

WORK→INT



Assessing and enhancing integration in workplaces

BACKGROUND REPORT

MIGRANT WORKERS IN THE UK HEALTHCARE SECTOR

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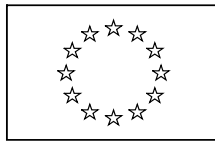
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IMPORTANT NOTE

The regulatory framework for migrant and UK health professionals covered in this report is influenced by government policy and is subject to regular change. Relevant sources noted throughout the text should be consulted for an accurate detailed picture of current policy. The report is correct at the point of completion of the final version on 1st September 2014.

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PART 1: The healthcare system

1.1 The institutional framework

1.1.1 The National Health Service

The UK healthcare system is dominated by the National Health Service (NHS), which came into being in 1948. It provides most of the healthcare in the UK, but provision is devolved in different countries (England, Wales, Scotland, Northern Ireland) and there are differences between the systems. In this report we will focus in detail predominantly on the English healthcare system, unless otherwise stated. Healthcare in the UK is funded by public taxation. Total expenditure on health in the UK in 2012 was 9.4% of GDP.¹ As set out in the NHS Constitution², healthcare is free at the point of use for citizens, permanent residents, and until recently³, migrants considered 'ordinarily resident'⁴ – e.g. labour migrants, family migrants, students on longer term educational courses – as well as asylum seekers. But for all (with some exceptions – e.g. <age 16, > age 60; unemployed/low income, those with some chronic conditions) there are charges associated with some services such as eye tests, dental care and prescriptions for medicines.

Since April 2013 the NHS has been operating within a new organisational structure (see Figure 1). NHS England, the main clinical commissioning board responsible to the Secretary of State and the Department of Health but operationally independent, oversees the provision of NHS services and controls most of the budget. The actual provision of services and management of the budget (around 66% of the entire NHS budget in 2013/14⁵) is performed at local level by over 200 Clinical Commissioning Groups (CCGs) to which all General Practitioner (GP) primary care practices in England belong. There are over 36,000 GPs in England, working in over 8,300 practices. CCGs commission most services including planned hospital care, rehabilitative care, urgent and emergency care, most community health services, maternity services and mental health and learning disability services. They can commission these services from any provider who meets NHS standards and costs, including from private sector providers, social enterprises and charities, as well as NHS organisations including hospitals.⁶ However, most care is provided by NHS organisations. NHS hospitals are

¹ <http://www.who.int/countries/gbr/en/> [accessed: 25/07/2014]

² <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf>

³ The 2014 Immigration Bill redefines the criteria of residence for access to NHS services such that only those migrants who have obtained indefinite leave to remain can access free hospital treatment. <http://www.migrantsrights.org.uk> [accessed 02/06/2014]

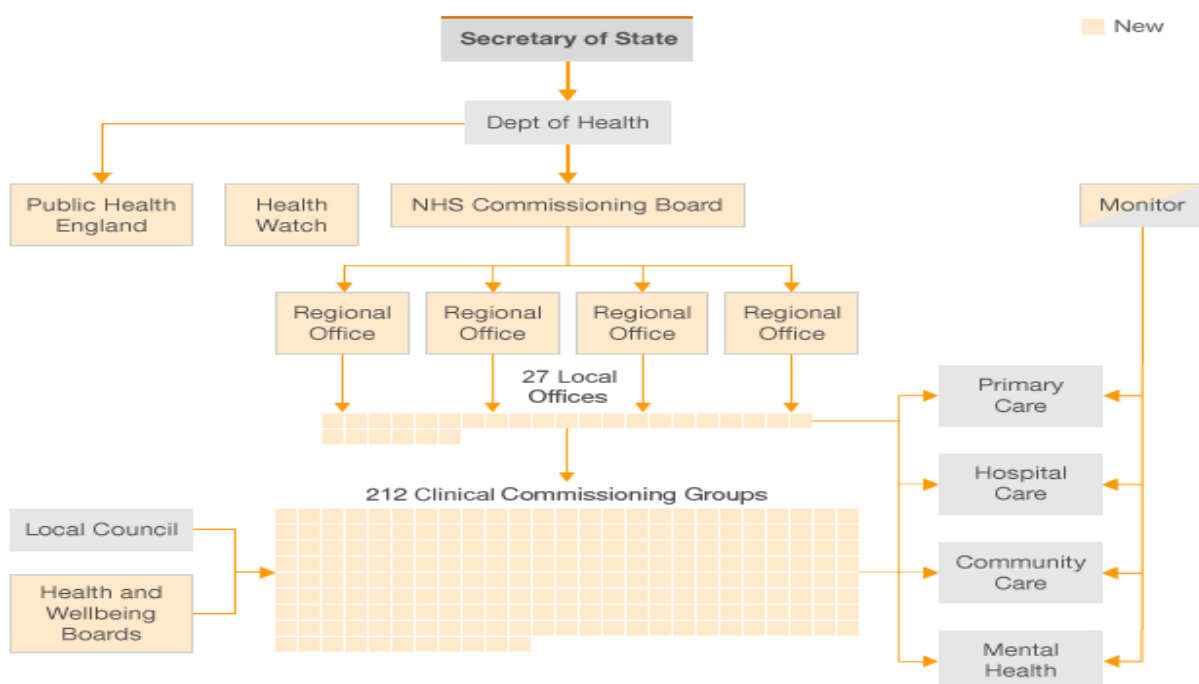
⁴ A common law definition as '[a person's] abode in a particular place or country which he/she had adopted voluntarily and for settled purpose as part of the regular order of his life for the time being, whether of short or long duration' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252864/OR_Guidance_2013-10-01_Revised_with_new_contact_details_New_DH_template.pdf [accessed 25/07/2014]

⁵ <http://www.england.nhs.uk/allocations-2013-14/> [accessed 29/04/2014]

⁶ NHS Choices: the NHS in England <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx> [accessed 28/04/2014]

organised within Trusts⁷, some within Foundation Trusts which have more autonomy over service provision. In April 2014 there were 160 acute trusts (including 101 foundation trusts). Acute trusts, within which hospitals provide acute care, formed just over 60% of all trusts.⁸ All service provider organisations are regulated by the Care Quality Commission (CQC) for quality and safety standards. A regulator called Monitor also promotes competition, regulates prices and ensures the continuity of services if an organisation providing NHS funded services experiences financial difficulties (Department of Health, 2013).

Figure 1: The NHS organisational structure in England



Source: BBC <http://www.bbc.co.uk/news/health-19674838>

Local Authorities (Councils) have direct input into the planning, provision and operation of health services at local level, and work with Public Health England (PHE), an operationally independent executive agency of the Department of Health, to improve public health locally. NHS England commissions about half the public health budget including national immunisation and screening

⁷ In general NHS trusts organise and provide hospital services that are commissioned by the Clinical Commissioning Groups. Foundation trusts have significantly more managerial and financial freedom, and are meant to involve patients and local communities in decision-making. <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx> [accessed: 30/07/2014]

⁸ <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs> [accessed: 30/07/2014]. Other trusts include those providing mental health care, ambulance services and community care.

programmes and public health services for children aged 0 – 5 such as health visiting. Local authorities promote more joined up working at local level across the NHS, public health, social care and other services, predominantly through local Health and Wellbeing boards (Department of Health, 2013).

1.1.2 The private health sector

The private healthcare sector in the UK is small and information on it is difficult to find. It is parallel to the NHS and is largely private insurance-based for users. Only around 11% of population have private healthcare insurance (The King's Fund, 2014). Private healthcare cover provided can be limited – for instance often not including maternity or mental health cover, and generally not including general practice or accident/emergency. While the private health sector's main sources of funding include insured and self-pay patients, and overseas visitors to the UK, it relies heavily on the support provided by NHS purchase of services. In 2011, around 87% of the market in private mental health hospitals was purchased by the NHS.

Most doctors in the UK practise in the NHS, even if they practise privately as well. Accurate numbers are not available but it is estimated from a small British Medical Association (BMA) survey in 2009 that around 53% of NHS Consultants undertook some private practice although this proportion is a drop from just under 60% in 2005. The BMA survey also suggested that private practice is dominated by older consultants and men. Fewer than 10 per cent of new consultants were practising privately and just under two-thirds of consultants who were practising privately had done so for 25 years or more. Only 30% were women even though more of the consultant workforce overall was female at the time. Work - life balance and increase in NHS consultants' pay (until the economic crisis at least) may be issues that affect the composition of doctors working in the private sector. At the same time, in the case of nurses and other healthcare workers, there appears to be a more diversified market, with workers moving back and forth between the NHS and the private sector (Commission on the future of health and social care in England, 2014). See also Figure 4 below for data on distribution of health professionals across public and private sectors.

