

STAFF SHORTAGES AND IMMIGRATION IN THE HEALTH SECTOR

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Project overview

“A set of review papers on the micro-level determinants of employer demand for migrant labour and the alternatives to immigration for responding to labour shortages in key sectors of the UK economy.”

This paper is part of a research project commissioned by the Migration Advisory Committee (MAC), a body of independent economists set up by the UK Government in late 2007. The MAC has been tasked to advise the Government where in the UK economy there are skilled labour shortages that can be “sensibly” filled by migrant workers from outside the European Economic Area (EEA).¹ The MAC’s current remit focuses on skilled labour shortages. Specifically, the MAC has been asked to produce a list of “shortage occupations” for Tier 2 of the UK’s new points-based system. However, future work may also involve analysis of low-skilled labour markets. As explained in its recent report on “Identifying skilled occupations where migration can sensibly help to fill labour shortages” (February 2008), the MAC’s methods will include “top-down” approaches (including analysis of available data from employer skills surveys and the labour force survey) and “bottom-up” approaches which provide more detailed micro-level information about the nature and determinants of labour demand, supply, staff shortages and alternatives to immigration for filling vacancies in key sectors and occupations.

This research project contributes to the MAC’s bottom-up approach by providing an independent analysis and assessment of the nature and determinants of staff shortages in key sectors and occupations of the UK economy. Given the short time period within which the MAC needs to produce its first list of shortage occupations (July 2008), the main method of this project has been to mobilise existing information and research rather than to generate new data. To this end, academic experts provided an analytical research perspective on staff shortages and immigration in seven sectors of the UK economy: agriculture, food processing, financial services, construction, hospitality, health care and social care. Although taking a sectoral approach, the seven “sectoral review papers” highlight and discuss key occupations in each sector. All sectoral review papers were written during April-May 2008 and are based on a common template of questions. A separate paper discusses key concepts, selected empirical findings from the sector papers, and the implications for a skills-based immigration policy.

¹ The EEA includes the EU 27 plus Iceland, Liechtenstein and Norway.

All papers in this research project were coordinated by Bridget Anderson and Martin Ruhs, with the assistance of Rutvica Andrijasevic and Karin Heissler (all at Centre on Migration, Policy and Society (COMPAS) at the University of Oxford). The full list of papers produced for this research project is:

Concepts and overview:

Anderson, B. and M. Ruhs (2008) "A need for migrant labour? The micro-level determinants of staff shortages and implications for a skills-based immigration policy", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Sectoral review papers:

Bach, S. (2008) "Staff shortages and immigration in the health sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Chan, P., Clarke, L. and A. Dainty (2008) "Staff shortages and immigration in construction", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Geddes, A. (2008) "Staff shortages and immigration in food processing", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Jones, A. (2008) "Staff shortages and immigration in the financial services sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Lucas, R. and S. Mansfield (2008) "Staff shortages and immigration in the hospitality sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Moriarty, J., Manthorpe, J., Hussein, S. and M. Cornes (2008) "Staff shortages and immigration in the social care sector", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

Scott, S. (2008) "Staff shortages and immigration in agriculture", A report prepared for the Migration Advisory Committee, Migration Advisory Committee (MAC), London

All papers can be downloaded at the MAC's website: www.bia.homeoffice.gov.uk/mac

Executive summary

1. Overview of the sector

The health sector comprises a large and very complex workforce with more than 150 main professional groups. The utilisation of migrant labour varies considerably between and within key occupational groups. The sector is dominated by the National Health Service (NHS) which employs around 70 percent of the sector's workforce. This report concentrates on medical and nursing staff because they have been the focus of most policy attention. It focuses mainly on the workforce in England where most analysis of the migrant workforce has been conducted.

Migration in the health sector has certain distinctive features. It is a high profile and politically sensitive issue which has been associated with 'brain drain'. Mobility is strongly influenced by the regulatory frameworks of individual governments and the use of common terminology, for example, 'nurse' or 'doctor', can disguise the fact that the role, expectations and training of these occupations differs significantly between countries. The UK is a very significant *source* country as well as a *destination* country for doctors and nurses.

