should not be targeted for active recruitment by the NHS, unless the government of that country formally agrees.

Whilst the period from 1999 to 2005 was one of unprecedented staffing growth for the NHS in England, from 2005 onwards, this growth in staff numbers came rapidly to an end.

Financial deficits emerged in the NHS from 2004-05 onwards, which the UK Parliament Health Committee attributed, in part at least, to the costs of workforce expansion, and costs of new pay contracts for NHS staff.

There have been subsequent changes in the UK migration policy, which also have impacted international recruitment. Medicine, nursing and other health professions are no longer classed as 'shortage' professions. This has lead inevitably to a significant reduction in the inflow of international clinicians to the UK NHS.

The UK situation highlighted the potential for the use of a policy of large scale international recruitment in order to meet staffing growth requirements. Key recommendations from the case study include:

- Migration should only be examined within the overall workforce planning mechanism in use at national level.
- Migration should not be used in isolation, or regarded as a cheap option, with "expendable" migrant health professionals.
- The role of recruitment agencies should be monitored or regulated.
- Bilateral agreements may be an effective way of managing the migration process between a source and destination country.

- A country level code, in a country where most employers and recruitment agencies are bound by the code, can be of some effect in managing the process of recruitment in an "ethical" and efficient way.

- There needs to be more effective monitoring of flows of health workers if a multinational code is to be implemented with any effect.

- In relation to active international recruitment, the recent evidence from England would suggest it can be an effective mechanism for rapidly scaling up the workforce- but that the very rapid pace requires careful monitoring if it is not to overshoot any planned targets for growth.

- Active international recruitment must also be carefully integrated within the overall workforce planning approach, so as to be fully effective.

RÉSUMÉ

Le Royaume-Uni compte 56 millions d'habitants, et en matière de santé, la plupart des prestations y sont fournies par le biais du *National Health Service* (NHS). Le NHS emploie plus d'un million d'agents.

A la fin des années 90, un des principaux obstacles à l'amélioration du NHS était la pénurie de personnel qualifié. La réponse du gouvernement a consisté à « étoffer » les effectifs du NHS. Pour ce faire, les pouvoirs publics disposent de quatre grands moyens d'action possibles : développer la formation dispensée dans le pays même, améliorer le taux de maintien des agents en poste (ce qui permet de diminuer les besoins en recrutement de nouveaux agents), convaincre les agents ayant cessé d'exercer pour le moment de « reprendre du service », et recruter des professionnels de la santé à l'international.

Soucieux d'étoffer rapidement ses effectifs, le NHS a eu recours au recrutement à l'international. L'opération a été facilitée par l'application de la procédure de traitement accéléré des demandes de permis de travail pour les professionnels de la santé, par le ciblage des personnes à recruter dans des pays précis (en faisant appel à des agences de recrutement spécialisées), et par la coordination du recrutement au niveau local au sein du NHS.

Ce recrutement à l'international prenait également appui sur un Code de bonnes pratiques. L'un des points clés de ce Code est l'interdiction faite au NHS de cibler les pays en développement dans sa politique de recrutement actif sauf accord formel du gouvernement du pays considéré.

Même si, entre 1999 et 2005, en Angleterre, le NHS a vu ses effectifs augmenter dans des proportions sans précédent, à partir de 2005 cette progression s'est très vite ralentie et a finalement cessé.

A partir de l'exercice 2004-2005, apparaissent au sein du NHS des déficits financiers que la Commission de la santé du Parlement britannique impute, du moins en partie, au coût du renforcement des effectifs et au coût découlant des nouvelles clauses de rémunération figurant dans les contrats des agents du Service.

Par la suite, la politique migratoire britannique a subi des modifications qui ont également eu un impact sur le recrutement à l'international. Désormais, la médecine, les soins infirmiers et les autres professions de la santé ne sont plus classés parmi les métiers « en tension », ce qui aboutira inévitablement à une réduction significative de l'afflux de cliniciens étrangers dans le NHS britannique.

L'expérience du Royaume-Uni a mis en évidence les possibilités offertes par le recours à une politique de recrutement à l'international de grande ampleur pour répondre aux besoins quand il s'agit d'étoffer des effectifs. Les principales recommandations de l'étude de cas sont les suivantes :

- L'immigration ne devrait être examinée que dans le cadre du mécanisme global de planification des effectifs utilisé au niveau national ;

- L'immigration ne devrait pas être utilisée isolément, ni être envisagée comme une solution « au rabais », ce qui reviendrait à considérer les professionnels de la santé issus de l'immigration comme des « produits consommables » ;

- Il conviendrait de surveiller ou de réglementer l'activité des agences de recrutement ;

- Les accords bilatéraux peuvent constituer un moyen de gérer effectivement le processus migratoire entre un pays d'origine et un pays de destination ;

- Dans un pays où la plupart des employeurs et des agences de recrutement sont tenus de se conformer à un code de bonnes pratiques applicable à l'échelle nationale, il devient dans une certaine mesure possible de gérer le processus de recrutement dans un souci d'éthique et d'efficience ;

- Pour avoir quelques chances de voir la mise en œuvre d'un code international suivie d'effets, il importe de surveiller de manière plus effective les flux de travailleurs de la santé ;

- S'agissant du mécanisme de recrutement actif à l'international, les observations faites récemment en Angleterre amènent à conclure à son efficacité quand on cherche à étoffer rapidement des effectifs, mais l'extrême rapidité du processus exige un suivi attentif afin de ne pas dépasser les objectifs de croissance que l'on s'est éventuellement fixés ;

- Pour être pleinement efficace, le processus de recrutement actif à l'international doit aussi être intégré avec soin dans la stratégie globale de planification des effectifs.

1. HUMAN RESOURCES FOR HEALTH IN THE UK

1. This chapter provides a background and introduction, by highlighting key characteristics of the UK (mainly England) health workforce, and by identifying significant policies.

The UK context

2. The main focus of the paper is on England, the largest of the UK countries. Since political devolution in 1998, the other three UK countries; Northern Ireland, Wales and Scotland, have responsibility for health policy. Whilst there are health policy variations and policy divergence in the four countries, all health professionals are registered at a UK level, and most aspects of HR policy are similar across the UK.

3. The UK has a population of about 56 million, and most healthcare is organised and delivered through the National Health Service (NHS). The UK NHS is funded from taxation and free at the point of delivery. As with any health care system, the NHS is a labour-intensive service industry. The NHS workforce is large, with more than one million mainly unionised staff working in several hundred hospital and primary care units. There is some private sector health provision, mainly in care homes and nursing homes, with a small independent acute sector that provides elective care.

4. Shortages of skilled staff have been highlighted as some of the main obstacles to achieving planned reform and growth of services in the NHS. The Wanless report, which reviewed NHS funding, stressed that "the UK does not have enough doctors and nurses…" (Wanless, 2002). The response by UK government was an explicit commitment to "grow" the NHS workforce, made highly visible by establishing specific staffing growth targets, such as the target set in the year 2000 for "20 000 more qualified nurses by 2004". The HR element of the NHS Plan were set out in a national NHS HR strategy 'HR in the NHS: More Staff, Working Differently' (Department of Health, 2002).

5. The main driver for NHS reform has been the NHS Plan, and within it, there has been a commitment to increase NHS staffing. This was set out in a series of specific targets (see box below). Most of these targets (particularly those for nurses) were met or exceeded. In fact, the extent of overshoot of some of the staffing growth targets in the period since the NHS Plan has been highlighted as a contributory factor in financial difficulties that impacted on some NHS trusts in England in 2006 (House of Commons, Health Committee, 2007).

Box 1. NHS Plan Targets (England)

The NHS Plan set targets for staff increase by 2004:

- 7 500 more consultants and 2 000 more GP's
- 20 000 extra nurses
- (2000 more midwives by 2005)
- 6 500 extra therapists
- 5 500 more nurses and midwives trained each year
- 1 000 more medical school places (in addition to the 1 100 already announced) (by 2005)
- 550 more GP registrars and 1 000 more specialist registrars

Source: Department of Health, 2005 ?

6. As a result of this policy impetus, and with increased availability in NHS funding, there has been growth in the numbers employed in the National Health Service. Whilst the UK population has also grown over the period, the rate of growth in NHS employment has been higher, and the staff to population ratio has therefore increased.

7. Between 1999 and 2005, the NHS workforce increased by 260 000, an increase in workforce size of more than 24%. Expansion was at its quickest in the period immediately after the publication of the NHS Plan (2000), as shown below.

Table 1: NHS Workforce growth 1999/2005

Year	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Total NHS workforce (headcount, 000s)	1 098	1 118	1 166	1 224	1 283	1 331	1 365
% increase	2.5	1.8	4.4	4.9	4.8	3.7	2.6

Source Health Committee report, 2007, para. 24

8. Staffing growth was not evenly distributed across different staff groups in the health service. The Health Committee report published in 2007 reported that growth was fastest amongst management staff (62%) and 'central functions' staff, which includes finance, Human Resources and IT (43%). Growth was considerably slower amongst nursing staff (23%), although an additional 75 000 nurses were employed during this period. The number of hospital consultants grew more than twice as quickly as the number of General Practitioners (see Table2).

Table 2: NHS workforce growth, 1999-2005, by main occupation

Staff Group	Total (1999)	Total (2005)	% Increase (1999-2005)
All	1 098 348	1 366 030	24.4%
Doctors (all)	94 953	122 987	29.5%
Consultants	23 321	31 993	37.2%
GPs	29 987	35 302	17.7%
Nurses	329 637	404 161	22.6%
Allied health professionals	47 920	61 082	27.5%
Scientific and technical	54 471	73 452	34.8%
Clinical support staff	296 619	376 219	26.8%
Central functions	73 996	105 565	42.7%
Senior management	24 287	39 391	62.2%

Source: Health Committee report, 2007, para. 25.

9. As noted in the Health Committee report, whilst the NHS Plan was a major driver for increases in staffing numbers, the actual rate of growth significantly exceeded targets and projections for most staff groups, because the staffing targets were not based on detailed planning. For example the NHS Plan set a target for increasing nursing numbers by 20 000 between 1999 and 2004. In fact, nursing numbers increased by more than 67 000 during this period. A follow up report, "Delivering the NHS Plan" (2002), set a revised target of 35 000 additional nurses between 2001 and 2008. This target was achieved within two years, rather than the allotted seven. The Health Committee concluded in 2007 that "Given the increase in funding, it was inevitable that the growth in staff numbers would exceed NHS Plan projections". Funding availability and active international recruitment fuelled the increase. Table 3 below provides a fuller comparison of actual staff growth relative to NHS Plan targets.

Table 3: Projected and actual staffing growth, NHS England

Staff Group	Projected new staff: 1999-2004	Actual new staff: 1999-2004	Variance
Consultants	7 500	7 329	3% under target
GPs	2 000	4 098	105% over target
Nurses	20 000	67 878	240% over target
Allied health professionals	6 500	11 039	69% over target

Source: adapted from Health Committee report, 2007, para. 26

10. There has been variable but significant growth across the various clinical occupations in the NHS. Table 4 below reports on long term numbers working as doctors and nurses in the NHS in England, and shows the increase in the available clinicians in relation to population.

Table 4: Number of doctors (specialists and generalists) and nurses (professionals, enrolled,) total and ratio per 1 000 population, over the last 2 decades (England)

Year	Population (thousands)	Doctors	Ratio	Nurses	Ratio
1985	47 057.40	72 101	0.653	U/A	U/A
1986	47 187.60	72 731	0.649	U/A	U/A
1987	47 300.40	73 244	0.646	284 600	0.166
1988	47 412.30	74 560	0.636	290 589	0.163
1989	47 552.70	76 101	0.625	296 937	0.160
1990	47 699.10	77 363	0.617	298 967	0.160
1991	47 875.00	78 170	0.612	321 926	0.149
1992	47 998.00	79 232	0.606	323 795	0.148
1993	48 102.30	80 738	0.596	319 325	0.151
1994	48 228.80	81 319	0.593	313 240	0.154
1995	48 383.50	84 459	0.573	316 893	0.153
1996	48 519.10	86 584	0.560	319 151	0.152
1997	48 664.80	89 619	0.543	318 856	0.153
1998	48 820.60	91 837	0.532	323 457	0.151
1999	49 032.90	93 981	0.522	329 637	0.149
2000	49 233.30	96 319	0.511	335 952	0.147
2001	49 449.70	99 169	0.499	350 381	0.141
2002	49 646.90	103 350	0.480	367 520	0.135
2003	49 855.70	108 993	0.457	386 359	0.129
2004	50 093.10	117 036	0.428	397 515	0.126
2005	50 431.70	122 345	0.412	404 161	0.125

Source: Department of Health (http://www.dh.gov.uk).

Gender mix

11. The gender composition in NHS doctors has changed over the decades, with some shift towards a higher proportion of females (see Table 5). In 1996, 34% of all medical and dental staff in England was female; in 2005, 37% was female. The proportion of consultants who were female had risen from 20 % to 26%.

