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Assessing and enhancing integration in workplaces

BACKGROUND REPORT

MIGRANT WORKERS IN THE IRISH HEALTHCARE SECTOR

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February 2015

FIERI

"Co-funded by the European Union"

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This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the European Commission cannot be held responsible for any use which may be made of the information contained therein.

List Of Contents

1. The Country Health System **1**

1.1 The Institutional and Regulatory Framework 1

1.2 Education and Training for Medical Occupations: 4
Career structure for doctors: 4

1.3. Education and Training for Nurses: 4

Language skills required: 5

Nurses and Care Assistants: 5

Doctors: 6

1.2 Highlighted shortages of national staff in the health sector 6

1.3 National policies aimed at filling this gap 9

2. The Regulatory Framework For Migrant Health Workers **9**

2.1 Conditions of entry into the country of Migrant Health Workers 9
Work permits 9
Green cards 10

2.2 Conditions of access to the health sector for Migrant Health Workers 11

2.3 Channels of recruitment of Migrant Health Workers 12
Medical Doctors 12
Professional Nurses 13
Care Workers 14

2.4 Procedures (and effectiveness) of the recognition of professional titles of Migrant Health Workers 14
Non-EU Migrant Health Workers 15

3 The Labour Market Integration of Migrant Workers in the Irish Health Sector: a Statistical Overview **15**

3.1 Statistics for Migrant Doctors 16

3.2 Statistics for Migrant Nurses 21

Statistics on Migrant Care Workers/Assistants 23

Concluding remarks **23**

List of References: **24**

List of Tables

Table 1: Census Data Table of Top 20 Population of Health Professionals in April 2011 _____ *16*

Table 2: Registration Data for non-EU Doctors registered in 2000 and 2010 by nationality _____ *17*

Table 3: EU graduates registered with the medical council Ireland _____ *18*

*Table 4 World region of graduation with basic medical qualification for doctors who retained registration 2012*_____ *19*

Table: 5 Country of basic medical qualification for doctors retained in the register 2012 _____ *20*

Table 6: Country of training of new EU registrants _____ *22*

*Table 7: Country of Training of Non-EU registrants*_____ *22*

1. The Country Health System

1.1 The Institutional and Regulatory Framework

The Irish health system has been undergoing constant reforms since the late 1990s, with changes focusing on both the organisation and the orientation of the health system. The main structural reform centred on the abolition of multiple Health Boards, and the creation of the Health Service Executive (HSE) in 2005. The HSE is a single, national body, and is governed by the Health Act 2004. The main responsibility for the health system in Ireland is held by the Government, the Department of Health and Children, the HSE, and the Minister for Health.

There is a complex relationship between State and private funding and service delivery in the Irish health service (Quinn, 2006). In Ireland, 67% of health spending was funded by government revenues in 2011, down from 75.7% in 2007 prior to the economic crisis (OECD, 2013). Total health spending accounted for 8.9% of GDP in 2011, of which 6% of GDP was public expenditure and 2.9% private. GDP spending in 2011 was slightly less than the OECD average of 9.3% (OECD, 2013). The Irish healthcare system is a mixture of a universal public health service and a fee based private system.The public/private mix of hospital beds is not typical across OECD countries, as some of the beds in acute public hospitals are designated for use by private patients (OECD, 2013). All persons who are ordinarily resident in Ireland may access the health service[1]. Those with means tested medical cards are entitled to health services free of charge (Quinn, 2006). As of September 2013, more than 1.8 million Medical Cards were in circulation, covering 40.6% of the population, an increase of almost 590,000 or 46% since the start of 2008 (HSE, 2013).

Total public health expenditure has risen from €10.2 billion in 2004 to €14.1 billion in 2012. Estimates for 2013 indicate a decline to €13.9 billion in expenditure (HSE, 2014). The reduction in the public share of health funding can be explained by a series of measures that have been introduced to make the public pay more for health services, including increases in the share of direct payments for prescribed medicines and appliances (OECD, 2013). Most of the reductions in public spending have been achieved through cuts in wages and fees paid to professionals and pharmaceutical companies, and through reductions in the number of health workers, investment plans have also been put on hold by the government (OECD, 2013). Government budget allocations to health have remained stable in relative terms considering vast budgetary cuts across government expenditure due to the economic crisis, health has more or less maintained its share of the decreasing overall budget available to government (26.7% in 2007 versus 25.9% in 2012). Nevertheless it is important to note that during this period demands, and demands on the finances and resources of the public health service increased significantly, partly due to the marked increase in the number of people eligible for medical cards

1 'Ordinary residence' applies to those who have been resident for the previous three tax years then become ordinarily resident from the start of the fourth year (Citizeninformation, 2014)

(Thomson et al., 2012), and also due to a reduction in staff. The current government has pledged to radically reform the health service, and plans to establish a universal health insurance system, which is a new direction for Ireland (Thomas and Burke, 2012).

The hospital sector in Ireland comprises of HSE-owned hospitals, private hospitals and voluntary hospitals. Public health services are provided in HSE hospitals and public voluntary hospitals, voluntary hospitals follow regulations set out by the HSE, and in practice there is very little difference between these two types of hospital[2]The majority of these hospitals also provide private health care, but they must clearly distinguish between public and private allocated beds. On admittance patients make a choice to be treated on a public or private basis by their consultant. There are 48 public hospitals in Ireland, including public hospitals and voluntary hospitals. Statutory hospitals are public hospitals which are directly managed, while voluntary hospitals are indirectly managed and have their own hospital boards. Voluntary hospitals are run on a not-for-profit basis by private organisations (usually religious institutions, or universities), and receive most of their funding from the State (Nolan, 2005). Voluntary, regional and county hospitals differ in terms of governance and management structure and the level at which services may be provided, and may also differ in terms of their teaching status (Layte et al., 2009). There are 28 voluntary public hospitals – among which are university teaching hospitals, such as St James's Hospital in Dublin. The 28 voluntary public hospitals are concentrated in major cities, leaving public provision in the rest of Ireland to the HSE (Bidgood, 2013). Teaching hospitals are HSE and voluntary, are affiliated to universities and some teaching hospitals have allocated private patient beds.