2. Employer demand: What are employers looking for?

Employer demand in the sector is shaped by the dominance of the professions in the workforce. Virtually all health professions are degree level qualifications and the main requirements that employers seek from health professions are regulated by the individual regulatory body. These requirements focus on technical expertise, experience in appropriate training posts, demonstration of technical proficiency in supervised posts, and evaluation by (practical) examination. Other criteria to gain registration usually focus on 'good character' and 'good health.' Employers have limited discretion in the requirements they can establish for health professionals.

3. Labour supply: Who wants to do what?

In terms of labour supply, in aggregate terms the NHS workforce is more in balance and is moving towards self-sufficiency to a greater extent than in the past decade. There has been significant expansion in the number of UK trained health professionals, although for nursing students attrition rates are high. Although the main focus has been on increasing training

commissions, attempts have also been made to attract staff back into nursing and other health professions. Overall, the Doctors' and Dentists' Review Body and the NHS Review Body concluded in 2008 that at present there were no overall problems with recruitment and retention among their remit groups, although there were some difficulties with particular specialisms and in certain regions.

The pattern of migrant labour supply differs between doctors and nurses. There has been a general upward trend among doctors being granted work permits since 2000, while for nurses there has been a sharp decrease since 2003-04. For doctors, since 2005, the General Medical Council has recorded an increase of around 25 percent in the number of registered doctors from A8 and A2 countries. Around 1,500 to 2,000 doctors from Poland registered annually (2005-2007) and the Czech Republic and Hungary also recorded doctor registrations of between 500 and 1,000 per year. In England, around a fifth of General Practitioners (GPs) contracted to the NHS received their primary qualification abroad, divided between the European Economic Area (EEA) (five percent) and elsewhere (16.5 percent)

In 2007, there were 686,866 on the nursing register. During the 1990s, until 1998, there was a sharp fall of around 35 percent in the number of new entrants to the UK from UK sources before increasing by more than 40 percent during the last decade. It was in this intervening period that overseas registrations filled the shortfall in terms of initial registrations. In the peak year of 2001-02, the number of non-EEA nurse registrants exceeded those from the UK, predominantly from India and the Philippines. Active overseas nurse recruitment has now virtually dried up as UK-educated nurse training has expanded, and entry level nursing posts were removed from the Home Office shortage occupation list in 2006.

4. Immigration and labour demand: How and whom do employers recruit?

There is little evidence to suggest that employers in the sector have a *positive* preference for migrant workers. The primary motivation has been to address skill shortages and fill vacancies. The use of migrant health professionals to work in unpopular specialties and localities is widely documented. In medicine, it has been the specialties of elder care, accident and emergency and psychiatry that have been viewed as lower status specialties and which have employed the greatest proportion of non-EEA qualified doctors. Although the sector is highly unionized and the NHS uses a national structure of pay and conditions, a common experience among overseas nurses has been the lack of recognition of their skills and previous experience.

Since around 2003-04 there has been a shift in government emphasis towards self-sufficiency. A number of initiatives have been taken at national and local level. These have been primarily to improve recruitment and retention and ensure that the NHS is an employer of choice, but it has also reduced the focus on migrant labour. Measures have included revamping pay structures, altering skill-mix and implementing policies of work-life balance.

5. Immigration and alternative responses: A need for migrant labour?

The health sector has a long history of employing migrant health professionals which reflects the historical under-investment in the sector's workforce with migrant labour channeled into the least popular specialties and geographical locations. After 1997, the Labour government actively encouraged nurses and medical staff to come to the UK and the emphasis was on attracting *qualified* staff with much less attention placed on training staff from overseas. More recently the UK has moved towards greater self-sufficiency and the shortages that existed in recent years have receded. The Department of Health has a clearly stated objective to ensure that UK qualified health professionals gain employment and that the investment in UK trained staff is utilised effectively.