Table 5. Number of doctors and dentists by gender (Male-M, and Female-F): all grades, and selected main grades (1996 and 2005)

	1996			2005		
	M	F	F as % of total	M	F	F as a % of total
Consultants	16 334	4 068	20	23 640	8 353	26
Registrars	7 593	3 792	33	10 916	7 090	39
Senior House Officer	8 403	5 810	41	12 215	9 427	44
ALL GRADES	42 366	21 847	34	56 992	33 638	37

Source: NHS Information Centre.

12. In nursing, about nine out of every ten NHS nurses is female (Table 6). This ratio has changed little over time. In keeping with many other developed countries, the NHS nursing workforce has been

ageing in recent years, as a result of large intakes to training in the 1970's and early 1980's, and because of an increase in the age of nursing students (Table 7).

Table 6. Number of qualified nursing, midwifery and health visiting staff by gender (Sept, 2005)

Gender	1995	2005
Male	29 689	37 820
Female	268 961	306 857
Unknown	-	36 580
Total	**298 650**	**381 257**

Source: NHS Information Centre (http://www.ic.nhs.uk/pubs/nhsstaff/nonmeddetailedpdf/file, Table 3.1).

Table 7. Number of qualified nursing, midwifery and health visiting staff by age (Sept, 2005)

Age Band (Years)	1995	2005
Under 25	15 663	11 268
25-29	42 650	36 309
30-34	55 605	51 120
35-39	46 237	55 151
40-44	36 826	64 059
45-49	35 519	55 205
50-54	24 716	38 228
55-59	14 385	24 885
60-64	4 228	7 388
65 & Over	314	1 064
Unknown	22 507	36 580
Total	**298 650**	**381 257**

Source: NHS Information Centre (http://www.ic.nhs.uk/pubs/nhsstaff/nonmeddetailedpdf/file, Table 4.1)

Country of qualification

13. The data on numbers of medical staff by grade and main country of qualification is shown in Table 8. Of the 86 660 medical staff in NHS employment in England in 2005, 53 494 were UK trained- in other words 62% were UK trained and 38% were either trained elsewhere- in the European Economic Area (6%) or elsewhere in the world (32%).Three quarters (74%) of hospital consultants were UK trained. In percentage terms, non UK doctors were most prominent in associate specialist and staff grade posts.

Table 8. Number of doctors (specialists and generalists) by country of qualification, 2005, NHS England (rounded percent in brackets)

	All countries	UK	Rest of EEA	Elsewhere
All Staff	86 660	53 494 (62)	5 212 (6)	27 954 (32)
Consultant	31 246	23 057 (74)	2 048 (7)	6 141 (20)
Registrar Group	17 657	9 992 (57)	1 200 (7)	6 465 (37)
Senior House Officer	21 109	11 002 (52)	959 (5)	9 148 (43)
House Officer & Foundation Programme Year 1	4 635	3 889 (84)	185 (4)	561 (12)
Associate Specialist	2 450	873 (36)	127 (5)	1 450 (59)
Staff Grade	5 327	1 469 (28)	480 (9)	3 378 (63)
Hospital Practitioner/Clinical Assistant	3 587	2 773 (77)	171 (5)	643 (18)
Other Medical Staff	649	439 (68)	42 (6)	168 (21)

Source: Department of Health (http://www.dh.gov.uk)

Geographical distribution

14. The NHS in England is currently divided into 10 administrative regions. Table 9 shows the regional distribution of medical and dental staff and of qualified nurses, midwives and health visiting staff.

Table 9. Number of HCHS medical & dental staff and qualified nursing, midwifery & health visiting staff by regional distribution, 2005, NHS England (% in brackets)

Region	No. of HCHS Medical & Dental Staff	No. of Qualified Nursing, Midwifery & Health Visiting Staff
North East	4 928 (5)	22,291 (6)
North West	12 564 (14)	57,753 (15)
Yorkshire & The Humber	9 128 (10)	38,365 (10)
East Midlands	6 307 (7)	28,152 (7)
West Midlands	9 227 (10)	40,800 (11)
East of England	7 790 (9)	35,327 (9)
London	19 330 (21)	66,240 (17)
South East	12 661 (14)	53,175 (14)
South West	8 512 (9)	36,542 (10)
Special Health Authorities	183 (-)	2,612 (-)
England	90 630	381,257

Source: NHS Information Centre (http://www.ic.nhs.uk/pubs/nhsstaff/nonmeddetailedpdf/file), Tables 2.2a and 3.

Funding of UK Health care

15. Table 10 presents data on UK expenditure on the NHS and other health expenditure since 1973. The rapid growth in real expenditure on the NHS since 2000 is highlighted in the table, which shows the increase in expenditure as a % of GDP. The UK level of expenditure has moved towards the European average, which was a key pronouncement made by the Prime Minister..

Table 10. Data on growth of real health expenditure per capita, over the past 2 decades

UK health expenditure					Health care per capita		UK health care as % of GDP[5]		
Calendar year	NHS[1]	Private health care[2]	Other medical products[3]	Total	Cash £	Constant prices[4]	NHS	Private and other	Total
	£m	£m	£m	£m		1973=100			
1973	2 956	102	208	3 266	58	100	4.0	0.4	4.4
1974	3 835	120	235	4 190	75	112	4.6	0.4	5.0
1975	5 126	134	276	5 536	98	116	4.8	0.4	5.2
1976	6 054	166	313	6 533	116	119	4.8	0.4	5.2
1977	6 734	205	349	7 288	130	117	4.6	0.4	5.0
1978	7 600	231	403	8 234	147	118	4.5	0.4	4.9
1979	8 855	263	502	9 620	171	121	4.5	0.4	4.9
1980	11 257	355	615	12 227	217	129	4.9	0.4	5.3
1981	12 936	463	689	14 088	250	133	5.1	0.5	5.6
1982	14 106	593	787	15 486	275	136	5.1	0.5	5.6
1983	15 134	672	904	16 710	297	139	5.0	0.5	5.5
1984	16 080	623	1 080	17 783	315	142	5.0	0.5	5.5
1985	17 154	738	1 190	19 082	337	144	4.8	0.5	5.4
1986	18 595	846	1 364	20 805	367	152	4.9	0.6	5.5
1987	20 406	1 066	1 433	22 905	403	159	4.9	0.6	5.5
1988	23 646	1 246	1 595	26 487	465	173	5.0	0.6	5.7
1989	25 690	1 353	1 786	28 829	505	175	5.0	0.6	5.6
1990	28 426	1 623	1 919	31 968	559	181	5.1	0.6	5.7
1991	32 078	1 969	2 299	36 346	633	192	5.5	0.7	6.2
1992	35 436	2 015	2 731	40 182	698	205	5.8	0.8	6.6
1993	37 231	2 138	2 954	42 323	734	210	5.8	0.8	6.6
1994	39 715	2 391	3 794	45 900	794	224	5.8	0.9	6.7
1995	41 853	2 808	3 919	48 580	839	231	5.8	0.9	6.8
1996	43 522	3 335	4 199	51 056	880	235	5.7	1.0	6.7
1997	45 660	3 611	4 377	53 648	922	240	5.6	1.0	6.6
1998	48 138	4 109	4 692	56 939	977	248	5.6	1.0	6.6
1999	52 264	4 462	4 992	61 718	1 055	263	5.8	1.0	6.8
2000	57 067	4 927	5 265	67 259	1 147	282	6.0	1.1	7.1
2001	62 892	5 103	5 772	73 767	1 249	302	6.3	1.1	7.4
2002	70 196	5 453	6 026	81 675	*1 379*	*324*	*6.7*	*1.1*	*7.8*
2003e	*78 636*	*5 635*	*7 161*	*91 432*	*1 539*	*352*	*7.2*	*1.2*	*8.3*
2004e	*85 402*	*5 951*	*7 249*	*98 602*	*1 654*	371	7.3	1.1	8.5

Notes: e = OHE estimates

1. Including charges paid by patients.
2. Consumer expenditure on private medical insurance (PMI) and private medical treatment.
3. Figures relate to consumer expenditure on medical goods including medicines not purchased on NHS prescription, and expenditure on therapeutic equipment such as spectacles, contact lenses and hearing aids.
4. Figures have been adjusted by the GDP deflator at market prices and hence may include relative price effects.
5. Gross Domest*ic Produc*t at market prices.

Source: Office of Health Economics, Consumer Trends (ONS), Annual Abstract of Statistics (ONS), Economic Trends (ONS), The Government's Expenditure Plans (DH), Laing's Healthcare Market Review (Laing and Buisson).

Major policy priorities in UK healthcare

16. In England, and elsewhere in the UK, the NHS has continued to be the main source of acute care delivery. However policy priorities in recent years in all four UK countries have been to shift more NHS care to primary care and community based care. In England, more so than the other three UK countries, there has also been a shift towards a "purchaser/ provider" type of system; this has led to the growth of a more mixed economy of provider organisations, including foreign owned independent treatment centres, voluntary sector providers, etc.

17. In terms of impact on workforce policy and deployment, the main recent policy developments have been staffing growth, as noted above, a focus on supporting new ways of working (often based on care protocols and patient pathways), the introduction of new roles (such as nurse practitioners and advanced nurses, partly as a result of the impact of the European Working Time Directive reducing the availability of junior doctors hours) (*www.wise.nhs.uk*, 2007) and new pay contracts for NHS medical consultants, GPs, and a pay/competency career structure for other staff, the latter named the "Agenda for Change" initiative (NHS Employers, 2006), with an associated Knowledge and Skills Framework - KSF(Department of Health, 2004).

New roles and ways of working

18. New ways of working were supported by funding and technical support by the NHS Modernisation Agency (MA), which set up the "Changing Workforce Programme" (CWP) in 2001. The Changing Workforce Programme (CWP) was launched in 2001 with the aim of co-ordinating and overseeing the introduction of a number of new and amended clinical roles within the NHS. The CWP was hosted by the MA and managed a range of projects aiming to increase the flexibility of the health service workforce by training staff to take on additional responsibilities on top of, or in place of, their traditional work. In particular, the CWP aimed to introduce Assistant Practitioner roles (immediately below professional level) and Advanced Practitioner roles (allowing existing professionals to take on a range of additional responsibilities). Following the closure of the MA in 2005, a small part of the work of the CWP has been continued by the National Practitioner Programme (NPP). Since 2001, the CWP and NPP have overseen the introduction of new roles across a range of service areas including emergency care, critical care and in operating theatres. Examples of new roles include Surgical Care Practitioners, Endoscopy Technicians and community Emergency Care Practitioners, of which more than 700 are now working in the NHS.

19. Nurses in particular have taken on a range of advanced roles, for example in epilepsy, diabetes and emergency care. Research by the Royal College of Nursing shows that the number of nurses in advanced roles increased significantly from 2001 onwards (Royal College of Nursing, 2005). Nurses in advanced roles have been widely used in response to the challenges presented by the 2004 European Working Time Directive regulations. Extended roles have also been introduced within a number of other health professions, notably for physiotherapists in Accident and Emergency departments, and for radiographers in image reporting (House of Commons, Health Committee, 2007). Local differences between job titles and grades, and the fact that many of these new jobs and roles are not based on a registerable qualification, mean that it is difficult to assess their number4s and distribution. In evidence to the Health committee in 2007 Department of Health told the Committee that, in total, more than 100 new and extended clinical roles have been introduced in recent years (House of Commons, Health Committee, 2007).

20. The European Working Time Directive 93/104/EC, which restricts employees to 48 working hours per week, came into effect in the UK in October 1998. In August 2004, the directive was extended to cover doctors in training, who were limited to working no more than 58 hours per week. This will be

further extended in 2009 to reduce doctors in training to working a maximum of 48 hours per week. These changes are having a significant effect on workforce capacity, as junior doctors in the NHS in England have traditionally worked considerably more than 58 hours per week. The 2004 EWTD changes also stipulated that on-call time should be counted as part of doctors' working hours. As a result, the resident on-call system, whereby NHS junior doctors stayed overnight in hospital but were available for work, was replaced by more rigid shift working. These changes have had a significant "knock on" effect on non-medical staff; nursing staff, for example, have often been required to take on additional responsibilities in response to reductions in junior doctor capacity. In 2007 the Health Committee noted that "Thus the European Working Time Directive regulations have been an important reason for the introduction of new ways of working, and particularly the redesign of clinical roles" (House of Commons, Health Committee, 2007).

New pay contracts for NHS staff

21. The new pay contracts for consultants and for GPs have been criticised for being under-costed, and delivering significant pay increases without a simultaneous improvement in working practices or productivity (although these "benefits realisation" opportunities are highlighted as the main rationale for the new pay contracts, and continue to be anticipated) (House of Commons, Health Committee, 2007; Williams and Buchan, 2006). The National Audit Office published a review of the implementation of the consultants' contract in April 2007; it concluded: "We conclude that the contract is not yet delivering the full value for money to the NHS and patients that was expected from it although the Department believe that it is too early to judge this. The contract has helped to align consultants' pay levels with their contribution to the NHS. Some consultants are actually working the same if not fewer hours for more money. Whilst this may be in line with the Department's objective to reward consultants more appropriately for their NHS work, our survey showed that consultants' morale has been reduced in the process of implementing the contract. There is little evidence that ways of working have been changed as a result of the new contract and, although most consultants now have job plans, few trusts have used job planning as a lever for improving participation or productivity" (National Audit Office, 2007).