There are 21 private hospitals affiliated with the Independent Hospital Association of Ireland and involved in the provision of acute care (Department of Health and Children, 2013). These hospitals do not receive State funding, and operate independently of State health services. They collectively provide over 1 in 6 acute beds to the Irish healthcare system and employ circa 8,000 people[3]. Private health insurance is required to access services in a private hospital. However, since 2008 the numbers of households purchasing private health insurance has declined; there were 2,052,000 people insured with inpatient health insurance plans at the end of December 2013, this represents 45% of the total population, down from the 2008 peak of 51% in 2008.[4].All private health insurance providers must be registered with the Health Insurance Authority.[5]

In 2008 there were 11,660 public beds in public hospitals and nearly 4,400 private beds (2,461 in public hospitals and 1,926 in private hospitals) (HSE, 2008). The number of hospital beds in Ireland in 2011 was 3.0 per 1000 population, significantly less than the OECD average (4.8 beds). There are restrictions on the number of public beds that can be used for private practice (OECD, 2013). Acute

2 http://www.citizensinformation.ie/en/health/health_service_agencies/health_boards.html
3 http://hse.ie/eng/services/list/1/schemes/cbd/acchealthcareireland/Accessing_Healthcare_in_Ireland_under_CBD.html
4 http://www.hia.ie/publication/market-statistics/
5 http://www.citizensinformation.ie/en/health/health_insurance/private_health_insurance.html

hospital services are provided in HSE hospitals, public voluntary hospitals and private hospitals. Some hospitals are specialist, for example, maternity or psychiatric hospitals, while others are general. In 2011, there were at least 57 acute hospitals in Ireland and there are over 10,600 inpatient acute public hospital beds (ESRI, 2012; Bidgood, 2013).

The range of health and personal social services provided by the HSE and its funded agencies are managed within four Regions (Dublin Mid Leinster, Dublin North East, South and West). The HSE funds over 2,600 agencies which provide a range of health and support services on its behalf, agencies include the National Learning Network (NLN) which provides services to support children and adults with a range of disabilities and mental health needs.[6] The main function of a HSE Administrative Area is to provide or arrange for the provision of health, community care and personal social services to the people in its area. The main delivery point for community health and personal social services is through the network of 32 local health offices and local health centres. Primary healthcare in Ireland is mostly provided by general practitioners (GPs), GPs are both part of the public health system and independent from it, and are reimbursed by the state when they treat public patients (Bidgood, 2013). Hospital services are delivered by 10 hospital networks, based on the former regional board areas – these networks are accountable to the HSE National Hospitals Office (NHO) (Bidgood, 2013). In May 2013, Minister for Health James Reilly announced the reorganisation of Ireland's public hospitals into six groups, described as "the most fundamental reform of the Irish acute hospital system in decades" (Department of Health, 2013). Regional groups are being introduced to increase coordination and facilitate integration with community and primary care (Bidgood, 2013). The overarching aim of the wider health system reform programme is to deliver a single-tier health system based on Universal Health Insurance (UHI), with equal access to all based on need and not on ability to pay (HSE, 2013).The Government is citing the Dutch healthcare system as its model, which has been consecutively ranked number one among health systems by both the Commonwealth Fund and Euro Health Consumer Index (EHCI) (Bidgood, 2013).

Recognised healthcare occupational categories are: Nurses and midwives; Medical practitioners; Pharmacists, pharmacologists, ophthalmic and dispensing opticians; Dental Practitioners; Physiotherapists and chiropodists; Occupational and speech therapists; psychotherapists and other therapists; Veterinarians; Medical Radiographers; Medical technicians, dental auxiliaries and dental nurses; Other associate professionals; Nurses' aids (Bobek at al., 2011). The health sector has the highest number of employees in the public sector (Boyle, 2014). In 2012 there were approximately 104,000 persons employed in healthcare occupations, representing 5.7% of Ireland's workforce. Of this almost 90% of total employment was in professional occupations (equivalent to approximately 92,000 persons). Nurses and midwives accounted for just over three fifths of total employment in professional occupations (Behan et al., 2013). Ireland has a low number of doctors (2.7 per 1000 population) and high number of nurses (12.2 per 1000 population) (OECD, 2013). As of 31st Dec 2013 there was 1 approved consultant post per 1,761 population (HSE, 2014).

6 http://www.hse.ie/eng/services/news/newsarchive/2014archive/feb14/PACrehab.html

1.2 Education and Training for Medical Occupations:

There are six medical schools in Ireland, which are regulated by the Irish Medical Council. Between them they deliver nine undergraduate programmes (Medical Council, 2013). The medical training system in Ireland has changed significantly since 2006 when the Government introduced measures to reform medical education and training, measures involving the doubling of the number of medical places for Irish and EU students over a 4-year period, as well as the introduction of a new 'Graduate Entry Programme' (GEP) for medicine from 2007 (McDaid et al., 2009). This meant that the number of approved medical programmes increased from five in 2008, to nine programmes by May 2013. The introduction of four graduate entry programmes significantly increased the number of medical students in Ireland (Medical Council, 2013).

Career structure for doctors:

There are two broad categories of doctors working in hospitals in Ireland: (1) consultant doctors, which are senior positions; (2) non-consultant hospital doctors (NCHDs), which are junior positions. The whole training pathway of a doctor following the receipt of his/her medical degree takes a minimum of 10 years (Buttimer et al., 2006), and it takes about 15 years to become a specialist consultant doctor in Ireland. The career pathway from medical student to consultant encompasses the following stages:[7]

1. Medical Degree (4-6 years);
2. Internship (sometimes referred to as 'house officer'), 12 months;
3. Basic Specialist Training, 2 years. During this time a doctor works as a Senior House Officer (SHO);
4. Registrar Training;
5. Higher Specialist Training, 4-6 years;
6. Consultant.

Becoming a consultant would be desirable for most of doctors, however there are more junior hospital doctors in Ireland than consultant posts, meaning that many posts do not have a clear career path to achieve consultancy (Humphries et al., 2013). This situation has a strong effect on the retention of the Irish medical graduates, as well as migrant workers.

1.3. Education and Training for Nurses:

Nursing in Ireland is self-regulated. The regulatory body is *An Bord Altranais*, and registration with it is mandatory in order to practice as a Registered Nurse or Registered Midwife in Ireland (An Bord

7 Source: Royal College of Physicians of Ireland, 2014 https://www.rcpi.ie/article.php?locID=1.6.197.415

Altranais, 2014). Pre-registration nurse education is university and college based, all nursing programmes are at Level 8 Honours Bachelor Degree and the academic award is a Bachelor of Science (BSc) (NQAI, 2004). There are currently 13 Higher Education Institutions in Ireland offering 44 pre-registration honours degree programmes. There are five types of nursing programmes at pre-registration (degree) level: children's and general nursing incorporated, midwifery, general nursing, intellectual disability nursing and psychiatric nursing. (An Bord Altranais, 2014). An internship takes place during the fourth year of the degree programme, during which the student is a paid employee of the health service. Undergraduate education provides the appropriate foundation for nurses and midwives to practice at registration, and prepares them for ongoing continuing professional development (Department of Health and Children, 2011). Continuing professional development following registration is essential for nurses in order to acquire new knowledge that will enable them to practise effectively. There are five types of post-registration programmes leading to an additional registration with the Irish nursing board: nurse prescriber, midwifery, public health nursing, children's nursing and nurse tutor. Furthermore nurses can specialise in areas through diploma and Master Courses in universities across Ireland, an example of which is a Master of Science in advanced nurse practice (An Bord Altranais, 2011). To date no formalised statement has been made in relation to the scope of nursing and midwifery practice in Ireland. The scope of practice for nurses and midwives in Ireland has been defined with reference to EU directives, contemporary legislation, social policy, national and local guidelines, education and individual levels of competence (An Bord Altranais, 2014).