6. Conclusion: Implications for analysing staff shortages in the sector

Several policy implications arise from the fluctuations in labour supply and demand in the sector. First, it indicates that workforce planning in the sector has been poor and better monitoring and recording of the emigration of health professionals would be an important first step towards developing a more well-informed understanding of migration trends in the sector. Second, the aggregate picture of low vacancies and no serious recruitment and retention problems has often disguised continuing difficulties that health sector employers confront in recruiting and retaining staff in particular specialisations, grades and locations. It needs to be remembered that health care delivery comprises a highly interdependent and complex supply chain. Third, an emphasis on the quantity of health professionals does not pay sufficient attention to the quality of those staff and employer preferences for particular types of labour. Employers may not necessarily be willing to substitute EEA labour for non-EEA labour across all occupations as is assumed within government policy. Finally, to the nurses, International Medical Graduates (IMGs) and other health professionals that are the recipients of government migration policy, government policy is often perceived as unfair, inconsistent and politically expedient. The risk is that if shortages reemerge in the years to come, to what extent will nurses

from the Philippines and doctors from India, for example, be available to come to the UK when other countries will also be welcoming them across their borders?

Introduction

This report for the Migration Advisory Committee (MAC) focuses on the nature and determinants of staff shortages in specific occupations and the contribution of skilled migrant labour in the health sector. There is a long history of reliance on migrant labour to fill skill shortages in the sector. More recently, the Labour government set out its plans for substantial investment in the National Health Service (NHS) Plan (Department of Health 2000). Since 2002, there has been unprecedented government investment in the NHS with average annual real terms growth of 7.4 percent per year in the five year period to 2007-08. In cash terms the NHS budget in England has increased to £90 billion (HM Treasury 2007: 12). A substantial proportion of this investment has been channelled into growth in staff levels. The NHS Plan committed the NHS to employ 7,500 more consultants, 2,000 more General Practitioners (GPs), 20,000 more nurses and 7,500 Allied Health Professionals (therapists). These targets were exceeded, often substantially, by 2006 (Wanless et al. 2007: xix). The acute independent sector has also experienced real annual rises of revenue close to seven percent for the decade up to 2005 (Laing and Buisson 2007: 79). The NHS and the independent sector used active international recruitment to fulfil their staffing needs, especially in the period 1999-2004.

In 2008, the health sector labour market entered a different phase. The government's emphasis is on improving the productivity and demonstrating value for money of the existing workforce. It is using the levers of pay modernisation (*Agenda for Change*), the consultant and GP contracts, and the choice agenda to facilitate new ways of working and enhance flexibility (Department of Health 2007a). In contrast to the recent past which was characterised by rapid workforce growth, the Department of Health suggests that "NHS workforce capacity has increased to levels where we are now able to see the demand for staff equalling domestic supply" and continues, "the capacity issue has been addressed" (Department of Health 2007a: 31).

This report concentrates on medical and nursing staff because these are the occupations for which there is the greatest availability of data and they have been the focus of most policy attention. The primary focus is on recent migrants to the UK while providing some data on the proportions of migrants in key health sector occupations. Within the health sector research and policy community, the terminology used often refers to 'overseas' or 'internationally recruited' staff. This terminology is not very precise and does not always distinguish clearly between the

individual's country of birth, qualification and employment. In practice, policy makers are referring to health professionals that have usually been *actively* recruited in the last decade by employers to fill labour shortages and whose diploma or degree was obtained outside of the UK. The predominant source countries have been India, the Philippines and parts of sub-Saharan Africa rather than European Economic Area (EEA) nationals.