22. Two main characteristics of the NHS workforce in the period since 1999 have been staffing growth, and increase in pay for many groups; changes in working patterns and productivity are less easy to define and assess (House of Commons, Health Committee, 2007). Table 11 shows growth in the NHS medical paybill, and growth in average earnings for medical staff, as calculated by the Office of Manpower Economics, which acts as the secretariat to the pay Review Bodies for NHS medical and nursing staff.

Table 11. Office of Manpower Economics estimates on NHS medical staff earnings

	2001/02	2002/03	2003/04	*2004/05*	*2005/06*	*2006/07 (0%)*	*2006/07 (1%)*	*2006/07 (1.5%)*	*2006/07 (2%)*	*2006/07 (2.5%)*
1.1 Medical Paybill (£ billion)	4.589	5.161	6.142	*6.370*	*6.891*	*7.267*	*7.339*	*7.374*	*7.410*	*7.446*
1.2 Medical Paybill Per Head (£)	71636	75604	85000	*90146*	*95413*	*98871*	*99845*	*100332*	*100819*	*101307*
1.3 Medical Earnings Per Head (£)	60249	63640	70952	*75247*	*79644*	*82530*	*83343*	*83750*	*84156*	*84563*

Source: Office of Manpower Economics.

23. Private sector earnings of doctors are not easily obtainable. Much private sector practice is conducted by NHS doctors in their own time, so represents earnings above that which they earn in the NHS. From a British Medical Association survey of consultants in 2005, those reporting at least some level of involvement of private practice (i.e. in the majority of cases, this was *not* their sole source of income) earned a median of £30 000 and a mean of £53 955 in private practice. (Source: BMA personal communication

24. Additional information on pay rates for selected NHS staff categories is shown in Table 12, which provides information from the Doctors and Dentists Review Body (DDRB) and Nurses and Other Health Professionals Review Body (NOHPRB), and show estimates of percentage increases in pay over the period since 1992, and actual pay rates for house officers (junior doctors); grade C nurse (usually an enrolled nurse); grade D nurse (registered nurse- staff nurse), and basic grade allied health professional (e.g. a physiotherapist).

Table 12. Percentage increases in basic pay: NHS occupations, 1992/03 to 2006/07

	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	0/03	03/04	04/05	05/06	06/07
House Officer	5.5	1.5	3	2.5	3.8	3.4	4.2	3.5	3.3	3.9	3.6	3.225	2.7	3	2.2
Nurse (Grade C)	5.8	1.5	3	1	4	4.1	3.8	4.7	3.4	3.7	3.6	3.225	3.225	3.225	2.5
Nurse (Grade D)	5.8	1.5	3	1	4	4.1	3.8	4.7	3.4	3.7	3.6	3.225	3.225	3.225	2.5
AHP Basic Grade Therapist	6.4	1.5	3	1	4	4.1	3.8	4.7	3.4	3.7	3.6	3.225	3.225	3.225	2.5

Source: Office of Manpower Economics.

Shortages and maldistribution

25. Shortages of doctors, nurses and other health professionals were identified as a major constraint to achieving the objectives of the NHS Plan (see also the Wanless review for longer term assessment of staffing requirements) (Department of Health, 2001; Wanless, 2002), and as such, there has been much emphasis on achieving staffing growth in the period since the late 1990's. In general the level of shortages reported in the NHS has dropped off in recent years since the staffing growth actions have been implemented. This has been highlighted in the annual surveys of NHS employers conducted by the Office of Manpower Economics, and by NHS vacancy data.

26. Vacancy data can give some indication of the inability of the organisation to fill a post. The NHS in England reports "three month" vacancies- i.e. posts that have remained unfilled for three months or more. The most recent vacancy data available is for March 2006 in the NHS in England, and coincides with the period when financial difficulties were impacting on staffing in the NHS. Funded but unfilled posts that are recorded as vacant may give some indication of the number of jobs that are "hard to fill" because of staffing movement or shortages. However posts may be deliberately held vacant to contain staffing costs, as is happening in some NHS trusts in England where there are financial difficulties (Dinsdale and Duffin, 2005). The Review Body has noted the various limitations with the vacancy date and has suggested that "It is therefore more useful to focus on trends rather than absolute levels" (Office of Manpower Economics, 2006).

Table 13. Three-month vacancy rates for doctors/dentists by geographic distribution, 2006, NHS

Total England	1.8%
North East Total	2.3%
North West Total	2.5%
Yorkshire and the Humber Total	3.0%
East Midlands Total	1.7%
West Midlands Total	1.3%
East Of England Total	2.2%
London Total	1.8%
South Central Total	0.7%
South East Coast	1.1%
South West Total	0.9%

Source: NHS Vacancy Survey 2006

Table 14. Three month vacancy rates for registered nurses by geographic distribution, 2006, NHS

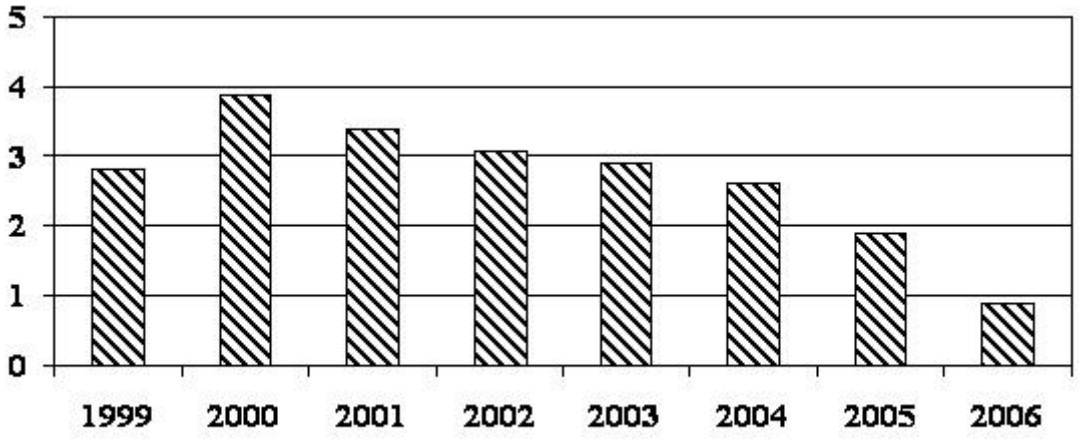
Total England	0.9%
North East Total	0.6%
North West Total	0.4%
Yorkshire and the Humber Total	1.0%
East Midlands Total	0.6%
West Midlands Total	0.2%
East Of England Total	1.4%
London Total	2.0%
South Central Total	1.1%
South East Coast	1.0%
South West Total	0.9%

Source: NHS Vacancy Survey 2006

27. The regional pattern of vacancies does vary; in recent years the regions in London and elsewhere in the South East of England have tended to report higher than average levels of three month vacancies, for non medical staff reflecting higher living costs in these regions.

28. However long term trends in vacancy rates in England appear to have been declining in recent years. Data on vacancies for qualified nursing staff (see Figure below), highlights that three month vacancies as having dropped year on year since 2000. The reported rate was 0.9% in 2006, down from more than 3% at the beginning of the decade.

Figure 1. 3-month vacancy rates: qualified nurses, NHS England (% at March 31st)



Source: Department of Health, 1999-2005; IC 2006.

29. Other surveys have reported higher vacancy rates- suggesting that the one- point- in- the –year survey conducted by the Department of Health may be helpful for trend data but may underestimate actual vacancy rates. In 2005, the Healthcare Commission study on ward staffing reported vacancy rates at ward level in medical care, critical care, surgery and paediatrics of 8%- 9%, with higher rates reported in London and the South East (Healthcare Commission, 2005a). Similar findings were reported by the Healthcare Commission report on Accident and Emergency Services, which highlighted overall nurse vacancy rates of 8-16% (healthcare Commission, 2005b). This was in contrast to the NHS "official" three

month rate of 1.9% at that time. Differences between the two findings are partly related to different definitions- the 3 month rate only records posts vacant for three months or more on the survey date, as opposed to all posts vacant on that date.

The funding difficulties that impacted on some NSH employers since 2005 have led to recruitment freezes and will have acted to suppress the vacancy rates in some organisations. In January 2006, the NHS Confederation, which represents nearly all NHS organisations, reported that those NHS trusts facing financial difficulties were taking a variety of "short term actions" (NHS Confederation):

- 90% are reducing agency staff costs
- 85% have put a freeze on new expenditure
- 82% have imposed a vacancy freeze
- 78% have seen staff reductions
- 52% have temporarily closed wards
- 48% are rescheduling work
- 38% have cancelled services or restricted eligibility for services
- 28% have frozen partnership or other contractual arrangements

30. A survey of 4 000 nurse managers, conducted in March 2006 for the RCN, reported that 45% of hospital based managers identified redundancies or reduction in nursing posts where they worked, in the last twelve months (49% in England, 28% in Northern Ireland, 32% in Scotland and 22% in Wales). The most frequently cited form of staffing reduction was recruitment freeze (reported by 50%), followed by posts cut or establishment reduced (Ball, J., 2006).

31. It is important to note that there is a variable pattern of change occurring, in relation to recruitment and retention of NHS nursing staff. In an interim report base on the responses to a survey carried out in March 2006 for the Review Body (Office of Manpower Economics, 2006), 33% of NHS employers responding to the survey reported that recruitment of nursing staff was "less difficult" over the last 15 months; 53% reported "about the same", and 10% reported "more difficult". Two thirds of NHS employers (65%) also reported that retention of nursing staff was "about the same" as 15 months ago; with one in five (20%) reporting that retention was "less difficult".

32. A focus only on "official" workforce data does not necessarily provide an up to date picture of the impact of recent financial changes. NHS staffing data has until recently been published annually derived from a September census, and normally several months to publish. A new reporting system, based on electronic staff records (ESR) is being introduced, which could speed up the process.

2. MIGRATION AND THE UK HEALTH WORKFORCE: TRENDS AND THE POLICY CONTEXT

33. This chapter examines the role international migration plays and has played in the management of the health workforce in relationship to other types of health workforce policies.

Policy options for staffing growth

34. As noted in the previous chapter, one of the key characteristics of the NHS workforce in recent years has been significant growth in staffing numbers. For any health professional group, there are four main policy options to "grow" the workforce - increase home based training; improve retention rates of current staff (to reduce need to recruit additional staff); improve "return" of staff currently not practising; and internationally recruit health professionals from other countries.

35. The NHS has adopted all four strategies in attempting to achieve staffing growth. It is important to note that the NHS is public sector funded, public sector employment, and training for health professionals is conducted in the public sector, based on public sector funding- so there is considerable scope for government policy intervention. The other three options are considered first in this chapter, before a detailed examination of the approach to international recruitment is examined in detail.

Expansion in domestic training

36. Alongside the increase in overall staff numbers, the NHS Plan set targets for expanding domestic training capacity. This led to rapid growth in the numbers entering initial training for the various health professions, across the period 1999 to 2005, as shown in Table 15 below.

Table 15. Numbers beginning training, various health professions, England, 1999- 2005

Year	1999	2000	2001	2002	2003	2004	2005	% Increase: 1999-2005
Medicine	3 972	4 300	4 713	5 277	6 082	6 294	6 298	58.6%
Dentistry	647	672	672	711	726	722	919	42.0%
Nursing	17 692	18 923	20 610	21 736	22 815	24 069	23 651	33.7%
Physiotherapy	1 473	1 780	2 157	2 345	2 418	2 360	2 360	60.2%
Occupational	1 173	1 385	1 563	1 692	1 822	1 981	2 008	71.2%
Radiography	581	578	690	818	833	860	864	48.7%

Source: Health Committee report, 2007, para. 32.

37. The increase in training capacity in England remained broadly in line with the central targets set out in the NHS Plan (House of Commons, Health Committee, 2007). However there was a long time-lag before these increases in training capacity could be translated into increases in workforce numbers: 2003 at the very earliest and later for most of the health professions, and later still for doctors. Thus, as concluded by the Health Committee in 2007 "the most concentrated period of growth in staff numbers, between 2000 and 2003, cannot be accounted for by the growth in UK training numbers; rather it resulted from international recruitment and other developments" (House of Commons, Health Committee, 2007).

38. In England, the focal points for NHS workforce planning are now the ten Strategic Health Authorities, which have lead responsibility to support assessment of workforce requirements within their geographic areas, in association with NHS employers at trust level (until 2006 there were 28 smaller SHAs; these were merged into larger planning units). Contracts for specified numbers of pre-registration places for medical, nurse and other health profession education are agreed with local education providers (universities *etc.*) on the basis of funding allocated by the Department of Health. A national overview of the likely requirements of numbers in different medical specialities and in other health professions is determined by the national Workforce Review Team (WRT), in consultation with SHA s and other stakeholders. The WRT produces annual recommendations on planning for all the main clinical groups, based on assessments of future recruitment levels, changes in skill mix, etc (*www.healthcareworkforce.nhs.uk/workforce_review_team/wrt_recommendations/2006_recommendations .html*). The process of workforce planning in the NHS in England has gone through several changes in recent years, and the recent UK Parliament Health Committee report on NHS Workforce Planning was critical of the lack of stability and capacity in workforce planning (House of Commons, Health Committee, 2007).