1.2. The health sector workforce

Definitions

The World Health Organisation (WHO) defines the health sector workforce as “all people engaged in actions whose primary intent is to enhance health” (quoted in Hunter et al 2009, p.13). However, while unpaid care – e.g. in the family – is implicated in such a definition, in keeping with the boundaries and

aims of the WORK-INT project, in this report the health sector workforce is operationally defined as comprising:

- 1) Those with health vocational education and training working in the health services industry;
- 2) Those with health training who are either working in a non-health-care-related industry, or who are currently unemployed or not active in the labour market (Hunter et al 2009)

Thus the main categories of health workers who are the focus of this report are **health professionals** such as medical doctors including complementary medicine professionals, nurses, midwives, dentists, dental nurses, paramedics, pharmacists; and **allied health/health associate professionals** such as physiotherapists optometrists, medical imaging technicians, medical laboratory technicians, pharmaceutical technicians, dental hygienists, nutritionists. The criteria applied refer to possessing **directly health related training and qualifications**. Thus, we will not be considering people working in the health sector but with non-health qualifications such as managers of hospitals or GP practices, medical secretaries, or personal care workers either in hospital or home settings.

Distribution

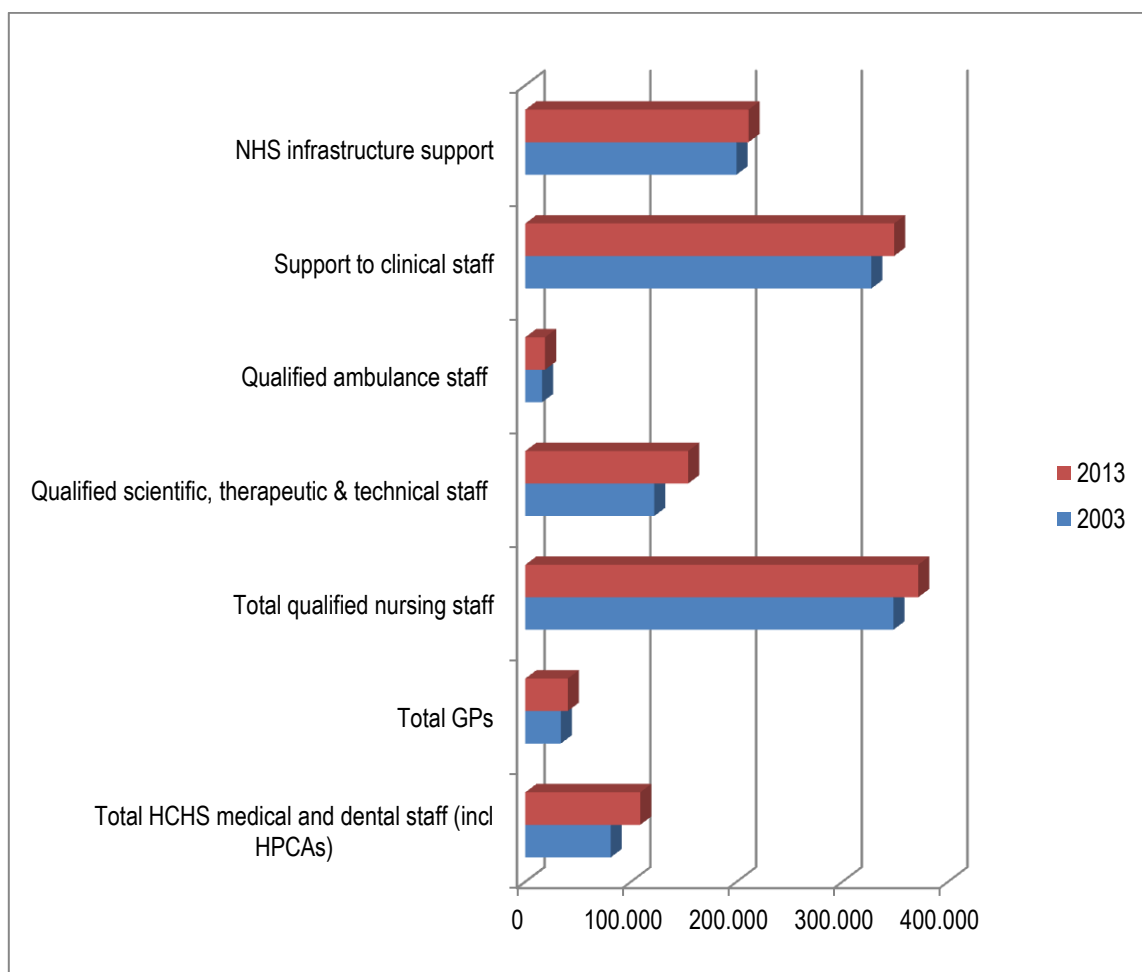
In 2012 the health sector in the UK employed the largest number of people, 3.7 million (13.5% of all UK employees). This represents a growth of 53,000 employees between 2011 and 2012, the second largest growth after Business Administration and Support Services (ONS, 2013).

Figure 2 shows the composition and distribution of the NHS workforce in 2013, compared to 2003.⁹ It can be seen that in 2013, among clinical staff, the number of nursing staff is more than three times that of doctors (excluding GPs). Non-clinical support to clinical staff make up the other major category, nearly 25% of all people working in the NHS. Within the 'infrastructure support' category, there were 36,360 managers in 2013, representing 2.7% of the 1.364 million staff employed by the NHS.¹⁰ Figure 2 also shows that the NHS workforce in 2013 is larger overall than it was in 2003. The average annual percentage change during this time period was 1.2%. There were also more people in each main category of the workforce in 2013 compared to 2003, and there was a positive average annual percentage change in each.

⁹ As at 30 September in each year.

¹⁰ <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs> [Accessed: 30/07/2014]

Figure 2: NHS workforce (main groups), England 2003 and 2013



Total NHS workforce: 2003 = 1,212,585; 2013= 1,364,165

HCHS = hospital & community health service; HPCA = Hospital Practitioners & Clinical Assistants

Source: Health & Social Care Information Centre (chart created from NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England, Medical and Dental staff – 2003-2013, as at 30 September, Table 1a.

<http://www.hscic.gov.uk/searchcatalogue?productid=14384&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top>
 [accessed: 21/05/14]

1.2.1 The regulatory framework for health professionals in the healthcare sector

The NHS underpins the UK-wide regulation of education and training, and career and pay structure of health professionals. In keeping with the new policy framework for the NHS, from April 2013 all workforce planning, training and education of health professionals in England (medical, dental, nursing, allied health professionals) is the responsibility of one organisation, Health Education England (HEE). The main function of the HEE is to ‘provide national leadership and oversight on strategic planning and development of the health and public health workforce, and allocate education and training resources’ (DH, 2012, p.7). At a local level, Local Education and Training Boards (LETBs) allocate training and funding, and bring together employers providing NHS funded services, education providers, the health

professions, local government and the research sector, to co-ordinate workforce plans for the local health economy in response to the Clinical Commissioning Groups' (CCGs') strategic commissioning plans. However, local education providers – e.g. universities and employers - are directly responsible for the provision and quality control of education at a local level, with the LETBs having responsibility for quality management and for meeting standards required by national regulators (DH, 2012).

Doctors

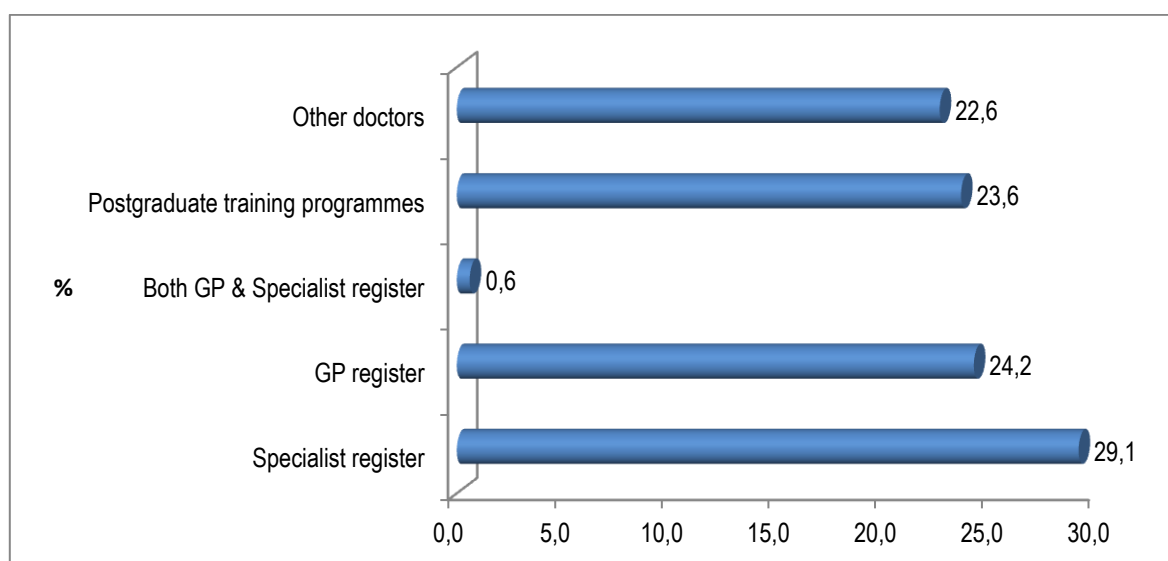
The basic medical education and training pathway in the UK generally starts at the undergraduate level. The undergraduate course is undertaken in a medical school and usually takes 5 years (or 6 years if a separate science degree is included at the end of the pre-clinical stage). Postgraduate training involves a two-year Foundation Programme, after which GP or Speciality training can be undertaken. General Practice training usually takes 3 years, whereas speciality training could take up to 8 years.¹¹