1. Overview of the Health Sector

1.1 Definition of the sector

The health sector comprises a large and very complex workforce with more than 150 main professional groups. These are broadly classified between the following professions: medical and dental, nursing and midwifery, and scientific and therapeutic. A sense of this complexity is garnered by examining the Home Office shortage occupation list. As of April 2007, medical consultant posts in almost 50 sub-specialities were listed as being 'shortage' occupations including Chemical Pathology, Endodontics, Oral and Maxillo-facial surgery, Otolaryngology and Paediatric Cardiology. It is important to bear in mind that the utilisation of migrant labour varies considerably between and within key occupational groups. Moreover, most research of the utilisation of migrant labour relates to nursing and medical staff, with few studies of other occupations. The sector is dominated by the NHS which employs around 70 percent of the sector's workforce (Skills for Health 2003).

The NHS remains a virtual monopsony purchaser of the services of most health sector professions, especially at the start of their careers. The dominance of the NHS is reinforced by its monopoly role as the only commissioner of basic level pre-registration education for professionals such as nurses and doctors in the UK. Consequently, not only is the NHS the dominant employer, but also the pay and conditions in the independent sector follow the NHS lead (Laing and Buisson 2007: 144). The command of the NHS extends beyond its numerical and economic dominance. Within political debate, the health sector is viewed as synonymous with the NHS. This is borne out by the responses of secondary school children to questions about their perceptions of working in nursing and allied health profession occupations (physiotherapy and radiography) which they associated exclusively with NHS employment (Arnold et al. 2001). Overall, it is therefore the NHS that has the dominant influence over effective demand and labour supply.

Independent sector

The independent sector is not insignificant, but its importance in workforce terms can be overstated. It includes independent hospitals providing acute, cosmetic and mental health services and the nursing home sector. There is much less systematic data collection in the independent sector. In acute medicine, the independent sector employs only a few hundred Resident Medical Officers (RMOs), often on an agency basis (Independent Healthcare Advisory Services, personal communication). The vast majority of medical consultants are employed by the NHS who exercise practice privileges in independent hospitals. In 1993, it was estimated that 85 percent of consultants were NHS employees (Laing and Buisson 2007: 145). For registered nurses, the latest data is from the discontinued 'Community Care Statistics – Private Nursing Homes, Hospitals and Nursing Homes.' This reported that almost 9,000 whole time equivalents (WTEs) qualified nursing staff were employed by independent hospitals and clinics in England in 2001/2001 and around 41,000 WTE registered nurses were employed in nursing homes.

Other sectors also employ some health professionals, including education, the armed forces and prisons but these are relatively small scale. Pharmacy is a distinctive occupation because a substantial proportion of pharmacists work outside of the NHS. The availability of private sector employment in retail has significant effects on recruitment and retention in the NHS (NHS Review Body 2008).

Since 1997 and the move towards political devolution, there has been increased divergence of health policy between each country (for example, between England, Northern Ireland, Scotland, and Wales). Workforce data is collected separately by country. The health professions, however, remain regulated on a UK wide basis by the General Medical Council (GMC), Health Professions Council (HPC) and the Nursing and Midwifery Council (NMC), and their registration data is therefore UK wide. There is also a UK wide pay and career structure via *Agenda for Change* which comprises two pay spines, divided into nine pay bands which replaced multiple occupational pay grades. The pay structure is underpinned by an NHS wide job evaluation scheme. *Agenda for Change* covers all staff with the exception of doctors and dentists that have separate contracts and some top managers. This report concentrates mainly on the workforce in England where most analysis of the migrant workforce has occurred.

1.2 Features of the health sector which influence the use of migrant labour

The migration of health professionals is a high profile and politically sensitive issue which has been associated with 'brain drain,' that is, undermining the capacity of countries to deliver adequate health care for its citizens. In sub-Saharan Africa, for example, a shortage of nurses and doctors is hindering achievement towards meeting the Millennium Development Goals (Physicians for Human Rights 2004: 22; World Health Organisation 2006). This has influenced the countries that the UK government considers 'ethical' to recruit from (for example, it does not recruit from sub-Saharan Africa).

The migration of health professionals is influenced strongly by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals. These factors influence national patterns of migration. The centrality of government regulation provides greater scope for policy intervention. For example, the Philippines has a systematic policy of training nurses (and other occupations) to work abroad (Ball 2004) and other countries (for example, China) have similar ambitions. State policy accounts for the high proportion of Philippine nationals among the UK non-EEA nurse workforce.