39. It is also important to note that the time lag for home based training- four years for a nurse to enter the workforce, and ten-twenty years for doctors and medical specialists, mean that this option was never likely to meet the short term staffing growth requirements of the NHS at the end of the last decade. This does not mean that the NHS has not invested in increasing home based training- it has, as is shown in the tables below; but it does mean that other interventions- particularly international recruitment, were necessary to achieve the staffing growth targets that were set in the NHS plan.

40. The tables below show the growth in numbers of applicants to, and entrants to, medical and degree based education in the UK (the majority of nurses in the UK are trained on diploma based courses- data is provided later in the report). There has been general growth in both applicants and entrants to these courses in recent years. The main constraint on the numbers of places available is educational capacity and funding from government for the places. In recent years, new medical schools have been opened in England (planned and funded by government) to increase undergraduate medical education capacity.

41. In 2001 the government announced funding for 1 033 more medical students in England. The places were allocated across 14 medical schools. Two new medical schools were to be created as a result of collaborations between Hull and York universities and between Brighton and Sussex. This followed on from the announced creation of another two new medical schools in 2000- at Plymouth and Exeter (the Peninsula Medical School) and at the University of East Anglia. These new schools were designed to meet regional shortages. This brought the number of medical schools in England to 21 (Bligh, 2001).

Table 16. Number of applicants and entrants to pre-clinical medical (allopathic and osteopathic) and nursing degrees in the UK over the past decade

	Pre-Clinical Medical Degrees		Nursing Degrees*	
	Applicants	**Entrants**	**Applicants**	**Entrants**
1996	12 025	4 894	4 302	1 916
1997	12 076	5 029	5 063	2 275
1998	11 807	5 119	4 948	2 226
1999	10 972	5 312	5 725	2 761
2000	10 226	5 714	6 919	3 265
2001	10 231	6 240	7 895	3 780
2002	11 935	6 959	8 752	4 325
2003	14 833	7 667	10 291	4 984
2004	17 826	7 955	12 038	5 684
2005	19 360	7 821	14 744	6 361
2006	18 949	8 011	15 734	6 356

* Please note that these figures refer to those undertaking nursing *degrees* only and do not include those training as nurses via other routes.

Source: UCAS.

Modernising Medical Careers

42. The education system for UK doctors has recently been changed significantly, by the introduction of a new government led initiative: Modernising Medical Careers (MMC). MMC aims to "improve patient care by delivering a modernised and focused career structure for doctors through a major reform of postgraduate medical education". It aims are "to develop demonstrably competent doctors who are skilled at communicating and working as effective members of a team". The introduction of MMC will bring about significant changes to career structures.

43. MMC is based on two-year foundation schools that will, for the first time, require doctors to demonstrate their abilities and competence against set standards. There will be an opportunity for these doctors to develop experience in a range of specialties. The GMC notes "This will offer doctors the chance to gain insight into possible career options or to build a wider appreciation of medicine before embarking on specialist training".

44. Post-foundation, specialist/GP training will be streamlined to "deliver specialists who are judgement-safe and able to deliver the care that is needed to treat patients, without compromising in any way on standards". Streamlined training will also afford further opportunities for supra specialisation that is flexible enough to allow doctors to adapt to accommodate changes in medical technology. In this way the new system under MMC aims to provide the right numbers of doctors to meet changing service needs.

45. The first full year of implementation of MMC is 2007, and difficulties have been reported matching applicants with available placements – leading to complaints from the British Medical Association, and a review of the matching process. The main factors causing difficulties have been technical issues with the new matching approach and associated software, and issues related to junior

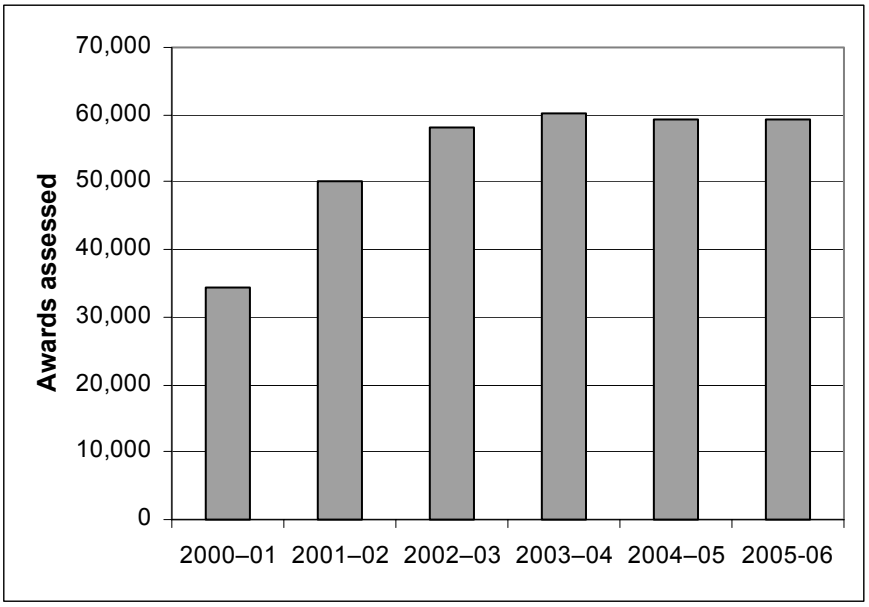
doctors not achieving their preferred choice of location- in part because the number of applicants exceeds the places available (BBC News, 2007).

46. Medical education and workforce planning is also impacted by the requirements of the Working Time Directive, discussed earlier.

Nurse Education

47. There are two entry routes to nurse registration – by diploma (3 years) or by degree (3 or 4 years). Data is collected separately on the two routes. The numbers of pre-registration nursing students in receipt of non-means tested NHS bursaries (Figure 2) in England is known and provides the best clue to recent trends in the size of the student population. They show that the number of nursing students on NHS bursaries grew from around 34 000 in 2000-01 to a little more than 59 000 in 2005-06 (including 7 325 on nursing degree courses).

Figure 2: Numbers of pre-registration nursing students with NHS bursaries, 2000-01 to 2005-06 (England)



Source: House of Commons, Hansard, Written Answers, 13 December 2004 and 6 June 2006.

48. The supply of "new" nurses from training in the UK has varied significantly over the last fifteen years. The numbers leaving training and entering the UK register declined rapidly in the early 1990's, but began increasing from 1997/8 onward. The number entering the UK register from UK training in 2004/5 was the highest it had been for the last fifteen years (Table 17).

Table 17. Initial entries to the NMC Register from pre-registration nursing and midwifery training in the UK, 1990/91 to 2005/06 by country

	England	N.I.	Scotland	Wales	UK total
1990/91	14 786	659	2 537	998	18 980
1991/92	14 184	726	2 513	846	18 269
1992/93	13 931	717	2 485	936	18 069
1993/94	13 992	707	2 334	915	17 948
1994/95	13 997	585	2 060	769	17 411
1995/96	13 527	581	1 920	842	16 870
1996/97	11 208	492	1 802	708	14 210
1997/98	9 416	437	1 688	541	12 082
1998/99	10 184	421	1 789	580	12 974
1999/00	11 048	363	1 909	715	14 035
2000/01	12 501	379	1 771	782	15 433
2001/02	11 712	393	1 786	647	14 538
2002/03	14 616	430	2 238	810	18 094
2003/04	15 862	457	2 331	812	19 462
2004/05	16 146	414	2 263	1159	19 982
2005/06	16 848	696	2 434	962	20 940

Source: UKCC/ NMC annual reports; disaggregated data not available for 2002/3 and 2004/5.

49. Some indication of the level of applications from abroad for education can be found by looking at data on the "domicile" of the applicant- see Table 18. UK and EU nationals would not have to pay the same level of fee for annual costs of education as would an applicant from outside the EU.

Table 18. Number of applicants for entry to nursing degree courses by domicile, 2000-2005

	2000	2001	2002	2003	2004	2005
Home	6 394	7 169	8 090	9 488	11 355	13 878
England	*5 357*	*6 126*	*6 541*	*7 515*	*8 953*	*10 988*
Wales	*473*	*525*	*783*	*1 050*	*1 343*	*1 672*
Scotland	*308*	*280*	*346*	*362*	*385*	*460*
NI	*256*	*238*	*420*	*561*	*674*	*758*
Other overseas	322	508	428	393	347	400
EU	203	218	234	410	336	466
Total	**6 919**	**7 895**	**8 752**	**10 291**	**12 038**	**14 744**
% change	***20.9***	***14.1***	***10.9***	***17.6***	***17.0***	***22.5***

Source: UCAS.

Retention and return

50. As noted earlier in the text, improving retention and return are two other policy options. Both have been the focus of national policy attention in the NHS in recent years.

51. The NHS in England explicitly set out objectives to become a "model employer", defined as "A management style that is both involving and facilitating will result in NHS staff feeling more valued, which benefits patients in turn".

52. "Elements of the model employer" approach identified by the Department of Health is discussed in more detail below.

- **Staff involvement and partnerships**: "Staff involvement enables staff at all levels to feel they are taking part in the decisions that affect them. On this page you can find links to reports on partnership working, and examples of best practice. It is intended to share successful practice by including examples of what works for you" (Department of Health, 2003).

- **Improving Working Lives (IWL)** The NHS Plan stated that all NHS employers would be assessed against performance targets including the "Improving Working Lives Standard", and that by April 2003 NHS organisations would be expected to be accredited for putting the Standard into practice. The standard included measures of availability of flexible working; access to continuing education *etc*. The IWL Standard made it clear that "every member of staff in the NHS is entitled to work in an organisation that can demonstrate its commitment to more flexible working conditions that gives staff more control over their own time". The Standard also required NHS employers to prove that they were investing in improving diversity and tackling discrimination and harassment.

- **A good practice database**[1] supported by NHS Employers enables the NHS to share examples of best practice. Organisations may search across a range of Recruitment and Retention policies including IWL.

- The development of **a Childcare Strategy for the NHS**[2] also played a role in the recruitment and retention of staff. More on-site nurseries were built to offer extra childcare cover. Other care initiatives are also being developed to meet the needs of staff with older children.

- **Zero Tolerance**: The Department of Health reports that it is committed to ensuring that NHS employees have the right to a healthy and safe working environment.

- **Equality and diversity:**[3] The Department of Health reports that it is committed to promoting equality and diversity, and values the benefits it brings. "Staff should feel valued and have a fair and equitable quality of working life, whatever their differences".

53. Annual staff surveys are also carried out by the Healthcare Commission. Based on samples of employees in different occupations in NHS employing organisations, this annual national survey is published, providing data by named organisation across a range of staffing related issues (satisfaction with pay, working practices, access to professional development *etc.*). The survey enables NHS organisation to benchmark its staff satisfaction levels with comparators in similar labour markets, etc .[4]

1. http://www.nhsemployers.org/kb/improving-working-lives.cfm.

2. See: http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modelemployer/NHSchildcarestrategy/index.htm.

3. See: http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modelemployer/Equalityanddiversity/index.htm.

4. See: http://www.healthcarecommission.org.uk/nationalfindings/surveys/staffsurveys/2006nhsstaffsurvey.cfm.

54. The latest annual NHS staff survey was conducted in October 2006, with more than 128,000 staff in 326 trusts giving their views and experiences of working for the NHS in England – there was a response rate of 53%. Key findings were:

- More than two thirds (68%) of staff in **acute trusts** reported that they were generally satisfied with their jobs, this figure has decreased slightly since 2005 (69%), continuing the downward trend from 72% in 2003 and 2004.

- Three quarters (75%) of staff in **primary care trusts** reported that they were generally satisfied with their jobs, compared with 77% in 2005, 78% in 2004 and 79% in 2003.

- Fifty-six per cent of staff at **ambulance trusts** reported that they were generally satisfied with their jobs, compared with 58% in 2005, 59% in 2004 and 57% in 2003.

- Nearly three quarters (73%) of staff in **mental health and learning disability trusts** said they are generally satisfied with their job. This is in line with findings from 2005 (73%) but a slight decrease from 2004 (75%) and 2003 (75%).

55. With 180 000 nurses and 57 000 doctors aged 50 and older, the challenge of meeting the need to replace those who retire - or delay their retirement- will become increasingly prominent as the decade wears on. There have been a series of policy research papers in recent years that have focused on the issue of the ageing nursing workforce (Buchan, 1999; Meadows, 2002; Watson, 2003). These papers have generally come to the same conclusions, that more needs to be done to 'age-proof' employment policy and practice in the NHS and other sectors to encourage the retention of older nurses at work, and that pension provision has to be made more flexible to support a more phased approach to retirement.

56. There have been previous policy led attempts to encourage more nurses to stay on in NHS employment up to and beyond their potential retirement date (HSC 2000/22; Nursing Standard, 2001). More recently, the NHS Pensions Scheme had come under a full review, with recent agreement to maintain a final salary scheme, but with greater contributions from employees.

57. It was announced in October 2005 that the UK government had "dropped" the proposal that staff currently employed in the public sector should have their retirement age increased to 65, and that a higher retirement age will be phased in for new entrants (BBC News Online, 2005). As yet it is unclear what impact this may have on retirement behaviour of current staff or on the future attractiveness of NHS careers.