Any person wanting to practise medicine in the UK in the NHS or in the private healthcare sector, needs to register with the General Medical Council (GMC) and hold a licence to practise. The GMC is the independent regulator for doctors in the UK and have a legal power “to protect, promote and maintain the health and safety of the public by making sure that doctors meet ... standards for good medical practice”¹² through controlling entry to the medical register and setting the standards for medical schools and postgraduate education and training. Doctors registered with the GMC could be on a Specialist register, a General Practice (GP) register (or both) or could be in approved postgraduate training programmes. As stated above, these training programmes are the two-year Foundation Programme after qualifying as a doctor or an approved GP or specialist training programme. Figure 3 shows that the distribution of doctors in the medical register is fairly equitable. The category ‘other doctors’ - the majority of whom had a licence to practice and were registered at a UK address - refers to those not on a Specialist or GP register or undertaking postgraduate training. They are not a homogenous group and may be working variously as ‘speciality doctors’ (but not specialist consultants), locum doctors, in private practice, academic research, and so on. Later in this report we will look closely at the way doctors qualified abroad are distributed across grades.

In 2012 the GMC introduced a system of revalidation for all doctors with a licence to practice. This means that they have to demonstrate every five years that they are keeping their knowledge and skills updated and that they are fit to continue practising. This is done through a series of regular appraisals with their employer based on a core guidance (GMC, 2013).

¹¹ <http://bma.org.uk/developing-your-career/medical-student/entry-to-medical-school> [Accessed: 30/07/2014]

¹² <http://www.gmc-uk.org/about/role.asp> [accessed: 19/05/2014]

Figure 3: Distribution of doctors in the medical register, UK 2012

Source: chart created from GMC (2013), p. 17.

Nursing and midwifery staff

The registration and regulation of nurses and midwives practising in the UK is undertaken by the Nursing and Midwifery Council (NMC). It sets and monitors the standards of their education, training, conduct and performance. A nursing degree, paid for by the NHS, and including a choice of a specialism from four options – adult, children, learning disability, mental health – as well as registration with the NMC is needed to train and work as a nurse in the UK. Half of the nursing degree is taken up by supervised placements in local hospital and community settings.¹³

To become a midwife a three year degree in midwifery is needed. However, a registered adult nurse could qualify through completing a shorter course of 18 months. As in the case of a nursing degree half the time on a midwifery degree takes place on supervised practice placements in community and hospital settings. Registration with the NMC is compulsory for practising as a midwife.¹⁴

From December 2015 a process of re-validation for all registered nurses and midwives, involving a declaration of practice experience over 3 years, evidence of professional development and a third party endorsement of their fitness to practice, will be introduced through the re-registration process on the NMC register.¹⁵

¹³ http://www.rcn.org.uk/nursing/work_in_health_care/become_a_nurse [accessed: 27/05/2014]

¹⁴ http://www.rcn.org.uk/nursing/work_in_health_care/become_a_midwife [accessed: 27/05/2014]

¹⁵ <http://www.nmc-uk.org/Nurses-and-midwives/Revalidation/Background-to-revalidation/> [accessed: 27/05/2014]

Other health professionals

Other health professionals such as dentists and pharmacists, and allied health professionals such as dental hygienists, physiotherapists, optometrists, medical technicians, are legally regulated by specific regulatory bodies. This means that their professional titles are protected by law. For instance, the Health and Care Professions Council (HCPC) regulates the following professions among which are most allied health professions:

Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetics, orthotics, radiographers, social workers in England and speech and language therapists.¹⁶

The HCPC sets standards for the education and training (e.g. provided by a higher education institution or a professional body), professional knowledge, skills, conduct, performance and ethics of the professionals it registers.

The regulatory body for Dentists and Dental Care Professionals (clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists and orthodontic therapists) who want to work in the UK is the General Dental Council (GDC). Dentists who work in a particular branch of dentistry – e.g. orthodontics – can also register on a specialist list. In 2012, 39% on the register were dentists; that is dentists are outnumbered by dental care professionals, particularly nurses (46%).¹⁷

Pharmacists and pharmacy technicians are regulated by the General Pharmaceutical Council (GPhC). It is the independent body that approves qualifications for pharmacists and pharmacy technicians and accredits education and training providers; and maintains a register of pharmacists, pharmacy technicians and pharmacy premises.¹⁸ To be on the register, pharmacists qualified in England, Scotland or Wales need to have a UK accredited four-year MPharm degree, have successfully completed 52 weeks of pre-registration training in England, Scotland or Wales, and have passed the GPhC's registration assessment.

¹⁶ <http://www.hpc-uk.org/aboutus/> [accessed: 27/05/2014]

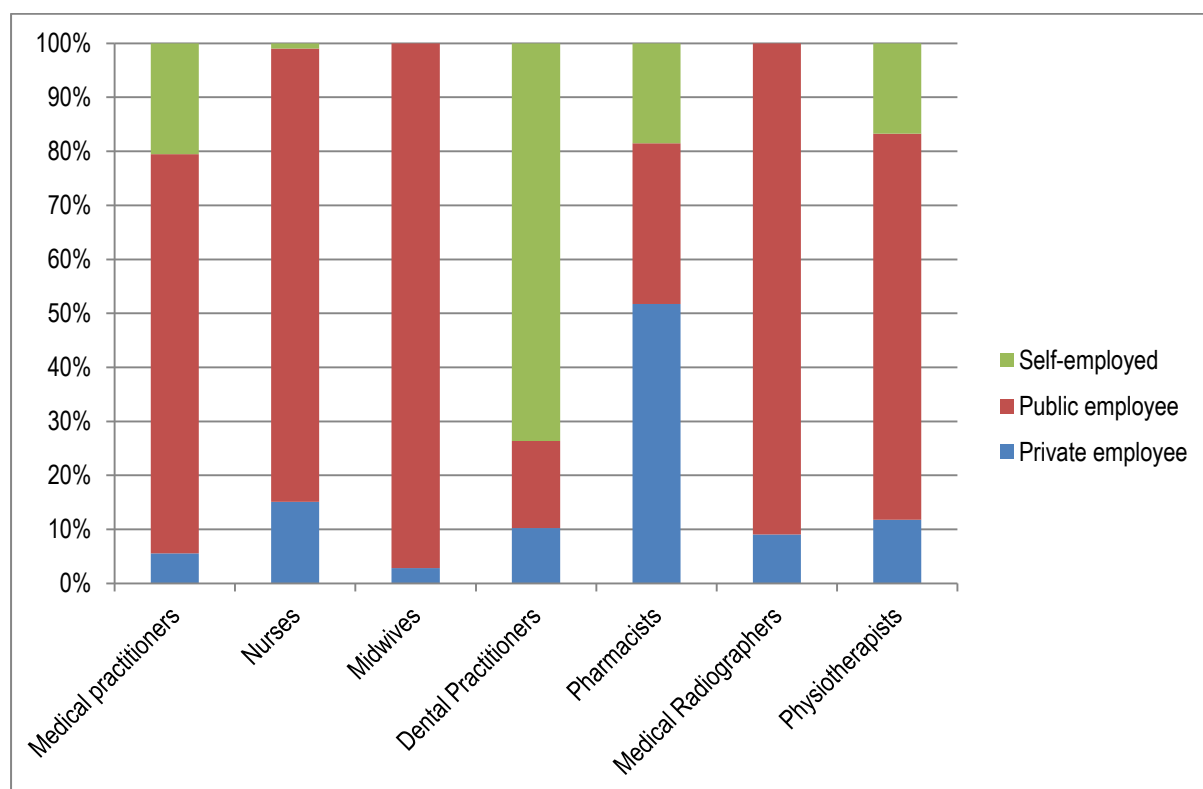
¹⁷ <http://www.gdc-uk.org> [accessed 05/06/2014]

¹⁸ <http://www.pharmacyregulation.org/about-us> [accessed: 27/05/2014]

1.2.2 Health professionals in the public and private sectors

Figure 4 shows the distribution of selected categories of health professionals in the UK across public and private sectors as employees, and as self-employed in the private sector (there is no self-employment given for the public sector) based on survey data. It is interesting that the majority of professionals in occupational groups are to be found in the public sector, the notable exception being pharmacists, just over half of whom work privately, and dentists, who are predominantly self-employed. Among doctors, nurses and midwives, over 70% are employed in the NHS. Doctors are more likely to be self-employed than be private sector employees. A higher proportion of nurses work privately, while hardly any midwives do so.