The use of common terminology, for example, 'nurse' and 'doctor', can disguise the fact that the role, expectations and training of these occupations differs significantly between countries. This presents challenges for some non-UK qualified health professionals in integrating into the UK healthcare context (O'Brien 2007). Although there is limited systematic research on these issues, employers may exhibit strong preferences for particular nationalities and be reluctant to employ others, even if their formal qualifications are ostensibly the same.

The main employer in the UK, the NHS, is state controlled and financed. The state is a distinctive employer that has to reconcile the expectation that it should be a 'model' employer with its duty to taxpayers as the guardian of the public purse to ensure affordability. This has led to under-investment with insufficient health professionals being trained in the UK. This substantial gap has been filled by reliance on non-EEA labour (Raghuram and Kofman 2002). The unpredictability of supply and demand which relates to poor workforce forecasting, fiscal constraints and technological change suggests that despite the current emphasis on self-

sufficiency, the UK health sector will continue to make significant use of non-EEA labour for the foreseeable future.

Although not the main focus of this report, it needs to be noted that the UK is a very significant *source* country as well as a *destination* country for doctors and nurses. Nurses born in the UK comprise the second most important stock of immigrant nurses after the Philippines among member countries of the Organisation for Economic Cooperation and Development (OECD). For doctors, the UK is the third most important source country after India and Germany. UK born doctors represent about 75 percent of the immigrant doctors from the OECD in Ireland and New Zealand, and more than 50 percent in Australia (Organisation for Economic Cooperation and Development 2007: 173). UK health professionals have historically been willing and able to seek employment overseas if conditions in the UK health sector have not been conducive to their career and lifestyle choices. These patterns account for some of the gaps between registration data and employment data. Many UK-trained doctors and nurses maintain their UK registration and are included in the General Medical Council (GMC)/Nursing and Midwifery Council (NMC) register, even though they are working outside the UK.

1.3 Policy issues within the sector: Workforce implications

Increased demand for health care is forecast, which stems from an ageing population and continuing medical and technological innovation (Wanless et al. 2007). The 'NHS Plan' set out a road map for the NHS after 2000. The 'Darzi Review,' building on his interim report, will report in summer 2008 and set out the direction for the NHS over the next decade (Darzi 2007). In response to forceful criticisms about the inadequacy of workforce planning in the NHS (Health Committee 2007), Lord Darzi is devoting considerable attention to workforce planning, education and training matters.

Community settings

In addition to affordability concerns, the emphasis on delivering services more locally is encouraging a shift in health service delivery from the acute sector to community settings. Hospitals are becoming more specialised and focused on providing services for the most complex cases, and at the same time there is increased emphasis on prevention and managing long-term chronic conditions (Department of Health 2006a). This requires an increased primary care workforce, but the balance between GPs and other health professionals will differ from the

past with more work undertaken by nurses and other members of the health care team (Department of Health 2007a). The boundaries between primary and secondary care are also becoming blurred. A key challenge is ensuring that sufficient staff with the appropriate skill set is available in the community. The Royal College of Nursing (RCN) survey data indicate that eight percent of NHS hospital nurses are over 50 years-old, but in community settings, the figure is 27 percent, rising to 35 percent in GP practices (Ball and Pike 2007: 15).

Provider diversity

Existing government policy such as the establishment of National Service Frameworks (NSFs) for each main service area and demanding waiting time targets has required workforce expansion. Government policy has also encouraged more diversity of providers arising from its policies of patient choice and the use of payment by results. Initially diversity occurred on the acute side via the establishment of Foundation Trusts (mostly acute hospitals) and Independent Sector Treatment Centres, but increasingly attention is being focused on alternative providers in the community. Primary Care Trusts (PCTs) are able to commission services from any provider using the Alternative Provider Medical Service (APMS) and outsource their commissioning to the private sector via the Framework for Procuring External Support for Commissioners (FESC). The development of GP practice-based commissioning may also stimulate more independent and third sector involvement. The experience of GP fundholding indicates that GPs are more willing to alter service provision than health authorities (Glennister et al. 1994). Although there is considerable uncertainty about the degree to which the independent sector will extend its role significantly beyond its current levels of activity (Laing and Buisson 2007; Wanless et al. 2007), at the very least, the independent sector needs to be more integrated into workforce planning.