58. As well as the focus on improving retention, another source of staffing growth has been policies to encourage "returners"- doctors and nurses who had left practice but have been supported and encouraged back to clinical work. There have been several thousand annual nurse returners in recent years.

59. There is little data on returners and it is difficult to make an accurate assessment of their actual contribution to achieving staffing growth. Table 20 shows data on returners for England, which suggests that on average in recent years about 3 800 nurses midwives and health visitors have returned annually to the NHS in England, but there is no indication of any upward trend. These data are no longer collected at national level.

Table 19. Nurses and Midwives on return to practice course, NHS (England)

Period	Nurse and Midwife 'Returners'
1999/2000	3 287

2000 /2001	4 478
2001/2002	3 762
2002/2003	3 795
2003 /2004	3 463

Source: Department of Health.

60. Overall, there has been little systematic or independent evaluation of the impact of these various recruitment and retention initiatives.

International recruitment - registration processes

61. The process of registration of non UK trained health professionals is based on a single UK wide registration process. Any health professional who wishes to practice in the UK must be registered with the relevant professional regulatory authority (e.g. the General Medical Council, the Nursing and Midwifery Council, *etc.*). Data from these professional registers is one source of information that can be used to assess trends in the number of applications and admissions from international sources.

62. There are two main types of applications. The first group is applications from individuals with general medical qualifications, or first level nursing or midwifery qualifications from the other countries of the European Union (EU)/European Economic Area (EEA). These staff have the right to practice in the UK because of mutual recognition of qualifications across the countries of the EU/EEA. As such, they can register in the UK via the relevant EU Directives.

63. The second group is health professionals from all countries outside the EU wishing to practice in the UK, who have to apply to the relevant UK registration authority for verification of their qualifications in order to be admitted to the Register. Most health workers from outside the EU will also have to apply for, and be granted a work permit to take up paid employment in the UK (some younger workers from the Commonwealth can have limited access on working holidays, others will be entering the UK for training purposes, and may be required to register but will not be 'working').

64. Relevant data is therefore available from the registration authorities in the UK – the GMC and the NMC – on the number of full registrations from home-based, European Economic Area (EEA), and other overseas places of first qualification. This enables an assessment of the relevant contribution of different sources to new inflow of registrants to the UK. As noted, registration is required to practice in the UK; but not all registrants will actually be in the UK, or practising in the UK.

Registration of Doctors

65. There are also four types of registration:

- **Full registration** – doctors need full registration for unsupervised medical practice in the NHS or private practice in the UK.

- **Provisional registration** – provisional registration allows newly qualified doctors to undertake the general clinical training needed for full registration. A doctor who is provisionally registered is entitled to work only in resident junior house officer posts in hospitals or institutions that are approved for the purpose of pre-registration house officer (PRHO) service.

- **Limited Registration** – granted for supervised employment in training posts in the NHS – mainly to overseas doctors.

- **Temporary Full Registration –** granted to doctors coming to the UK for a short period of time to provide specialist medical services.

66. The process for registration with the GMC, and the type of registration obtained, depends on:

- The country of qualification
- Nationality
- Background/experience.

67. Doctors must be registered with the GMC to practise medicine in the UK. To register, they must have a recognised medical qualification. The process for gaining registration with GMC depends on the country where the applicant obtained their primary medical qualification and the nationality of the applicant. There are three main groups of doctors for the purpose of registration. The registration processes are different for each group:

- Doctors qualifying from a UK medical school are eligible for provisional and full registration
- Doctors qualifying in another EEA Member State and who are nationals of an EEA Member State are eligible for provisional registration. They are also eligible to apply for full registration if their medical education includes a period of postgraduate clinical training (sometimes referred to as internship training).
- Doctors qualifying in other countries may be eligible to apply for provisional or full registration.

68. The GMC sets out in detail on its website the steps in process of application of overseas doctors, beginning with passing the language test- the PLAB test.

69. The GMC data below shows that in recent years approximately 60-65% of the annual number of new registrants has come from non UK sources. This is a reflection of the deliberate policy of international recruitment that was evident from the period 2000 to 2005. (Note, not all non UK qualified registrants will necessarily actually enter or practice in the UK) (Note: 2003 “overseas” data was inflated by change in requirements which began in 2004- many applicants registered before the change)

Table 20. Yearly number of new full GMC registrations (doctors) by place of qualification over the past two decades, and UK qualified as a percentage of total.

Year	Place of Qualification				UK as a % of total
	United Kingdom	EEA	Overseas	Total	
1986	3 637	650	1 664	5 951	61
1987	3 666	1 080	1 870	6 616	55
1988	3 760	1 308	1 753	6 821	55
1989	3 751	1 184	2 100	7 035	53
1990	3 564	1 031	2 093	6 688	53
1991	3 717	966	2 659	7 342	51
1992	3 586	1 054	2 312	6 952	52
1993	3 675	1 188	2 500	7 363	50
1994	3 657	1 444	2 539	7 640	48
1995	3 710	1 779	3 327	8 816	42
1996	3 822	2 084	4 047	9 953	38
1997	3 920	1 860	3 678	9 458	41
1998	4 010	1 590	3 580	9 180	44
1999	4 242	1 392	2 889	8 523	50
2000	4 214	1 192	2 993	8 399	50
2001	4 462	1 237	3 088	8 787	51
2002	4 288	1 448	4 456	10 192	42
2003	4 443	1 770	9 336	15 549	29
2004	4 662	3 491	4 610	12 763	37
2005	4 829	4 037	5 977	14 843	33
2006	5 154	2 788	5 547	13 489	38

Source: GMC.

70. The other point to note about the GMC data is that the number from UK qualification varies little year on year, in comparison to the wider variations in numbers from non UK qualification. This reflects the fact that the number of "new" doctors from UK qualification is largely set some years before and not open to short term policy change, whilst the numbers recruited or encouraged from other countries of qualification can change more rapidly in response to any change in policy.

Registration of Nurses

71. All nurses from non EU countries applying for registration are now required to complete a 20 day "Overseas Nurses Programme" (ONP) in the UK before registering, and many are also required to undertake a period of adaptation in the UK before they are registered. The ONP was introduced in September 2005 and represents a significant additional requirement for international nurses- to comply, they must find the time, and a place on an ONP course.

72. All applicants who apply for nurse registration and who meet NMC minimum requirements will be required to undertake all or part of the ONP. The ONP sets out common entry standards, a compulsory 20-day period of protected learning for all nurses trained outside the European Economic Area (EEA) and, where appropriate, a period of supervised practice. Every applicant will have to pass the specified International English language test (IELTS) before they can apply to go onto the ONP.

73. From 1st February 2007, all applicants to the nurses or midwives parts of the register must have completed and provide evidence of the British Council International English Language Test (IELTS)before submitting their application to the NMC.

74. They must complete the academic version of the IELTS test and achieve:

- At least 7.0 in the listening and reading sections
- At least 7.0 in the writing and speaking sections
- An overall average score of 7 (out of a possible 9).

75. The NMC will not accept applicants who score lower than this standard

76. The NMC data below shows a declining recent trend of proportionate reliance on overseas registrants- down from more than half in 2001/2, to about one third in 2005/6 (Table 21).

Table 21. Initial entries to the NMC Register 1993/4/91 to 2005/06 by country (nurses/midwives), and UK as an approx % of total entries

	UK total	EEA total	Other overseas total	UK as a % of total
1993/94	17 948	456	1 665	89
1994/95	17 411	798	1 654	88
1995/96	16 870	763	1 999	86
1996/97	14 210	1 141	2 633	79
1997/98	12 082	1 439	2 861	74
1998/99	12 974	1 413	3 568	72
1999/00	14 035	1 416	5 967	65
2000/01	15 433	1 295	8 414	61
2001/02	14 538	1 091	15 064	47
2002/03	18 216	802	12 757	57
2003/04	19 462	1 030	14 122	56
2004/05	20 588	1 193	11 499	62
2005/06	20 940	1 753	8 709	67

Source: UKCC/ NMC annual reports.

77. As noted above, the NHS is the main source of all employment of health professionals, and the public sector is the only location for pre-registration education of health professionals. The data above showed the high proportion of non UK trained new registrants entering the UK medical and nursing

registers. There are also significant numbers of non UK students in medical education and internship. Table 22 shows that in 2005 there were 185 EEA country nationals in residency/internship, and 561 from other countries, compared to 3 889 UK qualified.

Table 22. Number of medical students in residency/internship by place of birth or training, 2005, NHS England

Region/Country of qualification		**No.**
Qualified in the United Kingdom		3 889
Qualified in the remainder of the European Economic Area		185
	Austria	22
	Czech republic	34
	Denmark	4
	Estonia	1
	Germany	14
	Greece	2
	Hungary	5
	Iceland	1
	Irish republic	6
	Italy	1
	Latvia	11
	Lithuania	6
	Netherlands	1
	Poland	51
	Portugal	1
	Slovakia	2
	Spain	2
	Sweden	3
	Unknown - Europe	18
Qualified Elsewhere		561
	Albania	1
	Armenia	1
	Bangladesh	4
	Belarus	1
	Brazil	1
	Bulgaria	3
	Burma	8
	Burundi	1
	Canada	1
	Cayman islands	1
	China	1
	Egypt	2
	Ghana	1
	Grenada	12
	Guyana	1
	India	184
	Iran	8
	Iraq	23
	Jamaica	8
	Jordan	4

Region/Country of qualification		No.
	Kazakhstan	1
	Malaysia	1
	Nepal	3
	Nigeria	16
	Pakistan	165
	Peru	1
	Philippines	1
	Romania	13
	Russia	21
	Senegal	1
	Sierra Leone	2
	South Africa	2
	Sri Lanka	16
	Sudan	20
	Syria	5
	Thailand	1
	Trinidad & Tobago	3
	Uganda	3
	Ukraine	5
	United Arab Emirates	1
	Unknown	2
	Venezuela	1
	West Indies associated	2
	Yugoslavia	4
	Zambia	3
	Zimbabwe	2

Source: The Information Centre, Medical and Dental Workforce Census.

Work permits and the integration of international recruits into the workforce

78. As noted earlier, international recruitment provides a potential source for rapid "scaling up" of a health workforce, if recruitment of suitably qualified doctors or nurses from other countries can be achieved, this can provide a more rapid source of new recruits than can scaling up of training capacity in the country.

79. International recruitment was one of the main means by which the NHS in England increased its staff numbers, particularly in the period between 2000 and 2003. International recruitment was deliberate policy adopted by the NHS to enable rapid scaling up. In evidence to the Health committee in 2007, Andrew Foster, the then Director of Workforce at the Department of Health, explained to the Committee,

> *"…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…"*

80. Table 23 gives the total number of work permits issued for doctors and for nurses in the period since 2001. This data is not directly comparable with registration data (which works to a different annual cycle, and indicates intent to practice), and relates only to non EU applicants who have received a work permit to be employed in the UK. It is clear from the data that there has been a significant drop of in the number of permits issued to nurses in 2006. This reflects the changing circumstances in the UK, with international recruitment dropping off, and the main clinical grades of nurses being removed from the "shortage" list, which enabled easier issuing of permits for those groups.

Table 23. Work permit approvals, 2001- 2006, UK

	2001	2002	2003	2004	2005	2006
Doctors	838	2 439	3 264	4 317	3 884	3 037
Nurses	24 265	28 642	29 440	29 094	22 581	13 618

Source: Work Permits UK.

81. The Work Permits UK Freedom of Information Team has informed us that: "The Work Permit scheme is designed to help employers who need to recruit personnel from outside the European Economic Area (EEA) where no suitable resident worker is available. EEA Nationals are allowed to move and work freely within the EEA, and do not require permits. There are no limits or quota systems placed on the Work Permits scheme for Doctors or Nurses." However as noted earlier, two points should be considered. Firstly, designated "shortage" categories of occupation can more easily obtain work permits- currently, some specialties within the health sector remain on the shortage list, but the main clinical grades of nursing were removed in 2006. Secondly, the UK government is currently reviewing moving to a "points based" system of assessing immigrants.

82. The data presented earlier in the report gives overall trends in inflow of doctors and nurses. It highlights that, for the UK, until recently the EU countries have not been major sources of recruits. In recent years, the main sources for nurses have been India, the Philippines, Australia and South Africa; for doctors it has been India, Pakistan, and EU countries such as Poland and Germany. The recruitment of doctors from the EU countries is a relatively new phenomenon (other than from Ireland); previously recruitment was at a high level from countries such as South Africa. EU enlargement has not led to any new constraints on recruitment from those countries entering the EU, but there has been clarification information about the equivalency of qualifications in some of the accession states.

Stakeholder input and lobbying

83. Lobbying has been evident from professional associations, notably the British Medical Association (BMA) who have been concerned about the impact of recruitment on developing countries, and have promoted the notion of "self sufficiency" (see Box 2).

Box 2. British Medical Association notion of "self-sufficiency"

- All countries must strive to become self-sufficient in their healthcare workforce and should sign up to ethical recruitment policies
- Developed countries must help the developing world to retain their doctors and nurses, for example by providing incentives for their governments to invest in healthcare
- All countries must ensure their healthcare workers are educated and funded to meet the needs of their populations
- Action to combat the skills drain must take into account human rights, and should not prevent healthcare staff from working overseas if they choose to.