Language skills required

The ability to communicate clearly with patients and colleagues is a key requirement for all healthcare professionals in Ireland. Proficiency in the English language is therefore a core competency for all Non-consultant hospital doctors (NHCDs), and nurses working in the Irish public health service. The HSE requires that as part of the application process for training positions on specialist training programmes all applicants are required to demonstrate their competency in the English Language in line with HSE specifications (Royal College of Physicians Ireland, 2014)[8]. There are specific language requirements set out for registering Nurses and Doctors.

Nurses and Care Assistants

Nurses who have trained outside of the EU and want to work in Ireland must satisfy language conditions set out by An Bord Altranais. English language competence is required at a level that supports communication, therefore proof of English language competence is required in cases where English is not the first or primary language of the applicant (Walsh and O'Shea, 2009).

8 http://www.rcpi.ie/content/docs/000001/1240_5_media.pdf

As a condition of nurse registration for non-EU nurses, applicants whose first language is not English are required to demonstrate proof of English language proficiency. A minimum overall score of 7 required on the International English Language Testing System (IELTS) academic test. The assessment examines English language ability by testing listening, reading, writing and speaking skills (An Bord Altranais, 2011). Applicants from inside the EU do not have to demonstrate English language proficiency, instead it is the responsibility of the employer to ensure that the employee has sufficient language capabilities to complete the necessary duties. There are few statutory or regulatory standards or requirements in place for training for language and communication for Nurses. There is not an official or sector wide requirement for care assistants to possess a minimum level of English Language proficiency (Walsh and O'Shea, 2009).

Doctors

Previously, the Medical Council required that non-EU/EEA applicants seeking registration with the Medical Council either pass, or be exempted from the academic International English Language Testing System (IELTS). An overall score of 7.0 was required to pass. Separately, the HSE required that persons taking up Intern posts from July 2011 who did not complete the entirety of their undergraduate medical training in the Republic of Ireland, must demonstrate their English proficiency through the submission of an IELTS certificate. An overall score of 7.5 was required to pass. As of October 2012, the HSE required that all applicants applying for NCHD positions and non-training posts positions must provide either confirmation of completion of a medical degree in English, or IELTS certificate with an overall score of 7.5, and a minimum score of 7.0 in each of the four domains on the academic test (HSE, 2012).

1.2 Highlighted shortages of national staff in the health sector

Despite limited employment opportunities in the public healthcare sector, skill shortages persist for a limited number of occupations. The following healthcare professionals shortages were identified by the Skills and Labour Market Research Unit (SLMRU) in FAS in July 2013 (Behan et al., 2013):

- Medical practitioners (e.g. consultant radiologists)
- Radiographers (Clinical specialists)
- Nurses: (Senior roles) clinical nursing managers, advanced nursing practitioners specialised in intensive care and theatre nursing; and general nurses for roles associated with elderly people care.
- Specialist nurses, confined to older people care, cardio care, intensive and critical care, oncology, and theatre nursing.
- Cardiac technicians.

- Care assistants/home carers i.e. elderly care in nursing home settings or in their own homes.
- Speech and language therapists.

In the past the shortages in the health sector were understood to be a result of an insufficient number of Irish/EU graduates trained in medicine in Ireland. The annual intake to undergraduate medical programmes was subject to a quota, introduced in 1981, the quota restricted the number of places for Irish/EU students to 305 (FAS, 2005). The remaining places were reserved for the non-EU students who pay higher fees. As a result, in 2006, 60% of medicine graduates were not Irish, and the majority of them were expected leave the country after qualifying. The introduction of the 'Graduate Entry Programme' (GEP) in 2007 increased the number of Irish and EU medical graduates in the sector. By 2010/2011 there were 750 Irish and EU entrants to medical schools in Ireland on both, undergraduate and postgraduate levels (Humphries et al, 2013; Bidwell et al, 2012). The increase in the number of Irish graduates, however, proved to be insufficient in addressing the shortages problem. Due to a lack of career paths in Ireland, as well as bad working conditions, many Irish medicine graduates emigrate to other countries after finishing their degree. In 2011, the HSE Medical Education and Training Unit carried out a survey of doctors who had completed their intern year and found that around 50% of those surveyed NCHDs had emigrated (HSE, 2012). Many hospital departments are suffering NCHD shortages as increasing numbers of Irish junior doctors are electing to work abroad, while fewer foreign doctors are seeking work in the Republic. In July 2011 the HSE revealed that there were 191 NCHD vacancies in Irish hospitals (Bruce-Brand et al., 2014). In April 2014 the HSE advised that 34 hospital consultant posts were vacant and a further 219 consultant posts were filled by temporary or locum appointees (Minister James O'Reilly, 2014).[9] Humphries et al., (2013) identified a cycle of doctors' brain-gain-drain occurring in Ireland. It could be summarised as follows:

1. The Irish doctors decide to emigrate due to the lack of clear career paths, lack of training and bad working conditions in Ireland. As a result, shortages occur, mainly at a junior level (NHCD).
2. Doctors from non-EU countries are recruited to fill in those gaps.
3. Brain-waste occurs as the non-EU, highly qualified doctors are mainly employed at the lowest levels and often work as 'service doctors'.
4. Brain drain continues as the non-EU doctors decide to move another country (e.g. the UK) as the career paths, training and working conditions seem to better elsewhere.
5. Shortages occur again.

There are issues around equal access to professional development opportunities for migrant doctors. In 2013 the Medical Council Ireland found that the participation of internationally-trained doctors in specialist training was lower than that of doctors trained in Ireland. Furthermore just one-quarter of international medical graduates were registered in the specialist division of the register, as opposed to

9 http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2014040100007

over 50% of Irish medical school graduates (Medical Council, 2013). Apparent unequal opportunities could further explain why there are difficulties in retaining doctors.