Global workforce shortages

The World Health Report (2006) estimated that there is a shortage of 4.3 million health workers, 2.4 million of who are doctors, nurses and midwives. Developing countries especially in sub-saharan Africa confront acute problems because of low government expenditures on health, poor pay and conditions, and migration of the most skilled. Concerns about shortages of health professionals, in particular doctors and nurses, are also prominent in OECD countries and are projected to worsen over the next twenty years because of increased demand and an ageing health sector workforce. This has prompted increased competition between OECD countries for health professionals (Organisation for Economic Cooperation and Development 2007; Simeons and Hurst 2006). Consequently even if the UK is more in balance than a few years ago there is

no room for complacency, not least because UK trained health professionals could emigrate as has occurred in the past.

1.4 Current labour market issues in the sector

Workforce planning

There are number of key policy issues that impact directly and indirectly on the use of migrant labour. First, there has been increased attention directed at workforce planning. In England, workforce planning is undertaken by the ten strategic health authorities supported by the national Workforce Review Team (WRT). The WRT undertakes annual workforce reviews of over 150 health care professions and publishes an annual risk assessment (Workforce Review Team 2007). The Department of Health has its own workforce planning function, but it does not publish its forecasts. 'Skills for Health' also has a role in workforce planning, but this is currently under-developed (Health Committee 2007: 96). There has been considerable concern about workforce planning in the NHS which is a key issue given that around 70 percent of NHS funding relates to staffing costs. The Health Committee (2007) examination of NHS workforce planning concluded:

There has been a disastrous failure of workforce planning. Little if any thought has been given to long term or strategic planning. There were, and are, too few people with the ability to do the task. The situation has been exacerbated by constant reorganisation including the abolition of Workforce Development Confederations within 3 years. The planning system remains poorly integrated and there is an appalling lack of coordination between workforce and financial planning. The health service...has not made workforce planning a priority.
(Health Committee 2007: 3).

Concerns have been raised about the absence of data on internationally recruited staff. The NHS does not record how many international recruits it employs, so there is reliance on registration data, and there is virtually no useful data on outflows abroad. Broader concerns relate to 'short-termism' with health authorities reducing training commissions to reduce deficits, the separation of medical workforce planning from other professional groups, and uncertainties about attrition rates of students in nursing and other professions (Buchan 2007; Health Committee 2007).

Structure of the workforce

A second issue relates to an increased focus on the changing shape of the workforce; related to changing workforce roles and new ways of working. This builds on long-standing debate about skill-mix, substitution and the boundaries between occupations (see, for example, Allen 2001). There has been a substantial increase in the employment of assistant occupations such as Health Care Assistants, which has been accompanied by locally-directed changes to their role (Bach et al. 2008; Thornley 2003). There has been a proliferation of assistant roles in the therapies and midwifery professions to address recruitment and retention difficulties, to encourage new ways of working, and to facilitate 'grow our own strategies'. Some of these roles such as physician assistants are relatively new (Buchan et al. 2007) while others are long-standing, but there is little consensus on the consequences of assistant roles (Bach et al. 2007). For nurses, the growth of assistant roles stems in part from the extension of professional mandates and the widening of career paths (Witz and Annendale 2006). These developments could, however, create difficulties filling ward manager posts because clinical specialists' roles are viewed as much more attractive jobs (Wise 2007). Overall it can be anticipated that affordability concerns, supply-side difficulties, and user involvement will encourage the establishment of a more diverse workforce using more assistant and 'new' roles.