Source: BMA.

Recruitment agencies

84. The growth in the international recruitment activity has led in turn to a growth in recruitment agency activity, and in the number of agencies. In the UK, the establishment of the Department of Health list of preferred recruitment agencies, as part of the Code (see details below) has had the effect of focusing NHS recruitment efforts through a group of agencies that have been approved as having an ethical and effective approach but the preferred list is relatively new. The limitations of the Code in this respect are that it does not cover the independent sector use of agencies, and its remit does not extend to the role of in-country agencies which may play a role, e.g. as subcontractors. Agencies that comply with the Code cannot make excessive charges, and must work closely with NHS employers in planning recruitment and induction of new recruits.

Barriers to full integration of international recruits

85. There has been media coverage and some research that has highlighted that some recruited nurses have been unfairly treated- being misled about pay rates and working conditions, paid as care assistants when working as a nurse, and being excluded from training and development opportunities. These issues are most commonly reported in non NHS nursing homes, but there have also been reports of NHS international nurses being undergraded within the pay system (Buchan, 2005; Allen and Larsen, 2003).

86. The Institute of Public Policy Research has identified the main barriers as:

- **Language barriers:** affect completing applications and performing in interviews are considered the single largest obstacle to employment for refugees.
- **Recognition of qualifications:** it is unlikely that the qualifications obtained in their country of origin will be recognised in the UK.
- **Training Provision:** as suggested by the above figures on refugee doctors, only a small proportion of those who need to re-train or qualify to UK standards actually receive the training they need.
- **Discrimination:** despite the large numbers of non-UK trained medical staff now working for the NHS, discrimination still exists in the employment of migrant health workers and this is likely to be more acute for those tarnished by the stigma attached to asylum seekers and refugees.

Refugee health workers

87. The Department of Health established a working group to examine the situation of refuge health workers –see box below. The British Medical Association with DH funding support has a database of refugee medical doctors in the UK; the Royal College of Nursing has a database of refugee nurses.

Box 3. Department of Health working group on refuge health workers

- The requirement to be registered with the General Medical Council before being granted access to NHS patients quite rightly extends to all doctors wishing to train or work in the NHS. Similarly, the need to demonstrate both linguistic and clinical competence as part of the registration process applies across the board.

- It is clear that medically qualified refugees who have become senior doctors in their own countries have difficulties in adapting to the demands of the PLAB test, designed to test a doctors' competence to practice at a level at least equivalent to SHO grade, and the Working Group welcomes the steps already taken by the GMC to facilitate the registration of such doctors through the Senior Doctor route. Similarly, the Working Group endorses the principle that all other overseas doctors should be required to undergo the routine tests required of all applicants for Limited Registration.

- However, in addition to the actual examinations, further obstacles faced by medically qualified refugees are the costs relating to both the PLAB test and subsequent registration. Many such doctors will have left their countries with little or no resources and will be reliant on state benefits, and the cost of the PLAB test and, subsequently, Limited Registration are significant barriers. The number of medically qualified refugees seeking registration with the GMC annually is likely to be relatively small.

- The Working Group recommends that (i) the GMC waives the costs of the first two attempts at the tests required for registration; and (ii) where a medically qualified refugee has demonstrated eligibility for registration and has the offer of employment, the GMC defers, upon application by the doctor, the costs of registration until three months after that employment has begun.

Source: Department of Health.

Recent changes in international recruitment policies and practices

88. The Department of Health in England announced on 7 March 2006 that from 3 April 2006 International Medical Graduates (IMGs) - who are not UK or EEA nationals - wishing to work or train in the UK would need a work permit. To obtain a work permit an employer must show that a genuine vacancy exists, which cannot be filled by a doctor who is a UK or EEA national. The GMC notes on its website that "We anticipate International Medical Graduates' (IMGs) employment prospects will significantly worsen following the Department of Health announcement on 7 March 2006. This is in addition to the on-going difficulties IMGs have reported in seeking employment".

89. Until recently most nursing categories were listed as "shortage" specialities, which meant that their applications for permits (usually for 2 or 3 years in the first instance) were "fast tracked" but this no longer the case. Because the NHS faced funding difficulties in 2006 and the consequent problems that UK based new graduates were having in obtaining first jobs, the main clinical grades in nursing was removed from the shortage list in 2006. At the time of writing, NHS Employers, the body representing NHS organisations, is arguing that ALL listed health professional occupations should be removed from the Home Office "shortage" list (NHS Employers, 2007).

90. In addition to the tightening of entry requirements, there have also been changes to the registration requirements for both overseas doctors and nurses which have made it more difficult to register. These issues are discussed in more detail at appropriate points in the text. The Home Office is responsible for overall policies in relation to migration; currently it has outlined a new approach, based on a points based system (similar to Canada).

91. The GMC has highlighted that the recent changes in work permit requirements make it much less likely that overseas doctors will find jobs, noting that "There are currently no provisions to enable overseas doctors to come to the UK solely to look for work. While sensible enquiry about posts is expected, this can be done at a distance."(See Appendix for detailed chart.)

92. The steps outlined by the GMC are:

> *"Firstly, you should thoroughly research your employment prospects before you enter for the PLAB test. There is a significant cost associated with sitting PLAB, especially with coming to the UK to sit Part 2, and there is absolutely no guarantee of a job once you have passed. Find out the likelihood of opportunities in the specialty you wish to pursue. Historical information is of somewhat limited value, because the situation will change significantly as a result of the changes to the immigration rules. Make sure that your information is right up to date. Information on the number of applicants for each training post is becoming more readily available. Postgraduate Deaneries are beginning to publicise this information on their websites. If posts have been popular in the past, you should assume that they will continue to be popular. In fact, employers will not consider applications from overseas doctors who do not already have the right to work in the UK unless they have insufficient applications from suitably qualified UK and EEA doctors. Most training posts which begin in August 2006 have already been filled or will be filled very shortly. If you have not yet sat PLAB, you will not realistically be able to take up a training post until 2007.We aim to recruit to most August 2007 training posts in England using a new electronic recruitment system. The recruitment will start towards the end of 2006 and further information will be available nearer the time at www.mmc.nhs.uk. NHS Trusts are responsible for recruiting directly into their service posts. Again, electronic recruitment is being used more widely. Electronic recruitment makes it easy for you to apply for posts from your home country. If you decide to take PLAB, you should seriously consider returning home after completion of Part 2 to apply for posts. Employers will be aware of where you are located and allow you sufficient time to travel to any interviews."*

93. They also set out the detailed advice to overseas doctors considering coming to the UK for additional training (see also Appendix):

> *"From 3 April 2006 doctors and dentists in postgraduate training <u>will be considered for immigration purposes to be in employment rather than in training</u>. Permit-free training will no longer be available, and those who do not have right of residence in the UK or EEA will require a work permit to undertake employment.*

94. The only exception is for those graduating from a UK medical school who will be allowed permit-free training in order to complete the 2 year Foundation Programme.

95. Overseas students will still be able to complete their undergraduate studies with a student visa. On graduation from a UK medical school they will be eligible to apply for leave to remain in the UK as a

Postgraduate Doctor (permit-free training) to undertake a 2 year Foundation Programme and therefore to register with the General Medical Council.

96. They will compete on an equal footing with UK and EEA resident graduates in the allocation of posts. It is important that this provision remains so that they have a transferable professional registration on completion of their studies. Following completion of the Foundation Programme, if they want to remain in the UK then they will have to switch into another category of the Immigration Rules, such as the work permit system.

97. Overseas doctors will still be able to come and train in the UK. However, you will now be considered as being in employment for immigration purposes, and will therefore need to meet the requirements of an employment category of the Immigration Rules, such as the work permit system.

98. Work permits will only be issued where the post cannot be filled by someone with right of residence in the UK or Europe. The work permit is specific to the post and only for the duration of the post. Each new post will require a new work permit."

99. The GMC recently completed a survey of overseas doctors (GMC, 2007) who had completed the Professional and Linguistics Assessment Board examination (PLAB Part 2 exam) that showed:

- Of those IMGs who passed between January and September 2004 only 48% found their first post within six months. For those passing between October 2004 and February 2005 this dropped to only 35%. Of those who did find posts, 74% of the posts were for less than six months.

- Of those IMGS who passed between January and September 2004 19% had not found a post after a year. For those passing between October 2004 and February 2005 this jumped to 34%. The time it takes to find a position is increasing.

(Note: This GMC survey was designed before the changes in the work permit rules were announced on 7 March 2006, and refers to experience prior to this.)

100. For nurses and midwives, many applicants, even when successful in the initial phase of application, are stuck in the recruitment pipeline- awaiting a place on an ONP course, or an adaptation place. There is reportedly a significant backlog of international nurses awaiting full assessment before they can register to practise in the UK. In July 2005 the NMC reportedly estimated that there were "37 000 overseas nurses already in the UK who are unable to start work because they cannot find supervised practice placements" (Parrish and Pickersgill, 2005). More recently, reports have suggested that the cost and time involved in undertaking the ONP has contributed to the decline in international applicants, from 1,412 requests for applications in the month of September 2005, to 505 in January 2006 (Doherty, 2006).

101. The active international recruitment of nurses has also been directly affected by NHS funding difficulties, which is the other main factor that explains the significant drop in international registrations in recent years. After a period of unprecedented growth in NHS funding and in the NHS nursing workforce in the period up to 2005, financial difficulties and deficits in parts of the NHS, most notably in England, have led, in places, to recruitment freezes and redundancies. There are also reports of reductions in funding for future training of nurses (Parish, 2006), and of newly qualified nurses experiencing difficulties in finding nursing jobs (Herbert, 2006; Doult and Agnew, 2006).

Outflow/Emigration of health professionals

102. Some estimate of outflow of nurses from the UK can be determined using data held by the NMC on verifications reported to other countries. Whenever a UK registered nurse applies for registration in another country, that country's registration body should contact the NMC for verification of the nurse's details.[5]

103. Table 24 shows the verification data for 2004/5 and 2005/6. A total of 8,044 verifications were issued in 2004/5 and 7,772 in 2005/6, with Australia, New Zealand and the USA being main destinations.

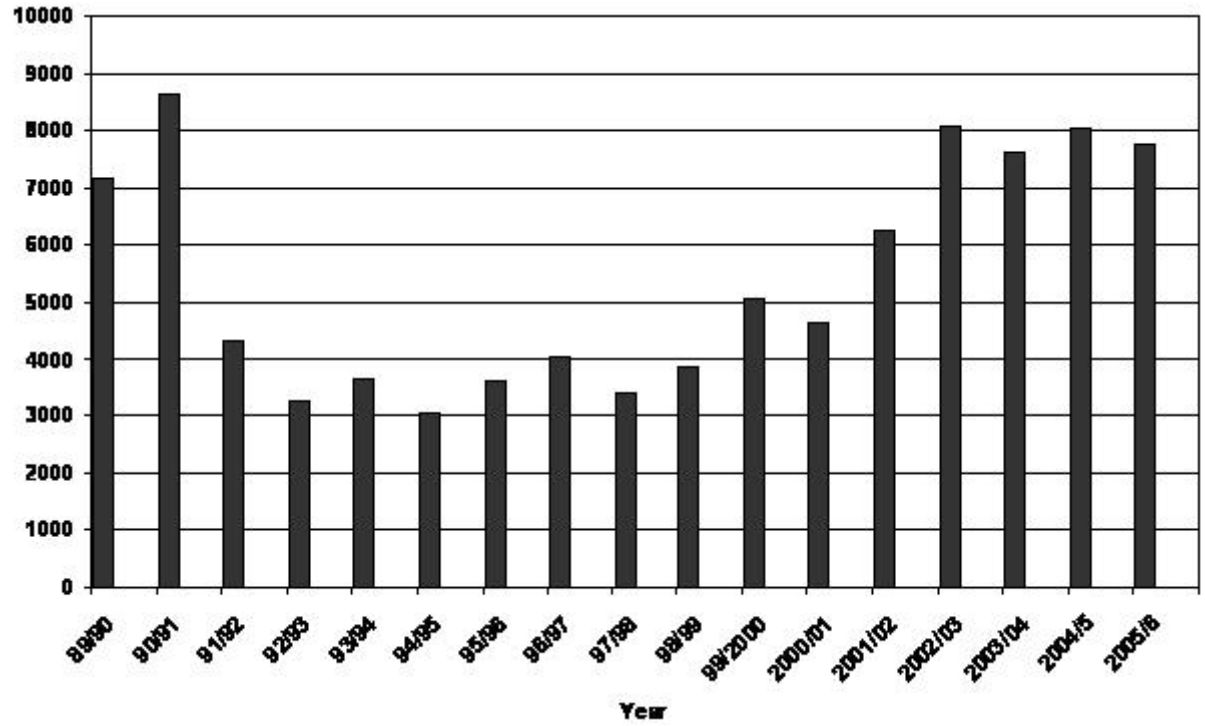
Table 24. Number of verifications issued to "destination" countries, 2004-5, and 2005/6

	2004/5	2005/6
Australia	3 296	3 047
Canada	461	404
New Zealand	1 097	1 423
USA	1 729	1 338
Others	1 461	1 560
Total	8 044	7 772

104. Overall trends in outflow are shown in Figure 3. The number of verifications issued declined in the first half of the last decade, but there has been a rising trend since the mid-1990s.