It seems that a similar brain drain cycle occurs in the case of nurses in Ireland. Shortages occur as a result of the emigration of the Irish-trained nursing professionals. These vacancies are then filled with non-Irish staff. A study on the retention of migrant nurses by Humphries at al., (2009) found that a large proportion of non-EU nurses consider further emigration onwards. In addition to better career opportunities elsewhere, non-EU nurses considered leaving Ireland as they experienced a lack of stability in terms of citizenship and family reunification, respondents reported frustration that their families did not receive entitlements to residency or citizenship as a family unit (Humphries et al, 2009). Irish legislation does not provide an explicit legal right to family reunification, or to reside in Ireland on the basis of existing family relationships in all circumstances (Strik et al., 2013). In a study of family reunification policies in six EU countries, Strik et al. (2013) found that Ireland provides the least security to family members of any group, including family members of own nationals, as there are no provisions that grant explicit rights: Ireland does not participate in the Council Directive 2003/86/EC on the right to family reunification. This leaves a much wider scope of discretion for the authorities, compared to other Member States (Strik et al., 2013). In a recent document on family reunification the Irish Naturalisation and Immigration Service (INIS) asserted that ministerial discretion will continue to apply to most decision-making on non-EEA family reunification, but it is proposed to provide greater detail on how that discretion will be used (McGinnity et al., 2014)

There is also some evidence of retention issues in relation to home carers in nursing homes and patients' own homes; the demand for carers is expected to continue to grow due to increased life expectancy, and an anticipated increase in the size of the older age cohorts (Behan et al., 2013).

In response to the economic crisis the government introduced a 'Moratorium on Recruitment and Promotions' in the Public Service in March 2009, which applies to the all recruitment, including Irish and non-Irish workers. There is a general moratorium on recruitment, promotion and acting appointments to all management and administrative grades and all other grades in the health sector with the exception of the following specified grades: Medical Consultants, Speech and Language Therapists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Behavioural Therapists, Counsellors (Mental Health and Disability Services), Social Workers, and Emergency Medical Technicians. The Minister for Finance has the authority to allow for the filling of some vacancies in very exceptional circumstances (HSE, 2014).

1.3 National policies aimed at filling this gap

As explained in point 1.2, the number of places on medical degrees was increased for the Irish/EU nationals. With a high number of graduates leaving Ireland, however, these numbers are still insufficient and shortages of medical staff constantly occur, especially at the level of NCHDs. These are often sourced from abroad, mostly through passive recruitment. A number of immigration policies for the non-EU medical workers have been introduced in order to fill in those gaps. It could be argued, however, that due to the recent recession Ireland is no longer attractive to foreign workers. The economic crisis has led to salary reductions, stretches on resources, no payment for overtime, and a loss of training grants (Bidwell et al, 2012). In addition to recruitment issues, Ireland has been experiencing problems related to retention of both Irish and foreign medical workers. Nevertheless, as it will be further discussed, there has been some active recruitment of doctors from abroad. In the case of nurses, Ireland has been involved in active recruitment of foreign staff since the early 2000s. There currently are no national policies aimed at filling the gap in the health sector. However the exemption of the Green cards income requirement[10] for highly skilled health workers, can be seen as a form of passive recruitment. Ireland has not entered into labour migration agreements relating to attracting qualified third-country nationals, and has few labour migration-related policies that involve a focus on specific third-countries (Talbot, 2013).

2. The Regulatory Framework For Migrant Health Workers

2.1 Conditions of entry into the country of Migrant Health Workers

Migrant health workers who are citizens of the European Economic Area (EEA) are allowed to move to Ireland – free movement of workers being a fundamental principle of the European Union – however they are required to validate their qualifications in order to practice medicine. The Government will not grant permission to take up employment to Non-EEA doctors or nurses who enter the State without the correct landing permission and, where applicable, the correct entry visa. There are two types of employment permit available for non-EU migrant health workers: Work Permits and Green Cards.

Work permits

Work permits are available for positions with a remuneration of €30,000 or more, permits for jobs with an annual remuneration below €30,000 are considered only in exceptional cases. Non-EEA migrants can obtain work permits if they are directly employed and paid by the employer (agency work is not accepted); the applicant must have the qualifications required for the job, a 'labour market needs

10 Green cards are usually available for jobs with annual remuneration of over €60,000.

tests'[11] also applies for the Work Permit scheme. In addition, there is a regularly updated list of ineligible jobs available on the Department of Jobs, Enterprise and Innovation website; there are currently no medical professions on the ineligible list.[12]

Green cards

The Green Card Employment Permit is designed to attract highly skilled people into the labour market with the aim of encouraging them to take up permanent residence in the State. Eligible occupations under this type of permit are deemed to be critically important, highly demanded and highly skilled, and in significant shortage of supply in the labour market.[13] Green cards are available for jobs with annual remuneration of over €60,000. They are also available for certain highly skilled jobs with remuneration of €30,000 to €59,999 per year. In the case of the health sector, these jobs currently include:

A. **Health Professionals** – Medical Practitioners; Pharmacists/Pharmacologists and related occupations; Registered Nurses; Specialist Nurses; Dental Practitioners; Clinical Nursing Managers and Advanced Nursing Practitioners.
B. **Health Associate Professionals** – Medical Radiographers; Audiologists; Dieticians; Medical Scientists; Orthoptists; ECG Technicians; Neuropsychological Measurement Technicians; Biochemists; Vascular Technicians; Respiratory Technicians; Cardiac Catheterisation Technicians and GI Function Technicians.

In March 2014 the Department of Jobs, Enterprise and Innovation announced that all doctors registering on or after 1 March 2014 (Immigration Stamp 4 holders[14] being exempt), whether for the first time or renewing their immigration permission, will be required to hold an employment permit for both public and private hospitals and health facilities. These new arrangements do not apply to doctors holding immigration permission Stamp 4, who may be renewed on this immigration permission for two years, provided they still continue to practice medicine. Under certain conditions Senior House Officers (SHOs) and Registrars in the public health sector may work without the requirement of an Employment Permit until their immigration permission expires, provided they continue to work in a public hospital or public health facility. If they wish to take up an offer of employment in a private hospital or private health facility within that time-frame an Employment Permit will be required[15]. Prior to this, since 2010, certain categories of medical workers were allowed to work in the public health system without an employment