Figure 4: Private and public sector employees and self-employed among selected health professional categories, UK, 2013



Source: Office for National Statistics, Annual Population Survey Jan-Dec 2013; chart created from Table 3 (JD 2013) <http://www.ons.gov.uk/ons/search/index.html?newquery=Nurses+and+midwives> [accessed 27/05/2014]

1.3 The policy framework for health professionals in the healthcare sector

National policies aimed at recruiting and retaining health professionals have undergone fluctuation over the past decades. The UK has a long history of using migrant labour to fill skill gaps in the health

sector. In post-World War II Britain nurses especially from the Caribbean and doctors especially from South Asia were encouraged to come to the UK from ex-British colonies to take up positions in the expanding NHS, particularly in lower grades and unpopular areas like mental health and geriatric medicine. Despite increasingly stringent restrictions on entry and stay for labour migrants from the 1960s to the 1980s, the immigration of migrant health professionals continued, fuelled by demand although the entry of nurses, particularly for training, was curtailed from the 1970s onwards (Snow & Jones, 2011).¹⁹ The Labour government's expansion of and investment in the NHS in the early 2000s²⁰ led to continuing labour shortages which were filled by active recruitment from abroad, particularly the Philippines and India for nurses. Some of the determinants of these labour shortages were the decline of nursing as a career choice for British school leavers and the emigration of British-born doctors to other countries – e.g. Ireland, New Zealand, Australia.

More recently there was a strong emphasis on recruiting 'home grown' healthcare professionals. The mechanisms for achieving self-sufficiency have included expanding medical schools and nurse training opportunities for UK nationals, raising wages, creating more support roles such as healthcare assistants and cadet schemes to encourage young people with fewer formal qualifications into nursing or allied health professions, attempts to attract former nurses back into the profession, promoting flexible working practices to achieve better work-life balance, measures to retain older workers beyond retirement age, and greater usage of temporary workers (Bach, 2008). The recent plethora of policy documents, particularly associated with the Coalition government's NHS reforms, focus a great deal on improving workforce planning through joined up organisational working at national and local levels but rarely contain any reference to recruiting overseas health professionals (DH, 2012).

At the same time, mechanisms for decreasing reliance on migrant labour include ever increasing restrictions on entry and stay of high skilled migrants through the points-based system (PBS) (see below) and the removal of most nursing and many medical and allied health posts from the Home Office shortage occupation lists compiled by the Migration Advisory Committee (MAC), an independent public body providing evidence-based recommendations to the government. Box 1 (below) sets out the most recent shortage occupations for healthcare professionals.

The MAC's weighing up of the evidence relating to workforce planning and development for the health sector that underpin their recommendations for the list of shortage occupations, resonates with the findings of other research showing the reasons for specific, selective demand for labour that has historically driven the rationale for international recruitment, and continues to do so. For instance in relation to the shortage of medical consultants in emergency medicine, the report states: 'the prime causes of shortage in emergency medicine were the low attractiveness and high attrition rate of the

¹⁹ <http://www.historyandpolicy.org/policy-papers/papers/immigration-and-the-national-health-service-putting-history-to-the-forefront> [accessed: 22/05/2014]

²⁰ For instance the NHS budget for England increased from 34.7 billion to 90.2 billion between 1997/98 and 2007/08 (Hoesch, 2012)

speciality' (MAC, 2013: p.87). There has also been an emphasis over time on recruiting already qualified overseas health professionals rather than those needing national resources for training. The other factors affecting the – present and future - balance between self-sufficiency and the need for migrant labour in the health sector include changing population health needs arising for instance from the ageing demographic structure and multi-morbidities of older people, increasing emphasis on prevention and management of long term chronic conditions, the need for more home and community based care and specialist primary care skills, changes in skills mix associated with technological development; features which are highlighted in the MAC report on shortage occupations - see also Box 1 below (MAC, 2013; Bach, 2008; Imison & Bohmer, 2013). Hoesch (2012) suggests that the demand for recruiting overseas health professionals in the UK is determined more by institutional than purely demographic factors; that is, the strategies employed by state and non-state actors – for instance professional associations/ trade unions such as the British Medical Association and the Royal College of Nursing) - around workforce development arising from economic (e.g. budget cuts) and political (e.g. government imperative for re-election) motivations. Over the past couple of years a greater movement towards active overseas recruitment is discernible, particularly of nurses, and particularly from EEA countries because the regulatory framework is much less restricted than for countries outside the EEA, as will be shown later. This movement towards greater numbers appears to be the result of a new trend in registered nurse shortages in NHS hospitals linked with a 'safe staffing levels' agenda deriving from reviews of the quality of treatment in some hospital trusts in England, which cannot be addressed in the short term because of the time lag in the supply of newly qualified nurses (NHS Employers, 2014)²¹.

1.3.1 Ethical recruitment policies and bilateral agreements

Codes of practice on international recruitment have been in existence in the UK from the late 1990s when there was considerable NHS workforce expansion including active recruitment of health professionals from abroad– see above. The aims of the current code of practice are two-fold: to prevent recruitment from countries that have shortages of health sector workers and only using recruitment agencies adhering to the code; and to ensure that once in the UK, workers from abroad are treated fairly and receive the same access to training as local employees. Based on an OECD list of countries that receive aid, at present most developing countries in Africa and Asia are countries from which the UK has agreed not to actively recruit health professionals.²² However, ever-increasing restrictions in immigration regulations and the tightening up of professional regulation requirements for health professionals from non-EEA countries (see above and Part 2 below) appear to have greater impact than ethical recruitment policies in reducing numbers of non-EEA health professional migrants to the UK. Codes of Practice have had variable effect particularly in relation to recruitment of nurses by private healthcare providers and the continuing voluntary migration of junior doctors from countries with a strong health professional migration culture (Young, 2013).

²¹ <http://www.nursingtimes.net/nursing-practice/specialisms/management/nice-sets-out-guidance-on-safe-nurse-staffing-levels-for-hospitals/5072964.article> [accessed 30/08/14]

²² <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/list-of-developing-countries> [accessed 27/05/14]

There is currently a Memorandum of Understanding (MoU) between The UK and the Philippines governments regarding the recruitment and employment of Filipino nurses and other health professionals such as physiotherapists, radiographers and bio-medical scientists in a way that gives them 'an opportunity to enhance their skills and explore best practice'.²³ In addition there is now an agreement between the UK and India that agencies can recruit healthcare professionals from India except from four states that receive Department for International Development (DFID) aid.²⁴ The Medical Training Initiative (MTI) for doctors from abroad to access a fixed period of training in the UK before returning to their country of origin is a scheme that can be viewed in relation to ethical recruitment policies and will be discussed in more detail in Part 2.

Box 1: Shortage occupations in healthcare

Valid from 6 April 2013

(4 digit SOC 2010 codes)

2211 Medical practitioners –

- **Consultants** in emergency medicine, haematology, old age psychiatry
- **Non-consultant, non-training, medical staff posts** in the following specialities: anaesthetics, general medicine specialities delivering acute care services (intensive care medicine, general internal medicine (acute)), emergency medicine (including specialist doctors working in accident and emergency), rehabilitation medicine and psychiatry.

2231 Nurses – only specialist nurses working in neonatal intensive care units.

2112 **Biological scientists and biochemists** – only Clinical neurophysiologist: practitioner and scientist grades.

2113 **Physical scientists** - nuclear medicine scientist, radiotherapy physics scientist, nuclear medicine technologist and radiotherapy technologist.

2217 **Medical radiographers** – HPC registered diagnostic radiographer, HPC registered therapeutic radiographer and sonographer.

Source: Migration Advisory Committee, 2013: Chapter 5

²³ <http://www.nhsemployers.org/-/media/Employers/Documents/Recruit/UK%20Philippines%20MOU.pdf> [accessed 02/06/2014]

²⁴ <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/list-of-developing-countries> [accessed 02/06/2014]

Part 3 of this report will consider current evidence on the prevalence and positions of migrant health professionals – particularly doctors and nurses for whom most of the evidence exists - in the health sector. One key consideration arising from the expansion of the European Union over the last decade and lesser capacity of the government to restrict labour migration from accession countries because of the directive on free movement, is whether EEA health professionals are replacing non-EEA migrant professionals. We will first consider, in Part 2, some of the barriers to non-EEA national health professionals working in the UK health sector through an examination of current immigration and professional regulation rules specific to them, in comparison with rules affecting EEA nationals.