5. The NMC data indicates an intention to nurse in other countries; it does not necessarily record an actual geographical move. There will also be some double counting when a nurse applies to move to more than one country, and some of the outflow will be of foreign nationals who, having undertaken pre- or post-registration nurse education in the UK, return home.

Figure 3. Annual number of verifications issued by IMC/UKCC, 1989/90-2005/2006



105. The NMC verification data gives some indication of outflow of UK registered nurses; what it does not tell us is how many of these nurses are UK trained, how many have been trained in other countries (and for how long the latter have been in the UK).

International recruitment: The policy context

106. Recruitment of doctors and nurses from the developing world has been controversial in the UK, and the Department of Health in England has attempted to limit the potential negative impact. It first established guidelines in 1999, which required NHS employers not to target South Africa and the West Indies. It then introduced a Code of Practice for international recruitment for NHS employers in 2001. This Code was strengthened in 2004, and now covers recruitment agencies, temporary staff working in the NHS, and private sector organisations providing services to the NHS (Department of Health, 2004).

107. The Code "promotes high standards of practice in the ethical international recruitment of healthcare professionals. All employers are strongly commended to adhere to this code of practice" (Department of Health, 2004).

108. The foreword to the Code notes that "international recruitment has formed an important element in a range of initiatives undertaken to build the NHS workforce and ensure that health services across the nation address the health needs of people today. The international mobility of healthcare professionals is a well established practice that has been going on for many years. More recent times have seen an increasingly large-scale, targeted international recruitment approach by many developed countries to address domestic shortages. This can benefit the healthcare professional in terms of enriching experience and a chance to increase their quality of life. However, concerns related to the impact this may have upon the healthcare systems of developing countries also need to be addressed" (Department of Health, 2004).

109. The key points of the Code are:

- Developing countries should not be targeted for active recruitment by the NHS unless the government of that country formally agrees [a list of developing countries is provided]
- NHS employers should only use recruitment agencies that have agreed to comply with the Code
- NHS employers should consider regional collaboration in international recruitment activities
- Staff recruited from abroad have the same legal protection as other employees
- Staff recruited from abroad should have same access to further training as other employees

110. The Code does not prevent health professionals taking the initiative to apply for employment in the UK, or to come to the UK for training purposes. Because the NHS does not record centrally how many international nurses it recruits or employs, it is not possible to verify the extent to which all NHS employers have complied with the Code, in terms of not actively recruiting from the developing world.

111. Responsibility for some aspects of international recruitment policy and practice have been transferred, since April 2005, to "NHS Employers", the new organisation set up to act as the lead body for NHS employing organisations. The Department of Health retains the responsibility for external policy and governmental relations, but NHS Employers leads on practical aspects of recruitment and induction of international recruits. On their website NHS Employers note "NHS organisations looking to recruit staff from overseas can get help and support from NHS Employers on how to proceed. We organise and facilitate international recruitment networks and provide advice to service users on:

- Ethical recruitment
- Work permit applications
- Registration issues
- Service of recruits
- Dealing with regulatory bodies."

Source: http://www.nhsemployers.org/Workforce/international_recruitment.asp

112. Another main policy instrument has been the use of bilateral agreements.

113. The UK has at various times in recent years had active bilateral agreements with Spain, India and the Philippines on recruitment of doctors and nurses and other health professionals (in most cases, nurses have been the main focus of activity), a protocol with the Republic of China, a memorandum with Indonesia that was apparently never fully operationalised and a memorandum of understanding with South Africa. Table 25 summarises the key points of these agreements

114. It is apparent that the agreements are primarily statements of principle and of broad objectives. The memorandum of understanding (MoU) with India and Indonesia are similar in wording; both of these MoU plus the Mo U between the Philippines and the UK refer to "projects" that will be used to assess the suitability and sustainability of international recruitment practices. The latter MoU also sets out developing a "Mutual Recognition Agreement" as an objective. They do not specify numbers of nurses or other health professionals that can be recruited, nor set time limits. Essentially these bilaterals are enabling agreements. The MoU with South Africa is different in content, focussing on staff and information exchange.

Table 25. Examples of bilateral agreements between UK and other countries in recent years

	China (2005)	India (valid to 2003)	Indonesia (valid only until 2004)	Philippines	South Africa (2003)	Spain
Type	Protocol "on Cooperation in Recruiting Health Professionals"	MOU: professional staff recruited from India to the NHS employment "to have an opportunity to enhance their skills and explore best practice"	MOU "to enhance health professionals' skills and explore best practice in health service".	MOU- cooperate in the development of the delivery and health care through recruitment in the Philippines and employment of Filipino nurses and other healthcare professionals in the United Kingdom	MOU: "The reciprocal educational exchange of healthcare concepts and personnel"	"Agreement" - to intensify bilateral exchanges of policy thinking and best practice in the delivery of healthcare
Main points	All nurse recruitment agencies from China that wish to engage with healthcare providers in the UK for the supply of health professionals should comply with the DH Code of Practice. NHS Trusts and many parts of the Independent Sector should not contract with any recruitment agency that does not abide by the provisions of the Code. All international health professionals legally employed in the UK are protected by relevant UK	To launch a pilot recruitment project between the Ministry of Health and Family Welfare in India and Regional Office of Department of Health "with a view to sustainable recruitment and employment of healthcare professionals from India"; "to intensify bilateral exchanges of policy thinking with regard to clinical workforce development and best practice in the delivery of healthcare"; and after discussions with the Department for International Development (DFID) and High Commission in India, we can confirm that agencies can recruit healthcare professionals from India. However, there are four	To launch a pilot recruitment project between the Department of Health in Indonesia and the Department of "with a view to sustainable recruitment and employment of health professionals from Indonesia"; "To intensify bilateral exchanges of policy thinking with regard health workforce development for health professionals and best practice in the delivery of healthcare";	To continue the recruitment project with a view to sustainable recruitment and employment of nurses and other healthcare professionals from the Philippines; To intensify bilateral exchanges of policy thinking with regard to nursing workforce development and best practice in the delivery of healthcare; To involve professionals staff and healthcare managers, with a view for a Mutual Recognition Arrangement in nursing and other healthcare professions between the Parties. There is a Memorandum	South African healthcare personnel can spend mutually agreed period of time on education and practice in NHS organisations; clinical staff from England to work in the Republic of South Africa, The Parties shall exchange information, advice and expertise in-professional regulation issues; workforce and strategic planning; public-private partnerships; twinning of hospitals; and training in healthcare management.	The NHS in England will look to provide training and employment opportunities for Spanish nurses A number of trained professional nursing staff will be recruited to work in the NHS where they will have the opportunity to experience British approaches to professional nursing care; -in the longer term NHS nurses may be able to undertake reciprocal visits to parts of the Spanish Healthcare system, particularly areas such as public health,

	China (2005)	India (valid to 2003)	Indonesia (valid only until 2004)	Philippines	South Africa (2003)	Spain
	employment law. The Chinese Government have asked that China be removed from this list but requested that no recruitment should take place in small rural areas.	states that receive DFID aid and should not be targeted for recruitment. These are Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal.		of Understanding between the UK and Philippine governments to enable the UK to recruit registered nurses and other healthcare professionals. Other healthcare professionals refers to physiotherapists, radiographers, occupational therapists, biomedical scientists and other Allied Health Professionals that are regulated by appropriate professional bodies in both countries.		where there is much to learn from the Spanish experience;

Source: Buchan et al 2007, forthcoming.

3. LOOKING FORWARD

115. The period from 1999 to 2005 was one of unprecedented staffing growth for the NHS in England, driven by nationally set targets, and fuelled by the availability of significant growth in funding. However, from 2005 onwards, there is evidence of a "sudden and distinct change in health service workforce trends" (House of Commons, Health Committee, 2007).

116. The growth in staff numbers came rapidly to an end. The Health Committee has identified that "overshooting of workforce growth targets between 1999 and 2005" as a major cause of this problem. Financial deficits emerged in the NHS from 2004-05 onwards, which the committee attributes, in part at least, to the costs of workforce expansion, and costs of the new pay contracts for NHS staff. The deficits have, in turn "driven the sudden downturn in workforce size". The direct links between unexpectedly rapid workforce expansion, the emergence of deficits, and subsequent staff redundancies, were acknowledged by the Secretary of State during the Health Committee's inquiry on NHS deficits (Health Committee, 2006).

> *"The reality is that the NHS has spent more of the growth money on additional staffing than was planned and has taken on significantly more hospital doctors and significantly more nurses…than the NHS Plan intended. That is why some individual organisations around the country are now having to make some very difficult decisions on their staff, including in some cases redundancy…"*

117. The Health Committee note that subsequent savings have been made in two main areas:

- Many **provider organisations**, who employ the great majority of NHS staff, have made direct savings by freezing or removing vacant posts, by not replacing retiring staff or, in a small number of cases, through compulsory staff redundancies; and

- Many **Strategic Health Authorities** have returned large surpluses in order to compensate for deficits elsewhere in the system (SHAs returned surpluses totalling £524 million in 2005-06); the savings required to achieve such surpluses have come mainly through cuts in education and training provision.

118. Estimates of the scale of current redundancies and job reductions (the removal of vacant posts from staffing establishments) have varied. A recent Office for National Statistics report estimates that the total number of NHS staff fell by 11 000 in the final quarter of 2006. The most recent NHS staffing data suggests a fall in non medical posts in the NHS in England of approximately 2% between 2005 and 2006 (Information Centre, 2007). Medical staff numbers have continued to grow, albeit at a slowing pace.

119. The number of compulsory redundancies is considerably lower than the number of job reductions. The Department of Health announced in February 2007 that 1 446 compulsory redundancies were made in the NHS in the first three-quarters of the 2006-07 financial year.79% of redundancies were among non-clinical staff.

120. The Health Committee noted in 2007 that "The downturn in workforce expansion has created pressure to protect job opportunities for UK-trained staff. This has resulted in recent attempts to constrain the level of international recruitment" As noted earlier, in March 2006, the Department of Health and the

Home Office announced an end to permit-free training for overseas medical staff. Postgraduate medicine is no longer classed as a 'shortage' profession, and doctors from outside the EEA are only be permitted to apply for UK training posts if there is a shortage of applicants from within the UK or EEA. Similar changes were announced for junior physiotherapy posts in July 2005 and for general nursing posts in July 2006. This will inevitably lead to a rapid and significant reduction in the inflow of overseas clinicians to the NHS, which is already beginning to be evident in data for 2006, as discussed earlier.

121. As noted earlier, the growth in domestic training capacity up to 2005 remained roughly in line with NHS Plan targets. However, there is evidence of a more recent downturn in training numbers. The Council of Deans and Heads of UK University Faculties for Nursing and Health Professions highlighted significant reductions in the number of non-medical training places commissioned ("training"commissions") by SHAs for the 2006-07 academic year. The Council stated that 10-15% cuts had been requested by 'nearly all' SHAs and that cuts were as high as 30% in some areas (Health Committee, 2007).

122. Another consequence of increasing deficits has been the increasing difficulty experienced by some healthcare graduates in finding employment within the NHS. It was reported that 68% of 2006 physiotherapy graduates were unable to find NHS physiotherapy work. Once again, the Committee heard that graduate unemployment had not occurred because staff were not needed, but rather because of the pressure to make financial savings and the failure to plan for the output of increases in domestic training capacity.

123. In short, the situation in the period since late 2005 has exposed a disconnect between financial planning and workforce planning. Staffing growth targets were overshot, partly as a result of high levels of international recruitment, and expansion in UK training capacity is now leading to larger numbers of UK based graduates entering the health care labour market. There is limited public information on future staffing needs and projections with which to assess the likely future impact of these changes.

124. Some analysis and future projections are conducted by the Workforce Review Team (WRT) of the NHS in England. WRT produces annual recommendations for planning for all of the main clinical staff groups in the health services. WRT recommendations cover future recruitment levels, training numbers and other factors including the effects of changes to skill mix. The WRT review process includes taking views from a range of organisations including the Workforce Programme Board (WPB), Joint Management Group members, the National Workforce Group (NWG), SHA planners, commissioners and directors of finance and the Department of Health "on their assessment of the situation and the associated risks and opportunities". In its 2006 report, the WRT acknowledged that their workforce recommendations for 2007/08 "were originally drawn up against a background of a difficult financial climate in which cuts in posts within the NHS and cuts in training commissions were being announced". This in turn had a knock-on effect on workforce planning, education commissioning and finance functions. WRT note the 15% reduction in the devolved central budgets for 2006/07, which include MPET, which "has left SHAs with little option but to cut workforce development plans and limited scope to implement these recommendations in the short-term". Their key conclusions in their 2006 report (WRT, 2006) are summarised below.