11 The labour markets needs test is that the employer must advertise the vacancy with the Department of Social Protection Employment Services /EURES employment network for at least 2 weeks, and in a national newspaper for at least 3 days, and also in either a local newspaper or jobs website (separate to DSP/EURES websites) for 3 days (DJEI, 2014).
12 http://www.citizensinformation.ie/en/employment/migrant_workers/
13 http://www.djei.ie/labour/workpermits/greencardemploymentpermit.htm
14 The immigration stamps, in conjunction with the Certificate of Registration issued by GNIB, are evidence of permission to be in the State (http://www.inis.gov.ie/en/INIS/Pages/Stamps). Non-EEA nationals tend to hold stamp 4, stamp 4 EUFAM or stamp 3 immigration permissions, depending on the status of the principal person. Stamp 4 is issued to a range of non-EEA nationals, including family members of refugees, parents and siblings of Irish- born children (McGinnity et al., 2014).
15 http://www.djei.ie/labour/workpermits/greencardemploymentpermit.htm

permit provided they met certain requirements, including the registration with the Irish Medical Council. Categories included Non-EU doctors registered on the trainee specialist division of the Medical Council of Ireland's register, or those working as Senior House Officers or Registrars (Bidwell et al., 2013). This could potentially be seen as another form of passive recruitment by the HSE. Migrant health workers who have acquired citizenship through naturalisation, birth or descent, or marriage or civil partnership do not require a work permit.

2.2 Conditions of access to the health sector for Migrant Health Workers

Every migrant health worker has to register with a relevant professional body to work in the State. The professional bodies are:

- Medical Practitioner: Medical Council of Ireland
- Nurse: An Bord Altranais (Irish Nursing Board)
- Diagnostic or Therapeutic Radiographer, Occupational Therapists, Medical Physicist, Psychologist, Speech and Language Therapist: Minister for Health and Children
- Physiotherapist: Irish Society of Chartered Physiotherapists

EU and non-EU migrant doctors whose qualification is not recognised under EU Directive 2005/36/EC must pass the Pre-Registration Examination System (PRES). The PRES consists of two parts – Level 2 is a written examination and is currently in the form of a Multiple Choice Questions (MCQ) examination. Level 3 is a clinical examination and is currently in the form of an Objective Structured Clinical Examination (OSCE) (Medical Council Ireland, 2014). Applicants must meet language requirements, as discussed above.

Applicants for the nursing register who trained outside of the European Union undergo an individual assessment for suitability. Furthermore, in order to be granted direct registration, the training programme/qualification must meet with the educational requirements and standards of Irish trained nurses. Applicants must also have completed a programme of not less than three years duration, and the programme must have had a balance of not less than one-third theoretical instruction and one-half clinical/practical instruction (Barrett and Rust, 2009). In addition there is a competency-based assessment during the period of adaptation, involving supervised practice and, if necessary, further education and training. The adaptation period takes at least 6 weeks to complete, but it is acknowledged that most candidates can require up to 12 weeks to achieve the required competencies (Quinn, 2006). If migrants have completed their nursing education and training in an EU member state the rules are different. Migrant health workers who completed their nursing education and training in an EU member state must attain certain qualifications/experience before entitlement to a direct registration with An Bord Altranais. An EU-trained applicant for General or Midwifery registration that meets with the

European Directive (EU Directive 2005/36/E: for more information see section 2.4), may register with the Nursing Board Ireland without having to undergo an educational assessment. An EU-trained applicant for General or Midwifery registration that does not meet with the European Directive, or is applying for a division of the register other than general or midwifery nursing has to undergo a full educational assessment with the Irish Nursing Board (An Bord Altranais, 2011).With regard to care assistants, non-EEA nationals must apply for a work permit on commencing work as a care assistant, and depending on the care setting, all migrant care assistants are also likely to be required to complete the FETAC level 5 training (Walsh and O'Shea, 2009).

2.3 Channels of recruitment of Migrant Health Workers

Medical Doctors

Despite severe shortages in doctors experienced by the Irish health sector, Ireland is characterised by a passive rather than active recruitment of non-EU doctors, and non-EU doctors generally migrate independently (Bidwell et al., 2012). During the Celtic Tiger period[16] the country was relatively attractive for migrants, hence recruitment was not needed. Furthermore, the Medical Council of Ireland had centres in Oman, India, Pakistan and Egypt in which doctors could apply for the required registration, which is one of few active recruitment strategies adopted by the government.

In 2008 the economic downturn heavily affected the health care system, and large scale budget cuts resulted in salary reductions, reduction in staff numbers through voluntary redundancies, loss of overtime and training. Furthermore the recruitment moratorium made Ireland a less attractive destination for foreign-trained doctors. Doctor shortages continued into 2009, and by 2011 it was reported that Ireland had been trying to address ongoing vacancy rates for NCHDs for 2 years (Bidwell et al., 2012). Due to acute shortages, campaigns were initiated to recruit doctors from other countries and agencies have been involved in the international recruitment of doctors both to public and private sectors in Ireland. In terms of the public health service, there have been five recruitment agencies in the framework agreement with the HSE since February 2010. The agencies were selected in a competitive tender process to supply temporary doctors to the HSE (Bobek et al., 2011).

Prior to 2011 Ireland conducted some recruitment of anaesthetists and locum GPs. In 2010, both the number of new visas issued and the number of new registered non-EU graduates decreased sharply. This suggests that rates of migration dropped, which could have exacerbated staff shortages and could help explain why Ireland needed to actively recruit doctors from overseas (Bidwell et al., 2012). In July 2011, due to the critical shortage of the NCHDs, Ireland conducted an active recruitment campaign

16 'Celtic Tiger' refers to the period of rapid economic growth that Ireland experienced in the mid-1990s and early 2000s (Fahey et al, 2007).

aiming to recruit 450 doctors from India and Pakistan and 290 doctors were recruited through this campaign. Urgent amendments to the Medical Practitioners Act were enacted in 2011 to create a new 'Supervised Division' of the medical register. The new doctors were recruited to this division, and as part of the qualifying process they were evaluated by the HSE and sat a tailored exam to assess their suitability for the posts. The supervised division regulations stipulate that the recruits cannot work outside their approved scope of practice, or do locum work (Talbot, 2013). The recruits were given two year contracts, and for most candidates, the two year period in the supervised division is coming to an end. If the candidates want to retain employment in Ireland they have to apply to either the general or trainee specialist divisions.

Separately, in November 2011 a memorandum of Understanding for a pilot exchange programme was agreed between the HSE and the College of Physicians and Surgeons of Pakistan. Doctors enrolled in CPSP's postgraduate training programmes spend two years gaining experience and training in Ireland. Participants will have their time accredited for training purposes by the CPSP and this will contribute to their career progression on return to Pakistan.[17] In 2013 a second recruitment campaign was conducted in Pakistan and South Africa (Humphries et al, 2013).