PART 2: The regulatory framework for migrant health professionals

2.1 Conditions of entry and work – non-EEA national health professionals

Conditions of entry and work for labour migrants (and their families) from outside the EEA are governed by the points-based system (PBS). The main visa types that apply to health professionals coming to the UK to work or study are Tier 2 (general), Tier 4, and Tier 5, and there are no differences in requirements between public and private sectors.

2.1.1 Doctors

Tier 2

A non-EEA International Medical Graduate (IMG) seeking to work as a doctor in the UK has to satisfy both immigration requirements and requirements for registration with the General Medical Council (GMC), the latter governed by law, the 1983 Medical Act. These are two separate processes.

An application for a Tier 2 (general) visa to work as a doctor in the UK requires a specific job offer and a Certificate of Sponsorship (CoS) from an employer or training board/deanery that demonstrates that the employer has not been able to find a UK or EEA national or UK permanent resident who can undertake the job (i.e. satisfies the Resident Labour Market Test) or that the job is a shortage occupation (see Part 1 above). The CoS applies to this job only; if a new job is sought, another CoS is required from the new employer. There is at present a cap on the number of Tier 2 visas that can be held, but this limit does not apply to shortage occupations.

Further, the applicant has to meet points criteria: attributes, maintenance funds, English language competence. For registration by the GMC, English language proficiency is demonstrated by a minimum overall score of 7.5 from June 2014 in speaking, listening, writing and reading on the International English Language Testing System (IELTS) with a minimum score of 7.0 in each area; exceptions may

apply to applicants who come from English speaking countries/have done relevant examinations in English.

To demonstrate relevant skills competence to obtain GMC registration, first of all the overseas applicant needs to have a primary medical qualification and to have completed work experience or internship of at least 12 months equivalent to the UK post-medical school Foundation Year 1 (FH01).²⁵ In addition he or she has to prove 'objective evidence' of knowledge and skills to work as a doctor in the UK by passing the Professional and Linguistic Assessments Board (PLAB) test. While the first part of the test can be undertaken in some source countries, the second clinical part needs to be taken in the UK, for which the applicant can obtain a business visitor visa²⁶ up to 6 months. A UK or international postgraduate qualification recognised by the GMC can take the place of a PLAB test result. As in the case of UK medical practitioners, entry into the specialist or GP register requires assessment of eligibility by the GMC.

The Tier 2 (general) visa is valid for 6 years, 3 years initially and then an extension of another 3 years. At the end of a continuous 5 year period on the visa, non-EEA doctors can apply for indefinite leave to remain, that is, permanent residency. From April 2014, new applicants with a CoS longer than 3 years can apply for a 5 year visa and settlement after that. Settlement criteria currently include a £35,000 salary threshold and a language and 'life in the UK' test.

Tier 2 migrant workers are allowed to be accompanied by spouses/partners and dependent children under age 18 subject to a minimum maintenance funds requirement. While spouses have leave to work in the UK, they are not allowed by the immigration rules to undertake employment as a doctor or dentist in training unless they have a degree in medicine or dentistry from a UK or UK recognised institution or not previously restricted in being employed as a doctor or dentist (Jayaweera & Oliver 2013).

Tier 4

Tier 4 is the immigration category for non-EEA students wanting to study in the UK, subject to acceptance on a course and an availability of funds requirement. International medical students graduating from a UK university have to obtain a new Tier 4 visa to undertake the two-year medical Foundation Programme, with sponsorship provided by the programme itself. In keeping with Tier 4 rules, they cannot sponsor dependants. At the end of the foundation programme if they want to work in the UK, they need to switch from Tier 4 to Tier 2 (general) and be subject to Tier 2 rules as stated above including needing to have a job offer for core or speciality training, the ability to sponsor

²⁵ Those who have not completed an internship may receive GMC provisional registration and be required to complete the Foundation Year in the UK.

²⁶ <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/immigration-rules-and-the-points-based-system/business-visitor-route> [accessed: 01/09/2014]

dependants and being able to apply for permanent settlement after 5 years. However, non-EEA graduates of UK medical schools switching from Tier 4 to Tier 2 are not subject to the numerical limit on Tier 2 migrants and have a one-off exemption from the Resident Labour Market Test – i.e. employers do not have to prove there is no suitable UK or EEA candidate available for the post. But the RLMT is applied whenever there is a change of sponsor.

Tier 5

IMGs from some countries can enter and stay in the UK for a fixed period of training of up to two years generally in the NHS through a Tier 5 Government Authorised Exchange Visa. The scheme is called the Medical Training Initiative (MTI) launched in 2009. In this scheme training capacity not required for UK specialist or GP training numbers set by the Education and Training Boards can be used by non-EEA doctors who already have some postgraduate training in countries of origin and have further training needs, the meeting of which would be beneficial to their countries of origin on their return. The scheme is sponsored by the Medical Royal Colleges through their umbrella organisation, the Academy of Medical Royal Colleges which provides support for overseas doctors in the scheme to obtain the required visa and employer sponsorship. Generally applicants do not need to sit the PLAB examinations. Trusts are required to balance organisation needs to fill spare capacity posts and the provision of educational and training support to MTI participants. MTI doctors are allowed to be accompanied by family members but cannot break their participation in the scheme within the two year duration or come to the UK on the MTI scheme again for 5 years after returning to their country of origin. There is no settlement pathway through the MTI. The main aim of the MTI is meant to be 'to contribute to improving the quality of healthcare in developing countries'.²⁷

The GMC has a special provision for refugee doctors such that they get a registration fee reduction in terms of concessions in taking and re-taking the PLAB test.²⁸ In addition the British Medical Association (BMA) has an initiative for refugee doctors that includes financial concessions, advice and support on employment issues, and access to educational materials.²⁹

2.1.2 Nurses and midwives

As in the case of doctors there are both immigration and professional regulation criteria to be met for non-EEA qualified people wanting to work as a nurse or midwife in the UK. The immigration regulations refer to Tier 2 (general) requirements as set out above, regarding sponsorship, time limits, attributes

²⁷ http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical_Education_and_training/MMC-international-recruitment/Pages/Medical-Training-Initiative.aspx [accessed: 30/08/14]

²⁸ http://www.gmc-uk.org/doctors/fees/fees_refugees.asp [accessed 04/06/2014]

²⁹ <http://bma.org.uk/practical-support-at-work/immigration/refugee-doctors> [accessed 04/06/2014]

etc. To register with the NMC, applicants need to have been practising as a registered nurse or midwife for at least 12 months (full-time or the part-time equivalent) after qualifying. Second level nursing qualifications – e.g. enrolled nurse, nursery nurse – are not accepted, neither are medical qualifications. The guidance states that the ‘training programme must have been entirely focused on nursing’.³⁰ Applicants must achieve a score of at least 7 in the listening, reading, speaking and writing sections of the IELTS test. To register with the NMC and work in the UK non-EEA trained nurses need to complete the Overseas Nursing Programme (ONP) or Adaptation to Midwifery Programme (AMP), a compulsory 20-day period of Protected Learning Time (PLT) and where appropriate a programme of supervised practice for a minimum of three months in the UK. Overseas trained nurses and midwives already in the UK who do not meet NMC registration requirements can upgrade overseas nursing qualifications to the European nurse criteria is by undertaking a pre-registration nursing or midwifery programme at a university. Similar professional and language criteria apply for nurses who are refugees, but they may not have to pay the NMC registration fee.

From October 2014 there is a change in the NMC registration process for non-EEA nurses and midwives. Instead of the ONP/AMP new applicants for nursing posts will need to demonstrate their skills and competence through a two part process in many ways equivalent to the PLAB examination for doctors: part 1, a computer based multiple choice test which can be taken in many source countries; and part 2, an Objective Structured Clinical Examination (OSCE) that needs to be completed in the UK. There will no longer be a requirement for a supervised practice period after arrival.³¹ As in the case of doctors, overseas-qualified nurses and midwives can enter the UK on a business visitor visa to undertake the OSCE but then must return to countries of origin to apply for a job and employer sponsorship as well as a Tier 2 visa, unless they already have a job offer and a CoS. It appears that this change in regulation is partially at least a response to recent shortages in the nursing workforce, that would enable employers to recruit staff faster to meet health sector demand.³²

2.1.3 Other health professionals

Similar immigration and professional criteria of regulation exists for all other health professionals. The Health and Care Professional Council (HCPC) assesses applications for registration based on scrutiny of education, training and experience plus a requirement of English proficiency through the IELTS test similar to the requirement for doctors and nurses/midwives above.³³

³⁰ <http://www.rcn.org.uk> [accessed: 27/05/2014]

³¹ <http://www.nhsemployers.org/news/2014/08/changes-to-the-nmc-overseas-registration-process> [accessed: 01/09/2014]

³² <http://www.bbc.co.uk/news/health-28943890> [accessed: 01/09/2014]

³³ <http://www.hpc-uk.org/apply/international/> [accessed 04/06/2014]