Employer of choice

Third, recruitment and retention is influenced by the degree to which the NHS is perceived as a model employer. The Audit Commission (2002) noted that targets and the paperwork associated with them were the most important reason why public sector workers left their jobs, and this was cited by half of former public sector workers. The NHS has made concerted efforts to become an employer of choice (Department of Health 2004) with numerous initiatives to improve working lives, promote work-life balance, boost the remuneration of staff and increase staff numbers. Nonetheless uncertainty remains about the state of employment relations, reflecting 'troubled times' for public sector professionals and anxieties about the growth of managerialism (Gleeson and Knights 2006; Hunter 2006). Other studies have pointed to the growth of agency nursing as being partly linked to the deterioration of permanent jobs (de Ruttyer 2008; Tailby 2006). Acute trusts in England spent around £790 million on temporary nursing cover in 2004-05 with trusts in the South, especially London, more reliant on temporary staff (National Audit Office 2006).

The NHS undertakes a large annual staff survey (circa 150,000 respondents) which provides some indication of staff morale (Healthcare Commission 2008). The aggregate survey results need careful interpretation, however. The survey includes a wide range of hospital providers, and staff group and results often differ markedly between occupational groups. In addition, there have been frequent changes in the wording of key questions which makes longitudinal analysis difficult. The 2007 survey indicates that staff exhibit reasonable levels of job satisfaction, have strong support from their managers, and had access to flexible working options. Almost two thirds of staff, however, worked additional hours (paid and unpaid), three percent of staff experienced discrimination (12 percent among black and minority ethnic staff) and only a quarter of staff thought their trust valued their work (Healthcare Commission 2008) (see Table 1). Overall, the NHS Review Body concluded that:

our view is that morale has indeed declined across the NHS over the past year and our discussions with staff and managers during our visits last year to a number of NHS organizations across the UK support this view. Workload, the effects of the staging of the award and lack of training opportunities appear to have been the key factors (NHS Review Body 2008: 74).

The annual staff survey indicates concerns about direct staff involvement. In relation to indirect (trade union) involvement, *Agenda for Change* bolstered forms of co-operative working. Nonetheless, experience across the NHS indicates that partnership working can easily be derailed by unanticipated organisational problems and partnership relations may not penetrate beyond a relatively small group of activists (Bach 2004a; Tailby et al. 2004).

1.5 The Health Sector Workforce: Overview

Detailed data on the NHS workforce in England is published by the NHS Information Centre (Information Centre 2008abc). The NHS pay review body (2008) whose remit now covers all NHS staff paid under *Agenda for Change* and the Doctors' and Dentists' Pay Review Body (2008) contains detailed information on the workforce, recruitment and retention, morale and pay. In 2007, the NHS in England employed 87,533 full time equivalent (FTE) medical and dental staff in hospital and community health services (HCHS), an increase of 53 percent since 1997. The increase in GP numbers from 26,359 to 30,936 was much less marked (17 percent).

In 2007, the NHS in England employed 893,087 full time equivalent (FTE) staff within the non medical workforce.² This represented an increase of 27 percent since 1997.

² Non medical staff comprise ambulance staff; administration and estates staff; health care assistants and other support staff; nursing, midwifery and health visiting staff; scientific, therapeutic and technical staff, and; healthcare scientists.

Table 1: NHS Staff that agree or strongly agree with the following statements

	2005	2006	2007
Support from immediate manager			
<u>My immediate Manager:</u>			
Encourages those who work for her/him to work as a team	67%	64%	71%
Can be counted on to help me with a difficult task at work	65%	63%	67%
Gives me clear feedback on my work	42%	41%	53%
Asks for my opinion before making decisions that affect my work	48%	46%	51%
Is supportive in a personal crisis	70%	69%	71%
Staff Involvement			
<u>Questions about the Trust where you work:</u>			
Senior managers here try to involve staff in important decisions			23 %
Communication between senior management and staff is effective			22%
Senior managers encourage staff to suggest new ideas for improving services			31%
On the whole, different parts of the trusts communicate effectively with each other			17%
Care of patients/service users is my trust's top priority			46%
Intention to Leave			
I often think about leaving this trust	4%	36%	36%
I will probably look for a job at a new organisation in the next 12 months	24%	25%	24%
As soon as I can find another job, I will leave this trust	17%	18%	18%
Job satisfaction			
	<u>% satisfied/very satisfied</u>		
The recognition I get for good work	42%	41%	39%
The support I get from my immediate manager	58%	58%	57%
The support I get from work colleagues	76%	75%	75%
The opportunities I have to use my skills	64%	63%	64%
The extent to which my trust values my work	28%	27%	26%
My level of pay	-	-	29%