Professional Nurses

In the case of nurses, Ireland adopted active recruitment strategies since early the 2000s in order to fill shortages in the sector. In 2000 a 'Nursing and Midwifery Recruitment and Retention Initiative' was launched with an aim to tackle nursing shortages. The initiative was designed to attract inactive qualified nurses and midwifes back into the public health service, retain nurses and midwifes in the public health service and address the need for more trained nurses in specialist areas (Bobek et al., 2011). Between the years 2000 and 2006, 9,441 nurses were issued with work visas, of which 90% were from India and the Philippines. The number of work visas issued to nurses accounted for 60% of all skilled professionals work visas in that time period (Humphries et al., 2008). In 2001 and 2005-2007 there was particularly strong overseas recruitment, with approx. 2,000 work authorisations and visas issued to nurses in each of those years. This was linked to active recruitment projects by the Dublin Academic Teaching hospitals (DATHs) and the HSE due to the lack of Irish nursing graduates in those years (Humphries et al., 2008). In 2006, the Dublin Academic Teaching Hospitals recruitment project targeted India, Bahrain, Singapore and the Philippines (Walsh and O'Shea, 2009).

A number of recruitment agencies were involved in the nursing recruitment process, and travelled to countries such as the Philippines and India. The HSE has built up a relationship with the Philippines, so as to enable Ireland to attract more qualified nurses to come and work (Barrett and Rust, 2009). Between 2000 and 2010 35% of new recruits into the Irish health system were non-EU nurses (Humphries et al., 2009; 2012). In the past decade nearly as many nurses were recruited internationally

17 http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/seanad2013031300025

as trained locally: 14,546 non-Irish nurses were recruited, while 17,264 were Irish nationals trained locally (Humphries et al., 2012). There is also substantial recruitment of nurses by private agencies into private institutions, particularly from India (Quinn, 2006).

The trend in recruiting nurses abroad reversed with the onset of the recession, and the recruitment moratorium which both halted international recruitment. Furthermore the recession appears to have contributed to nurse emigration (of Irish and non-EU nurses) (Humphries et al., 2012). The number of employment permits issued in the healthcare and nursing sector fell from 2,185 in 2008, to 370 in 2012. This is primarily related to a change in the channels available for doctors to avail of employment in Ireland (Behan et al., 2013) which meant that certain categories of medical workers could work in the public health system without an employment permit, and could also be due to the economic recession, or problems attracting workers (Quinn and Gusciute, 2013).

Humphries et al. (2012) state that consideration must be given to the long-term sustainability of Ireland's reliance upon overseas nurse recruitment, particularly in the light of global competition for nurses (Humphries et al., 2012). To date there have been no efforts made to retain the recruited migrant health workers in the Irish health system (Humphries et al., 2008).

Care Workers

The State has not been involved in a recruitment drive for care workers or care assistants. In a survey on the role of migrant care workers in ageing societies, Walsh and O'Shea (2009) found that networks featured strongly as pathways to employment for migrant carers. Nevertheless 40% of employers surveyed used recruitment agencies to employ migrant care workers (Walsh and O'Shea, 2009).

2.4 Procedures (and effectiveness) of the recognition of professional titles of Migrant Health Workers

Access to regulated professions is regulated by law and in order to work in that profession in Ireland, you need the approval of the designated competent authority. Persons cannot be employed in their professional capacity in the statutory health service, in either a permanent or temporary capacity, unless their qualifications have been recognised (HSE, 2014). The European Union has established a number of directives to facilitate international access to regulated professions.

EU Migrant Health Workers

EU migrant health workers are regulated under the EU Directive 2005/36/EC, this Directive applies to EEA nationals with EEA qualifications who wish to practice a regulated profession in an EEA State other than that in which they obtained their professional qualifications. In the case of the health and

social care professions, the Directive does not provide for automatic recognition of professional qualifications obtained in another Member State outside of Ireland. The general system provides for an assessment, on a case-by-case basis, of the qualifications of an applicant against those required to practise in Ireland. If the qualification is not comparable with the Irish qualification then it cannot be recognised. If the qualifications are comparable but gaps are identified, post-qualification professional experience of the applicant is taken into account. If deficits still remain, under the Directive, applicants must be offered a compensation measure i.e. a choice of completing an adaptation period or taking an aptitude test. A final decision must be communicated to the applicant within 4 months of submission of a complete application.[18] If granted recognition, a statement of equivalence is issued to the applicant advising that the professional qualification they possess is equivalent to the Irish entry-level qualification and that the applicant is eligible for consideration for employment in the Irish publicly-funded health sector. Suitability for a particular post including, qualification, fitness to practise, language proficiency and Garda vetting, if appropriate, is a matter for the individual employer.[19]

Non-EU Migrant Health Workers

In the case of persons with qualifications obtained outside the EEA member states, the Directive provides that each member state can assess such qualifications according to its own national rules. In Ireland an administrative process, similar to that contained in Directive 2005/36/EC, is in place for the assessment of non-EEA qualifications. However it involves stricter verification of qualifications and work experience. If the qualifications obtained do not immediately meet Irish standards compensation measures are not offered. The assessment process is administered by the National Validation Office, and applicants are issued with a decision letter within 6 months. This process is separate from the pre registration examination system (PRES). No information of effectiveness can be provided at this stage. The HSE however, states that the validation of qualification takes up to four months for the EEA nationals and up to six months for non-EEA nationals. Each application is assessed on case-by-case basis.[20]

3 The Labour Market Integration of Migrant Workers in the Irish Health Sector: a Statistical Overview

There is no comprehensive source for health worker data in Ireland, instead a compilation of sources provide a summary of migrant health workers in Ireland. The main source for detailed nationality breakdown of health professionals in Ireland is Census 2011. Census 2011 was conducted in April

18 http://www.kildarestreet.com/wrans/?id=2010-09-29.3013.0
19 http://www.hse.ie/eng/staff/jobs/validation/
20 http://www.hse.ie/eng/staff/Jobs/Validation/Appendix2.pdf

2011, and found that overall, UK, Indian and Filipino nationals accounted for more than half of all non-Irish workers in the Human Health and Social Work sector.

Table 1: Census Data Table of Top 20 Population of Health Professionals in April 2011

		2011	%
Irish		69,446	79.7
	of which Irish-English	345	0.4
	of which Irish-American	428	0.5
	of which Irish-Other	1,053	1.2
Non-Irish		15,528	17.8
EU27 excluding Irish		4,836	5.6
	of which UK	2,578	3.0
	of which Polish	685	0.8
	of which German	334	0.4
Asian		8,249	9.5
	of which Indian	4,398	5.0
	of which Filipino	2,824	3.2
	of which Pakistani	404	0.5
	of which Malaysian	332	0.4
African		1,542	1.8
	of which Nigerian	570	0.7
	of which South African	314	0.4
	of which Other African	656	0.8
American		425	0.5
	of which American (US)	250	0.3
All nationalities		87,111	

Source: Census 2011 Microdata, available at www.cso.ie

In terms of occupational distribution of nationality, Sudanese (48.5%), Egyptian (18.6%) and Pakistani (17.9%) nationals recorded a higher than average number in the 'higher professional' category. This reflects the high numbers of medical doctors among these nationalities. Indians and Filipinos had the highest percentages in the 'lower professional' category (which includes nurses and midwives) with 53.2 per cent and 44.3 per cent, respectively (CSO, 2012).