The General Dental Council requires dentists qualified in non-EEA countries to take an Overseas Registration Exam (ORE) similar to the medical PLAB test and involving both a written and clinical component, to register and practice unsupervised in the UK. Applicants may also need to undertake a year-long vocational training commensurate to continuing professional development required from British graduates. However, given the removal of dental practitioner occupations from the shortage occupation list (see above), occupational opportunities to practise as dentists are limited.³⁴

To register and work as a Pharmacist in the UK anyone qualified as a pharmacist outside of the European Economic Area (EEA) or are a non-EEA national with an EEA pharmacist qualification (other than a UK-recognised pharmacist qualification) need to successfully complete a year-long Overseas Pharmacist Assessment programme at a UK university and obtain a minimum score of 7 in the English proficiency test (IELTS), and in addition undergo 52 weeks pre-registration employment training, and pass the General Pharmaceutical Council assessment. These last two requirements are in common with UK applicants (see Part 1 above).³⁵

2.1.4 Equality and discrimination

While there have been successive, and progressive, race relations legislations over the last half a century that addressed discrimination, as Spencer points out these have largely addressed the situation of ethnic minorities rather than recent migrants even though discrimination on grounds of 'race' includes colour, nationality, ethnic or national origins (Spencer, 2011, p.213). The 2010 Equality Act brought in a single duty on all public bodies to eliminate discrimination and increase equality of opportunity in both employment and service provision, and to enhance good community relations.³⁶ However there are two broad exemptions to the Equality Act which affect employment and other domains: these are firstly, affecting different visa requirements for nationals of different countries according to immigration rules; and secondly, allowing direct discrimination on grounds of nationality, and indirect discrimination based on residency requirements and length of residence (Jayaweera & Oliver, 2013). As Spencer points out:

[T]he intentional exclusion of some migrants from full access to jobs and services, on the basis of their immigration status, may leave public bodies unsure as to whether the duty to advance equality should embrace this section of the community or not (Spencer, 2011, p.213)

³⁴ <http://www.gdc-uk.org/Dentalprofessionals/ORE/Pages/default.aspx> [accessed 04/06/2014]

³⁵ <http://www.pharmacyregulation.org/registration/registering-pharmacist/overseas-non-eea-qualified-pharmacists> [accessed: 04/06/2014]

³⁶ <http://www.legislation.gov.uk/ukpga/2010/15/contents> [accessed 04/06/2014]

2.2 Conditions of entry and work – EEA national health professionals

Doctors who are EEA or Swiss nationals can enter and work in, the UK without any immigration restrictions. There are restrictions applying to Croatian nationals at present.³⁷ In accordance with EU law, the medical registration process is also straightforward if basic medical training has taken place and a recognised qualification is gained in an EEA member country or Switzerland. EEA citizens with TCN qualifications that have been recognised by another member state and have practised there at least 3 years can also register (Directive 2005/36/EC).³⁸ From June 2014 there is a GMC requirement for new EEA registrants to prove they have sufficient knowledge of English to practise medicine before being granted a licence. This may require them to take an English test as in the case of IMGs – see above.³⁹

Nurses or midwives with EEA qualifications also have no restrictions on entry to work in the UK under EU law. Registration with the NMC depends on compliance on meeting precise requirements for the recognition of professional qualifications under EU Directive 2005/36/EC on the Recognition of Professional Qualifications. The two routes to recognition of qualifications are 1) automatic recognition – e.g. where qualifications were gained after the country of origin implemented EU standards; or 2) acquired rights – where qualifications do not meet automatic recognition requirements but additional documentary evidence of qualification certification can be submitted. ⁴⁰ In December 2013, a House of Commons Health Committee review report of the NMC raised concerns regarding English language testing requirements for nurses coming to the UK from EU countries, arising from Directive 2013/55/EU (amending Directive 2005/36/EC)⁴¹ on the recognition of professional qualifications and Regulation:

When the UK transposes the Directive it would be helpful if the new powers in the resulting UK legislation could enable us to impose language controls after the recognition of the qualification but before registration...We have begun preliminary discussions with the Department of Health on this issue and we look forward to working with them to create legislation that both meets the requirements of EU law and protects patients (House of Commons Health Committee, 2013, p.16)

There are similar pathways to registration of other EEA qualified health professionals and allied health professionals under the directive.⁴²

³⁷ <https://www.gov.uk/croatian-national> [accessed: 27/05/2014]

³⁸ <http://www.gmc-uk.org> [accessed: 27/05/14]

³⁹ http://www.gmc-uk.org/doctors/registration_news/24556.asp [accessed: 27/05/14]

⁴⁰ <http://www.nmc-uk.org> [accessed: 27/05/14]

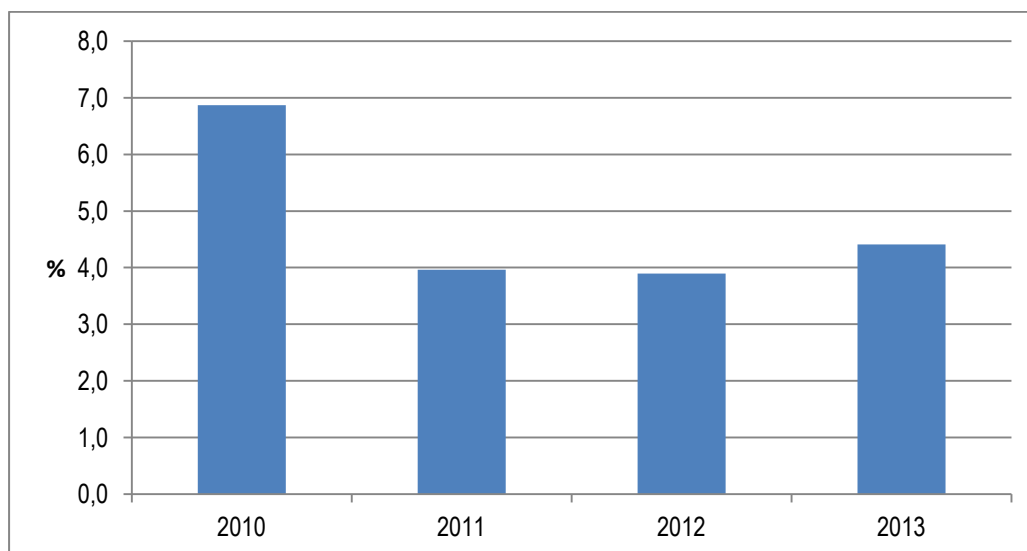
⁴¹ http://ec.europa.eu/internal_market/qualifications/policy_developments/legislation/index_en.htm [accessed 04/06/14]

⁴² See for example: <http://www.pharmacyregulation.org> [accessed: 04/06/2014]

PART 3: Migrant health professionals: available data on presence and roles

As stated in the previous section, non-EEA national health professionals qualified outside the EEA have to obtain a PBS Tier 2 visa to work in the UK as skilled workers. Figure 5 shows Home Office data on the proportion of Tier 2 applications from 2010 to 2013 for work visas in the area most relevant to the health sector: human health and social work. In keeping with the increasingly stringent restrictions for entry to work in skilled jobs the proportion of applications has decreased over time, although there is a slight increase from 2012 to 2013 which might be better understood with longer-term trend data. Note that the chart refers to applications that have obtained sponsorship certificates from employers, and not the proportion of workers who have actually entered the UK to work in the sector, which may be lower.

Figure 5: Visa applications for Tier 2 Human Health and Social Work Activities as percentage of Tier 2 total, UK 2010 - 2013*



* Applications for work visas using sponsorship certificates.

Source: chart created from Immigration statistics, 2010-2013, Home Office. <https://www.gov.uk> [accessed 28/05/2014]

In 2012 according to ONS statistics, 22% of nurses in the UK and 35% of medical practitioners were born abroad. The total non-UK born population in employment made up a much lower proportion of the UK workforce: 14% ((Sumption & Young 2014).

3.1 Trends in the presence of doctors and nurses in the workforce

3.1.1 Doctors

Data from the GMC registers shows that between 2007 and 2012 there was a 2% decrease in the number of International Medical Graduates (doctors with primary medical qualification gained outside the EEA) on the medical register, while there was a 12.2% increase in the number of EEA qualified doctors and a 4.3% increase in the number of UK qualified doctors.⁴³ This reduction in the number of IMGs is largely accounted for by the decrease in registrants under age 30 – i.e. a -61% change between 2007 and 2012 compared to a +6% change among the 30-50 years age group. This could be associated with increasing immigration restrictions for non-EEA graduates affecting recently qualified/more junior level doctors who may most likely want to immigrate to the UK (see Part 1.3 above). In contrast, for the <age 30 group there was a 17% increase in the number of EEA doctors on the register over this time period (GMC, 2013, p. 23). Thus it does appear that free movement and the largely automatic recognition of EEA qualifications is currently favouring the supply of EEA doctors in comparison with that of non-EEA doctors.