125. The first problem the WRT identified was with funding allocation for supporting training/education of health professionals. The WRT reported that the impact of short term financial problems in some Strategic Health Authorities (SHAs) had been exacerbated by funding allocated for education/ training budgets being re-directed by some SHA's to achieve a balanced budget. The WRT noted that the reduction in education/training budget allocation from the Department of Health, coupled with the further use of some of the remaining funding to achieve financial balance for each SHA were both " putting pressure" on education/training budgets at SHA level. The WRT reported that feedback from

professional bodies has raised serious concerns about the impact of this on pre- and post-registration training for a number of staff groups, and that SHAs "are looking for savings in those areas with the greatest return, e.g. in nursing.."

126. Secondly, the WRT highlighted that their analysis of nursing supply trends suggested future problems- that reductions in international recruitment and higher retirement levels were likely to reduce growth in the nursing workforce and subsequently lead to workforce reductions, even without reductions in the number of training commissions.

127. Thirdly, WRT flagged concern about the need to better capture the workforce planning and policy implications of the "mixed economy" of providers that is developing in the NHS in England. "Future NHS workforce planning will also need to consider the role, capacity and workforce numbers employed by independent sector (IS), social care, voluntary and other providers. This can only be achieved by gathering robust workforce data intelligence which also needs to incorporate activity undertaken in foundation trusts". The WRT noted that the Information Centre for Health and Social Care (IC) is currently assessing how to facilitate a suitable data collection "supported by DH who are framing the contractual obligations for IS providers to supply workforce data".

128. The key challenges identified by the WRT in its assessment of the assessment of the current national workforce planning context are listed in the box below.

Box 4. Key workforce planning challenges identified by WRT

- Reductions in training commissions and in total number employed are inevitable in some areas.
- Funding pressures are threatening post-registration learning and therefore skill mix solutions and retention strategies may be hard to support.
- Risks to the training infrastructure of significant short-term disinvestment need to be recognised.
- In some professions the number completing training is greater than the number of suitable posts, whilst at a senior level there are vacancies e.g. physiotherapy.
- There are tensions between some national policies and initiatives that appear to point in opposite directions, e.g. Working Time Directive policies to achieve 2009 compliance, including new ways of working, and increased use of nurses and other staff to take on responsibilities or medical students, at the same time as more medical graduates are leaving medical schools).

Source: WRT 2006.

129. Further information can be gleaned from a "leaked" Department of Health report in early 2007 (Health Service Journal, 2007) that suggested that planning projections indicated "an excess supply of 3,200 consultants ; a shortage of 15,000 nurses; a surplus of 16,000 allied health professionals; a shortage of 1,200 GPs and 1,100 too few junior and staff-grade doctors".

130. The full details of this report have not been made publicly available. However it should be noted that there have been concerns expressed by many stakeholders about reductions in intake to pre-registration nursing and midwifery education in 2006/7, as a result of SHA level financial difficulties. Commentators, including the UK Parliament Health Committee, have argued that these reductions are not planning based, but short term financial driven (House of Commons, Health Committee, 2007). They have

also commented that there are "serious problems with the current workforce planning system, most importantly the lack of integration between different parts of the system and the lack of people, systems and skills to do the job effectively" (House of Commons, Health Committee, 2007) and "Workforce planning has too often been a series of isolated decisions and initiatives rather an integrated process. A number of changes are required to improve integration: most importantly, workforce planning, financial planning and service planning must be more closely aligned in all NHS organisations. This will require closer working between staff in Finance and Human Resources departments and more accurate, joint forecasting of future supply and demand" (House of Commons, Health Committee, 2007).

Future health expenditure

131. Whilst there is a link between funding levels and increase, and NHS staffing levels, it is difficult to be precise about future trends. Work for the Wanless report, published in 2002, assessed future NHS funding on three different funding scenarios ("solid progress"; "slow uptake", "fully engaged"), and made some broad brush assessments of future staffing needs. At that time, it was projected that a "solid progress" scenario, with increased funding, would lead to staffing growth, but with demand likely to exceed supply for nurses and for doctors. The rapid funding growth that supported NHS staffing growth in the earlier part of this decade came as a result of government commitments to raise expenditure on health care in the UK towards a "European Union" average level (Appleby, 2007).

132. [In a health system with public funding, public sector employment, and public sector funding of training, there are policy levers open to government, and a close link between NHS staffing and expenditure levels] Staffing growth was both fuelled and enabled by increases in NHS funding from 2000 to 2006. However, the projections of NHS funding growth over the next few years suggest it will be very difficult to sustain the levels of funding growth seen in that period. This is turn will end the rapid growth in staffing seen in recent years. The most recent assessment on NHS funding over the next few years highlights that the emphasis will switch to achieving productivity growth with available staffing, rather than supporting staffing growth (Appleby, 2007).

Conclusions

133. The UK situation in the period up to 2005 has clearly highlighted the potential for the use of a policy of large scale international recruitment in order to meet staffing growth requirements. The pre-requisites are that the destination country must be attractive to recruits (the UK benefited from relative high pay levels, perceptions of good career prospects; economic stability, education opportunities for children, English language; plus the ability to use NHS networks to support large scale recruitments).

134. Policy instruments such as the Recruitment Code, as well as bilateral agreements also played some role in "managing" the process. As the process matured, there was also better co-ordination across government departments (Home office, Department of Health) to facilitate ease of recruitment. It became clear, however, as highlighted in the recent UK Parliament Health Committee report, that the policy drive to increase staffing was not well co-ordinated at all points with financial planning, leading to an overshoot of staffing growth targets.

135. The financial situation in the NHS will determine any other changes in staffing levels and mix. NHS funding is not projected to grow so quickly over the next few years as it did in the period up to 2006, so it is unlikely that there will be staffing growth of the scale in the earlier part of this decade. Indeed the latest data highlights reductions in non medical staff, and the "leaked" Department of Health projections suggest there may be an oversupply of junior medical staff over the next few years, even with the ending of active international recruitment. This latter issue is not solely related to international recruitment however, it also reflects changes in the medical career structure. This may lead to more recently qualified health

professionals looking to move to other countries. There have been anecdotal reports of recruiters from Canada and Australia targeting England as a result of media reports about difficulties for recently qualified UK nurses and allied health professionals.

136. International recruitment was a quick way of achieving staffing growth, and has now been reduced markedly as more new staff come into the labour market from UK training, and as financial difficulties hit some NHS employers. In a country such as the UK, where most healthcare employment is within the public sector, such international recruitment activity can be an attractive policy option for government, as it can be flexibly reduced or increased using available policy instruments such as work permit requirements, targeted recruitment activity *etc*. The danger is that if it is not well co-ordinated with home based workforce planning, this can lead to the situation currently pertaining in the UK, with overshoot of staffing growth targets, financial problems, and domestic graduates having a difficult time finding employment.

137. As such, migration should only be examined within the overall workforce planning mechanism in use at national level. What is missing in the current scenario in England is firstly, close integration of financial planning and monitoring with workforce planning, and secondly, close monitoring of the actual numbers of all types of professional staff coming into the UK from other countries. Any country planning "scaling up" of staffing has to assess the options (home based growth through increased training capacity, improved retention, improved "returners"; active international recruitment) but must then track and monitor the actual affect of the mix of options that are selected.

138. It is also necessary that any developed country take account of its recruitment impact on the developing world. The UK has gone further than most by introducing a Code of conduct to manage this process, and to highlight the rights of migrant health workers.

139. Key recommendations would be:

- Migration should only be examined within the overall workforce planning mechanism in use at national level.
- Migration should not be used in isolation, or regarded as a cheap option, with "expendable" migrant health professionals.
- The role of recruitment agencies should be monitored or regulated.
- Bilateral agreements may be an effective way of managing the migration process between a source and destination country.
- A country level code, in a country where most employers and recruitment agencies are bound by the code, can be of some effect in managing the process of recruitment in an "ethical" and efficient way.
- There needs to be more effective monitoring of flows of health workers if a multinational code is to be implemented with any effect.
- In relation to active international recruitment, the recent evidence from England would suggest it can be an effective mechanism for rapidly scaling up the workforce- but that the very rapid pace requires careful monitoring if it is not to overshoot any planned targets for growth.

- Active international recruitment must also be carefully integrated within the overall workforce planning approach, so as to be fully effective.

TABLE OF ACRONYMS

Associate – Specialist career grade for NHS medical staff

Consultant – Senior career grade for NHS medical staff

CWP – Changing Workforce Programme

DDRB – Doctors and Dentists Review Body

DH – Department of Health

EEA – European Economic Area

EU – European Union

EWTD – European Working Time Directive

GDP – Gross Domestic Product

GMC – General Medical Council

GP – General Practitioner

IWL – Improving Working Lives

JCPTGP – Joint Committee on Postgraduate Training for General Practice

KSF – Knowledge and Skills Framework

MA – Modernisation Agency

MMC – Modernising Medical Careers

MoU – Memorandum of Understanding

MPET – Multi-Professional Education and Training

NHS – National Health Service

NOHPRB – Nurses and Other Health Professionals Review Body

NMC – Nurses and Midwives Council

PLAB – Professional and Linguistics Assessment Board

PMETB – Postgraduate Medical Education and Training Board

RCN – Royal College of Nursing

Registrar – Senior Registered Medical staff

SHA – Strategic Health Authority

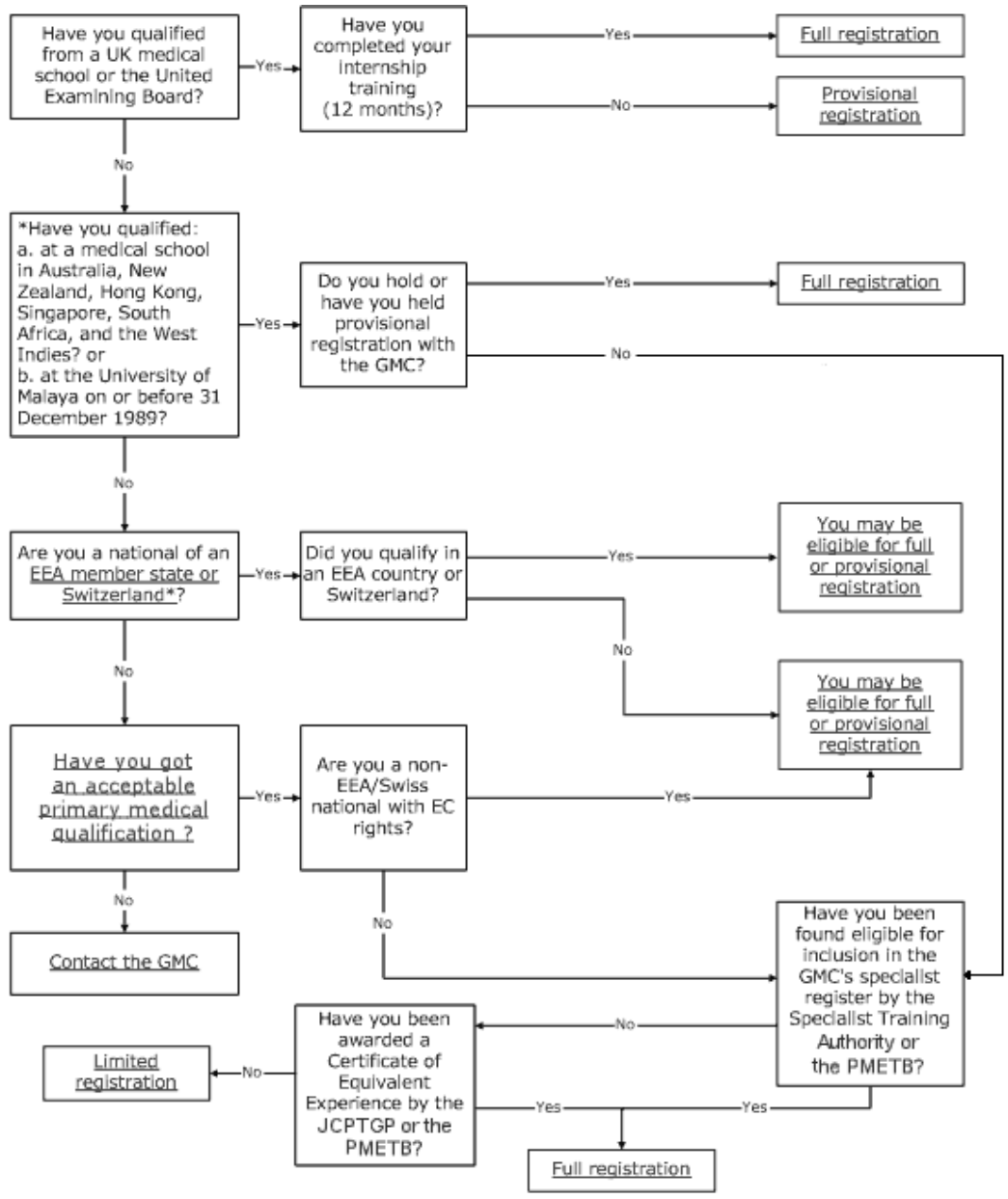
House Officer/ Senior House Officer – Postgraduate trainee doctor

UK – United Kingdom

WRT – Workforce Review Team

APPENDICES

Figure 4: Possible types of entry to UK and status of registration- General Medical Council



* UK Nationals should contact us on 08453 573456 (UK calls) + 44 161 923 6602 (International calls) or email us at registrationhelp@gmc-uk.org for separate advice

Source: GMC

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