3.1 Statistics for Migrant Doctors

The main source of data on doctors in Ireland is the Medical Council Ireland (MCI) practitioner register: in order to practice as a doctor in Ireland a candidate must register with the Medical Council.

Registration data may, however, under or over-estimate the numbers of foreign nurses and doctors working in Ireland. Registration with the MCI does not mean that migration to Ireland has actually taken place, for example analysis of the MCI Register revealed that although South Africans comprise the largest number of non-EU doctors registered in Ireland (n=1,632), 81% (1,330) remain resident in South Africa (Bidwell, 2013). An estimated 24% of South African doctors register in Ireland as a 'safety net', with a view to possible future migration to Ireland (Bidwell et al., 2012). Little is known about non-EU migrant doctors in terms of where they come from, where they work and how long they intend to remain in Ireland[21].

Table 2: Registration Data for non-EU Doctors registered in 2000 and 2010 by nationality

	2000		2010	
	(N)	% of total of non-EU registered Doctors	(N)	% of total of non-EU registered Doctors
Pakistan	375	39.2	1,075	22.7
India	186	19.4	460	9.7
Egypt	79	8.3	194	4.1
Australia	58	6.1	196	4.1
Sudan	64	6.7	403	8.3
South Africa	54	5.6	1,582	33.4
Nigeria	36	3.8	389	8.2
Other	105	11	443	9.3
Total	957		4,472	

Source: Medical Council Ireland Register Data 2000-2010

Table 2 shows registration data for non-EU doctors in 2000 and 2010 and the biggest source country of foreign trained doctors in 2000 was Pakistan (39.2% of registrations). By 2010, South Africa had become the biggest source country (33.4% of registrations). In 2000 the other key source countries for non-EU graduates registering in Ireland were: India (19.4%), Egypt (8.3%), Sudan (6.7%), Australia (6.1%) and South Africa (5.6%). In 2010, similar source countries were recorded namely: India (9.7%), Pakistan (22.7%) and Sudan (8.3%). The largest increase was for South African graduates, increasing from 5.6% in 2000 to 33.4% in 2010. By 2010 Nigeria appeared as a new source country: 8.2% of those registered in 2010 were Nigerian graduates (Medical Council Ireland, 2010). However it is not

21 http://www.doctormigration.com/

known how many of those registered are residing in Ireland, as registration does not mean that migration to Ireland has actually taken place.

In 2009 an estimated 55% of the 4,639 public sector NCHDs were foreign-trained, as were 6% of Ireland's 2,245 consultants and 5% of Ireland's 2,500 GPs (FAS, 2009; Bidwell et al., 2012). The number of foreign-trained doctors registered with the MCI rose from 1,746 in 2000 to 6,274 in 2010, an increase of 259% over 10 years. The largest annual growth was seen from 2001 to 2002 and there was a decline from 2009 to 2010, when the number of foreign-trained doctors registered dropped by around 300 (Bidwell et al., 2012).

The proportion of foreign-trained doctors rose from 13.4% of all registered doctors in 2000 to 33.4% by 2010. The largest increase was in foreign-trained doctors from outside the EU, rising from 972 (7.4%) in 2000 to 4,740 (25.3%) of registered doctors in 2010. The number of foreign-trained doctors from other EU countries doubled from 780 in 2000 to 1,521 in 2010 (Bidwell et al., 2012). As of 2012, 23% of doctors on the Medical Register were non-EU trained, and a further 4% were non-EU citizens trained in Irish medical schools (*Medical Council Ireland unpublished* in Humphries et al.,2013).

Table 3: EU graduates registered with the medical council Ireland

	2000		2010	
	(N)	**% of total EU registered Doctors**	**(N)**	**% of total EU registered Doctors**
UK	607	76.7	677	44
Germany	55	7	~	7.9
Italy	~	3.7	~	3.1
Poland	~	0	~	15.1
Hungary	~	0.3	~	5.5
Romania	~	0.3	~	3.6
Other	~	11.9	~	12.1

Source: Medical Council Ireland. Note: ~ Indicates that this data is unavailable

Table 3 demonstrates data on EU graduates registered with the Medical Council in Ireland in 2000 and 2010. In 2000 UK nationals were the highest number of EU registered doctors, accounting for nearly 77% of all EU registered doctors. German nationals made up 7% of all registered EU doctors, and Italian nationals accounted for 3.7 %. In 2010 the proportion of UK nationals decreased to 44% of all

EU registered doctors, and in this period the proportion of Polish doctors increased from 0% to 15.1% of all EU registered doctors. The proportion of Italian and German doctors remained similar.

Another source of information on migrant doctors is visa data, however visa data under-estimates the numbers of doctors actively working in Ireland (Bidwell et al., 2012). Between 2000 and 2010 a total of 5,009 visas were issued to non-EU national doctors, and a total of 5,998 non-EU graduates entered the MCI register. For most years, the number of entrants to the register exceeds the number of new visas issued; this difference is particularly marked for 2007–2009. Bidwell et al. (2012) state that there are several reasons for the discrepancies between the registration and working visa data, the main reason being that registration data relates to country of training, whereas the visa data records nationality. This means that non-EU nationals who train in Ireland would appear as 'Irish graduates' within the Medical Council Ireland (MCI) data, but are likely to be categorised as non-EU nationals for immigration purposes. Furthermore non-EU graduates do not require a working visa if they already hold an Irish or other EU passport, are spouses of Irish or EU nationals or are asylum seekers/refugees. Additionally, in 2010 revised conditions were introduced meaning that not all non-EU graduates registering with the MCI required work visas. The correct figure for non-EU doctors migrating to Ireland will lie somewhere between the registration data and the visa data (Bidwell et al., 2012).

In 2012 10,656 (65.1%) of those retained on the medical register were graduates of medical schools in Ireland. The proportion of doctors who are graduates of an Irish medical school has remained relatively stable since 2008, at around 65% (Medical Council Ireland, 2013). Table 4 shows that in 2012 34.9% (5,715) of Doctors retained on the register held a basic medical qualification from outside Ireland. Over 13% of those who graduated from a non-Irish school graduated in an eastern Mediterranean country, nearly 10% graduated in a European country other than Ireland, and 7.5% graduated in an African country.