3.1.2 Nurses and midwives

Up-to-date published data on numbers and proportions of nurses and midwives according to source country registrations is limited. In the year ending 31st March 2008 there were 1020 new registrations by nurses and midwives from India; but in the same year there were 456 new entrants from Poland and 382 from Romania thus overtaking the Philippines (249 new registrations) (NMC, 2008, p.7). Table 1 shows changes in source country registrations with the NMC from 2004 to 2008, bringing out the huge reduction of non-EEA nurse and midwife registration and the increase in EEA registrations within these years. Bach (2008) suggests that these patterns are likely to change even more in recent times as active recruitment of non-EEA nurses has very significantly reduced and nursing largely removed from the shortage occupation list (see above, Part 1).

A very recent (January 2014) survey undertaken by NHS Employers of overseas recruitment of nurses by the NHS shows that among 109 organisations employing qualified nursing staff, 45% actively recruited from abroad in the 12 months before the survey, overwhelmingly (96%) from EEA countries – mainly Portugal, Spain and Ireland (NHS Employers, 2014, pp. 19-22).

⁴³ The expansion of medical schools in England in this time period may have led to an increase in UK doctors (GMC, 2013).

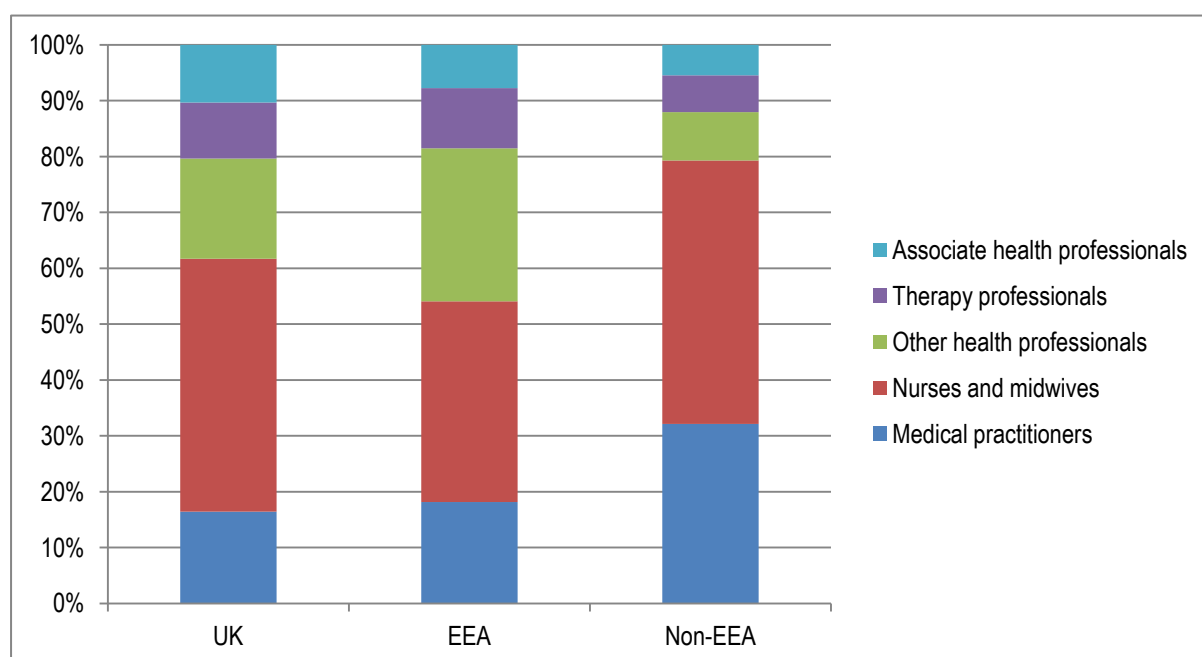
Table 1: Initial admissions to the register by UK country, European Economic Area countries and overseas countries

Country	2004	2005	2006	2007	2008
England	15,862	16,146	16,848	17,270	17,538
EEA	1,033	1,193	1,753	1,484	1,872
Overseas	14,122	11,477	8,709	4,830	2,309

Source: extracted from NMC (2008) - *Statistical Analysis of the Register 1 April 2007 to 31 March 2008*, Table 6, P. 6

3.2 Health professionals: employment characteristics by nationality

In this section we look at some characteristics of health professionals in the UK according to nationality groups (UK, EEA, non-EEA) using national data.

Figure 6: Occupational group by nationality, 2012 - 2013

Other health professionals = psychologists, pharmacists, ophthalmic opticians, dentists, veterinarians, medical radiographers, podiatrists, health professionals n.e.c.

Therapy professionals = physiotherapists, occupational therapists, speech and language therapists, therapy professionals n.e.c.

Associate health professionals = paramedics, dispensing opticians, pharmaceutical technicians, medical and dental technicians, health associate professionals n.e.c.

Note: non-weighted cell counts among EEA and non-EEA therapy professionals and health associate professionals <30.

Source: original analysis of the Annual Population Survey July 2012 - June 2013, weighted percentages.

Figure 6 derives from analysis of the Annual Population Survey (APS), July 2012 – June 2013.⁴⁴ It shows a disaggregated distribution of health professional occupations among UK, EEA, and non-EEA national health professionals. Nurses predominate in all three categories – 45% and 47% of UK and non-EEA health professionals respectively, and 36% in the non-EEA category. But among EEA nationals a substantial proportion (a little over a quarter) are in all the ‘other’ health professional occupations taken together (associate health professionals, therapy professionals, other health professionals). It is also interesting in the light of the evidence (above) of a recent drop in non-EEA qualified doctor numbers compared to EEA qualified doctor numbers, that a greater proportion of non-EEA national health professionals are doctors (nearly a third) compared to EEA counterparts (less than a fifth).⁴⁵ This possibly reflects historical trends in recruitment of doctors particularly from former British colonies, as shown in Part 1 of this report.

GMC data on the distribution of doctors by country of primary medical qualification and age puts further light on these patterns. Table 2 shows that while IMGs made up only 5% of doctors <30 years old in 2012, they made up 29% among doctors over age 50. It appears then, as also shown in the time trends analysis above, that doctors from outside the EEA are an ageing population group and that fewer of them are young and recent arrivals.

Table 2: Place of primary medical qualification of doctors on the medical register according to age group, UK, 2012 (percentages)

	< 30 years	30-50 years	>50 years	Total
UK graduate	90%	57%	62%	63%
EEA graduate*	5%	12%	9%	10%
International				
medical	5%	31%	29%	27%
graduate+				
Total (n)	36,584	148,318	67,651	252,553

*European Economic Area (EEA) graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

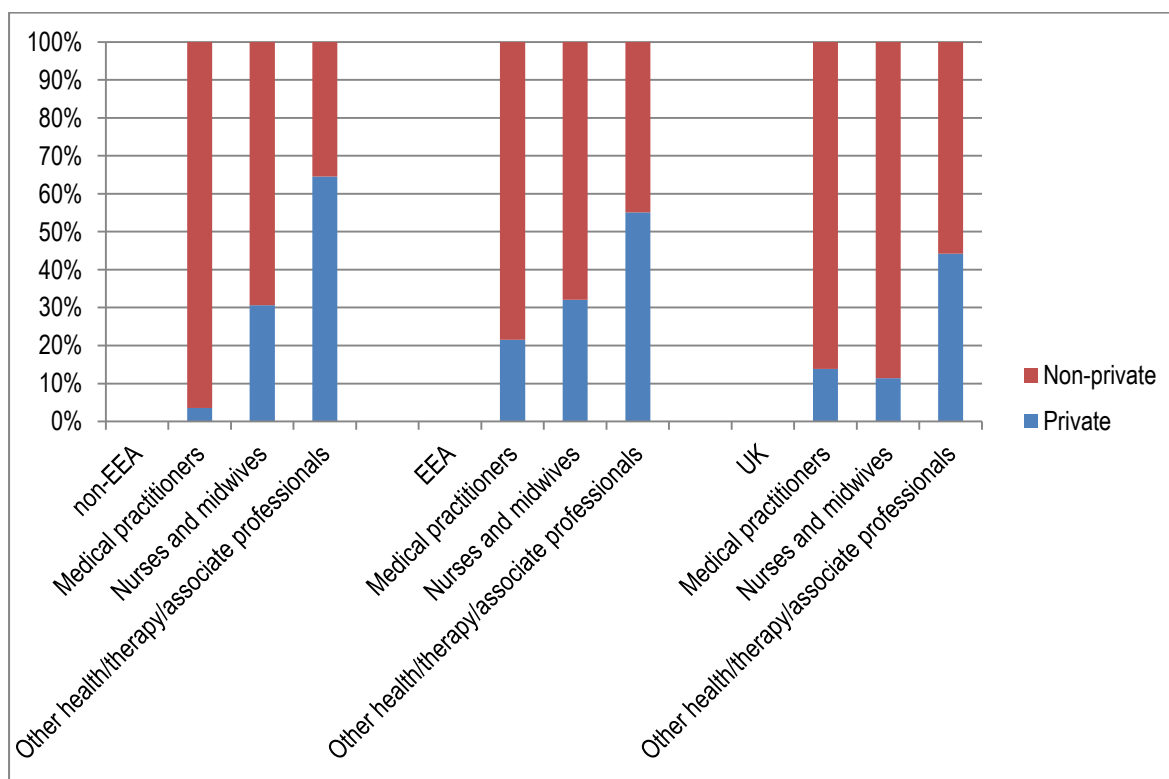
+International medical graduates are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland.

Source: General Medical Council 2013. Extracted from Table 1 Demographic characteristics of doctors on the medical register in 2012, p.18.

⁴⁴ The Annual Population Survey (APS) is a major survey series comprising key variables from the Labour Force Survey (LFS), all its associated LFS boosts and the APS boost. We would like to thank the Office for National Statistics, Social Survey Division, and the UK Data Archive for permission to use the Annual Population Survey for analysis. We acknowledge that these organizations bear no responsibility for the analysis or interpretation of the data in this report.

⁴⁵ It is important to note however that while the GMC definition of EEA and non-EEA (IMG) refers to place where primary medical qualifications are gained, in the APS analyses discussed in this report EEA/non-EEA/UK refers to nationality.

Figure 7: Private or non-private sector by nationality and occupational group, UK 2012-2013



Health professionals are coded according to whether they do mainly private work/work in a private hospital or mainly NHS work (non-private).

Note: some unweighted cell counts for non-EEA and EEA national categories are <30.

Source: original analysis of the Annual Population Survey July 2012 - June 2013, weighted percentages

Figure 7, again from APS data, shows that in all three nationality categories relatively high percentages of 'other' health professionals compared to doctors, nurses and midwives, work in private healthcare workplaces. This is line with the fact that in the UK, health professionals like dentists and pharmacists are largely self-employed or work in the retail sector (see Part 1 and Figure 4 above). Nevertheless there are clear nationality differences: for instance more than 90% of non-EEA national doctors work *mainly* in the NHS compared to just over three quarters of EEA nationals. Also the proportion of both EEA and non-EEA national nurses and midwives working in the private health sector is nearly three times as much as the proportion of UK national nurses and midwives who are similarly employed.

Other analyses in the APS show that over three quarters of workers in all health professional categories in each nationality category (UK, EEA, non-EEA) are in permanent employment, although for doctors the highest percentage is among UK nationals.⁴⁶

Table 3: Place of primary medical qualification of doctors on the medical register according to type of register, UK, 2012 (percentages)

	Specialist register (n=73,481)	GP register (n=61,062)	Other doctors (n=57,093)
UK graduate	61%	77%	34%
EEA graduate*	15%	6%	14%
International medical graduate⁺	24%	17%	52%

*European Economic Area (EEA) graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

⁺International medical graduates are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland.

Source: General Medical Council 2013. Extracted from Appendix 1: Tables 1, 2, 3 p.106

Table 3 shows that IMGs form a far higher percentage (just over half) among 'other' doctors than among specialists or GPs. As stated in Part 1, other doctors refer to non-specialist grades including speciality doctors (known previously as staff grade doctors), locum doctors, those in private practice or academic research etc. (GMC, 2013). These figures bear out other evidence that non-EEA qualified doctors tend to be employed in lower levels of the medical hierarchy (Bach, 2008). From the (limited) GMC evidence it is difficult to say whether this is because of lesser recognition of non-UK qualifications or whether it is more related to direct discrimination in recruitment and career progression.

Evidence from recent GMC registers also bears out other evidence of the over-representation of IMGs in particular specialities; at present these are obstetrics and gynaecology, general psychiatry, paediatrics and histopathology. Doctors with their primary medical qualifications in EEA countries appear to be over-represented in general surgery and ophthalmology. Half the growth in ophthalmology from 2007 to 2012 was accounted for by EEA graduates; while in obstetrics and gynaecology, there was a 1% decrease in UK graduates but a 70% increase in non-EEA graduates (GMC, 2013, p.29).

There are also geographical differences in the employment of UK, EEA and non-EEA medical graduates. The UK country with the highest proportion of IMGs is Wales (28%) whereas for EEA

⁴⁶ Data not shown because of small unweighted cell counts.

doctors it is Northern Ireland (10%). Within England there is a higher percentage of IMGs in the East and West Midlands NHS regions (37% and 32% respectively) than in London or the Southeast (25% each). The highest percentage of EEA qualified doctors is also to be found in the East of England region (10%), but there is a similar percentage in London (GMC, 2013, p.30). When broken down by primary and secondary care in each NHS region, it can be seen that while in London and the West Midlands one in four GPs is an IMG, in the Southwest region IMGs represent only one in 21 GPs. There are higher proportions of IMG specialists in the East of England and West Midlands than in the Southwest. These uneven geographical patterns of employment of non-EEA qualified doctors are congruent with the geographical distribution of non-EEA populations in England, and the UK as a whole. But it is also important to recognise that often non-EEA doctors are found in geographical areas – e.g. metropolitan areas - that are less attractive to UK graduates (GMC, 2013, p.31).

APS analysis by nationality and taking all health professional categories into account shows that South East of England, and Wales figure among the top three localities⁴⁷ for all three nationality categories (UK, EEA, non-EEA), but Outer London is more common among non-EEA health professionals, and East of England among their EEA counterparts.⁴⁸

CONCLUDING REMARKS

This report has provided an overview of the regulatory framework for, and positions of, migrant health professionals in the UK within a context of the (English) health system, information about the healthcare workforce as a whole and the general regulatory framework around medical practitioners, nurses, midwives and other health professionals. It has paid attention to the changing policy structure surrounding the recruitment and treatment of health professionals from overseas working in the UK, and particularly to differences between the regulatory frameworks and situations of EEA migrants, and those of migrants from outside the EEA.

There is a fairly considerable body of research and analysis on migrant health professionals in the UK but most of the existing work does not reflect current developments relating to the health sector workforce. This is largely because there has been a massive shift in health policy and in the structure of the NHS on the one hand, and in immigration policy on the other, over the past few years. These shifts also need to be viewed within the economic crisis in the UK as in many other European countries. Much of the existing research is based in an era when there was far more active recruitment of migrant health professionals, particularly nurses, from lower income countries especially in the global south irrespective of whether this phenomenon was officially sanctioned or not. Further, there has been a

⁴⁷ Region defined according to government office regions rather than NHS regions.

⁴⁸ Data not shown because of small unweighted cell counts.

greater expansion of the EU recently, and longer term manifestations of the population impact of the increased flow of migrant workers from Accession countries since 2004 (Rienzo & Vargas-Silva, 2013).

This report highlights the continuing importance of health professionals from outside the EEA for the UK healthcare sector. But the policy framework and evidence reviewed also shows that there is a *qualitative* shift away from a reliance on high-skilled ‘foreign’ labour to staff the healthcare sector to a ‘native’ workforce educated and trained in the UK. This is manifested most strongly in Department of Health rhetoric in health policy documents and in the language surrounding the continual tightening of rules on conditions of entry and stay - e.g. more stringent English language tests, a minimum income requirement for settlement etc. - for high-skilled migrants under-pinned by a rationale of achieving better integration, as evident in these words of a government minister:

*Settlement in the UK is a privilege. We are sweeping aside the idea that everyone who comes here to work can settle, and instead reserving this important right only for the brightest and best.*⁴⁹

The increasing restrictions on non-EEA high-skilled workers, including health professionals (PBS Tier 2, Tier 4, Tier 5 – see Part 1) on entry and settlement of themselves as well as of their families, are likely to have a detrimental effect on their experiences and views relating to integration, both within the workplace and beyond it.

At the same time, there is occurring a *quantitative* shift in migrant health professionals from non-EEA nationals to EEA nationals. Despite the rhetoric of facilitating and encouraging ‘home-grown’ health professionals, there appears to be a considerable reliance on EEA nationals to fill hospital positions and some allied health professional gaps. Even though it is not possible at present to restrict health professionals coming from EEA countries to work in the UK, because of their free movement rights and recognition of qualifications, there is evident a concern, particularly in the regulatory bodies, to ensure that these migrants meet stringent professional standards and English language competence (see Part 2).

The NHS reforms have taken place over the past year or so, and are still continuing. It is difficult to predict the long term effect of local commissioning of health services and the increasing ‘privatisation’ of service supply, on professionals who deliver these services. Especially given the relatively uneven distribution of migrant health professionals in the healthcare sector, the impact of these reforms on the demand and supply of migrant health professionals as well as on their experiences of integration in their professions and workplaces remains to be seen.

⁴⁹ <https://www.gov.uk/government/news/attracting-the-brightest-and-best-migrant-workers>

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