Table 4 World region of graduation with basic medical qualification for doctors who retained registration 2012

World region	N	%
Ireland	10,656	65.1
Africa	1,227	7.5
Americas	66	0.4
SE Asia	492	3
Europe (excluding Ireland)	1,575	9.6
Eastern Mediterranean	2,187	13.4
Western pacific	168	1

Source: Medical Council Ireland, 2013

Table: 5 Country of basic medical qualification for doctors retained in the register 2012

Country	N	%
Pakistan	1,200	21.3
South Africa	768	13.6
United Kingdom	560	9.9
Sudan	527	9.3
India	467	8.3
Nigeria	411	7.3
Egypt	196	3.5
Romania	196	3.4
Poland	166	2.9
Hungary	130	2.3
Australia	115	2
Germany	94	1.7
Libyan Arab Jamahiriya	87	1.5
Iraq	82	1.5
Czech Republic	52	0.9
Slovakia	48	0.9
Italy	41	0.7
New Zealand	35	0.6
Bulgaria	34	0.6
Latvia	33	0.6
Lithuania	25	0.4
Syrian Arab Republic	24	0.4
Spain	23	0.4
Netherlands	22	0.4
Russian Federation	21	0.4
United States of America	21	0.4
France	17	0.3
Ukraine	16	0.3
Bangladesh	14	0.2
Haiti	12	0.2
Belgium	11	0.2
Greece	10	0.2
Belarus	10	0.2
Jordan	10	0.2
Total	5,715	100

Source: Medical Council Ireland, 2013

Doctors who qualified abroad were more likely to exit the register than those who qualified in Ireland. In 2012 the exit rate for Irish-qualified doctors was 5.8%, compared with 16% for those who qualified in the Western pacific, 15.3% in Africa, 14.9% in Europe (excluding Ireland), 14.3% in the Americas, 10.4% in south-east Asia and 7.1% in the eastern Mediterranean countries (Medical Council Ireland, 2013).

Table 5 shows the country of basic medical qualification for doctors retained on the medical register in 2012. The table does not illustrate countries which were the country of qualification for less than 10 doctors. Overall the top five countries for medical qualification were Pakistan (21.3%), South Africa (13.6%), UK (9.3%), India (8.3%) and Nigeria (7.3%).

The Register of Medical Practitioners 2008-2011 showed an overall total of 18,798 practitioners, with the total Non EU being 4,854 of which 511 were Indian (Talbot, 2013). Ireland's medical workforce has an especially heavy reliance on international medical graduates, the proportion of international medical graduates in the workforce has stood at around 35% for the past five years (Medical Council, 2013). In 2008 Ireland had the second highest reliance on foreign trained doctors in its medical workforce across OECD countries (OECD, 2008). However the data estimates of medical practitioner density in Ireland based on registration data may overestimate the supply of doctors, since many doctors registered in Ireland are not in practice, not practising in Ireland or not practising full time (Medical Council Ireland, 2013).

3.2 Statistics for Migrant Nurses

The main source of data for migrant nurses in Ireland is the Irish Nursing Board (An Board Altranais) Register. In order to practice nursing in Ireland a person must register with the Irish nursing board. Beyond secondary immigration and registration data, no information is routinely gathered about the migrant nurse workforce, therefore we cannot ascertain how many of the registered nurses are employed in Ireland, and which sectors they are employed in (Humphries et al., 2008).

Between 2000 and 2008, 10,968 non-EU nurses from 75 different countries newly registered with the An Board Altranais. Most of these nurses (87%) were from India or the Philippines, two countries which were the focus of Ireland's international recruitment campaigns (Humphries et al., 2009). Overall, between 2000 and 2010, 35% of new recruits into the health system were non-EU migrant nurses (Humphries et al., 2012). The period between 2000 and 2010 saw almost as many nurses recruited internationally as trained locally – 14,546 non-EU and non-Irish EU-trained nurses joined the Irish

nursing workforce between 2000 and 2010, alongside 17,264 Irish-trained nurses (Humphries et al., 2012).

Table 6: Country of training of new EU registrants

2010		2011	
UK	211	UK	170
Poland	16	Poland	22
Lithuania	13	Romania	14
Spain	10	Portugal	9
Germany	9	Spain	6
Plus 13 other countries		Plus 11 other countries	

Source: Irish Nursing Board, Annual Report 2011

Table 6 demonstrates the country of training of new EU registrants to the Irish nursing board register in 2010 and 2011. In both years UK nationals accounted for the largest number of new registrants (170 in 2011), and Polish nationals accounted for the second largest number of registrants (22 in 2011).

Table 7: Country of Training of Non-EU registrants

2010		2011	
India	13	India	49
Philippines	11	Philippines	12
USA	5	USA	2
Australia, New Zealand & Nigeria	4 each	Australia, Iran, Russia & South Africa	1 each
South Africa, Kenya, China & Canada	1 each		

Source: Irish Nursing Board, Annual Report 2011

Table 7 shows the country of training of non-EU registrants to the Irish Nursing Board register in 2010 and 2011. In both years Indian nationals accounted for the highest number of registrants (49 in 2011) followed by Philippine nationals (12 in 2011).

Statistics on Migrant Care Workers/Assistants

In 2007-2008 migrant workers accounted for 27 per cent of care workers caring for older people (MRCI, 2012).

Statistics on Public/Private Employees

Data is not available in Ireland on the breakdown of public and private employees in the health sector.

Concluding remarks

This study has examined the labour integration of migrant healthcare workers in Ireland. The Irish healthcare system relies on international medical graduates from a wide range of countries, in particular from India, Pakistan, the Philippines and Africa. There is a lack of comprehensive data on the medical workforce in Ireland, therefore it is difficult to ascertain how many of those registered in Ireland are actually working in Ireland. A brain drain cycle occurs in the case of nurses and Doctors in Ireland, shortages occur as a result of the emigration of the Irish-trained professionals, and issues in retaining migrant health workers.

The economic downturn has heavily affected the health care system, and large scale budget cuts resulted in salary reductions, reduction in staff numbers through voluntary redundancies, loss of overtime and training. Furthermore a moratorium of recruitment means that many hospital departments are suffering shortages, during challenging economic and fiscal conditions for the State, and for health services in particular. A recent working group report for the Department of Health recognised that there are particular issues and challenges in relation to the recruitment and retention of doctors, and recommended a focus on graduate retention in the public health system, and recruiting Irish medical graduates (HSE, 2014).

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