Source: (Healthcare Commission 2008).

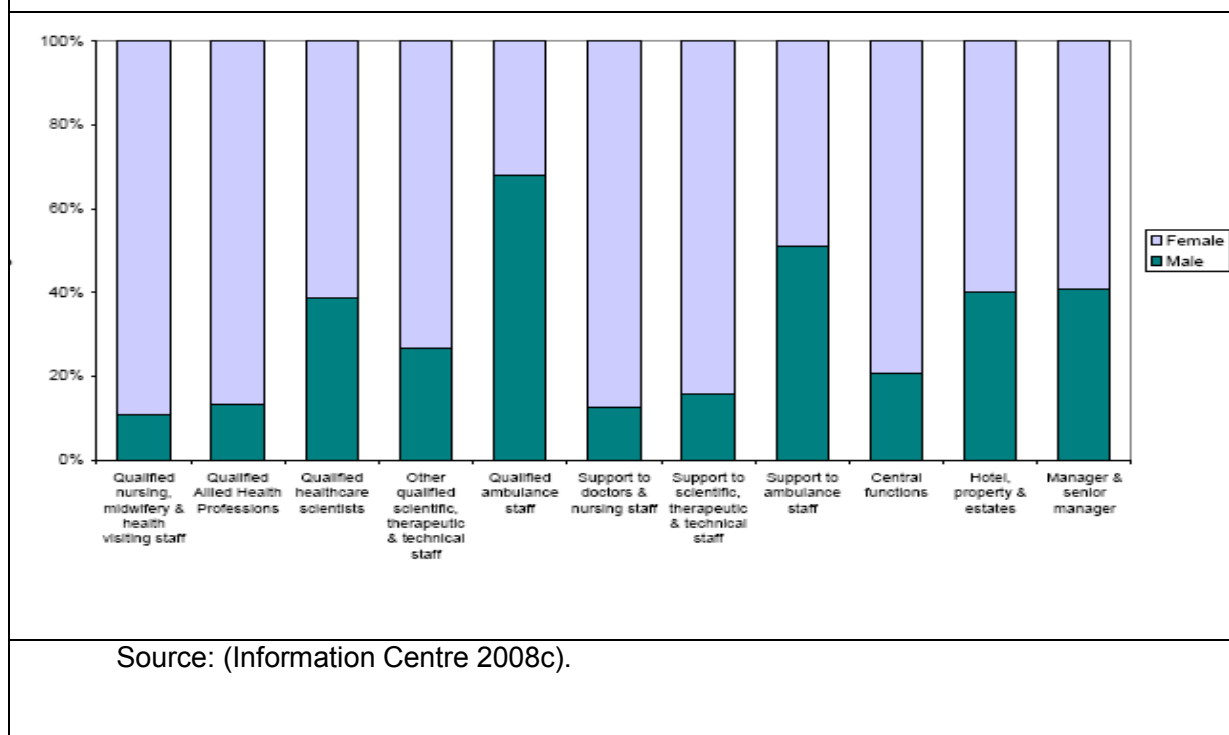
In contrast to medical staff (consultants and GPs) whose numbers continue to increase slowly, for non-medical staff the trend has been reversed with staff numbers decreasing by around two percent in 2006 followed by a smaller decrease in 2007(0.7 percent). The main trends are shown in Table 2. Overall the growth in the workforce has exceeded NHS plan targets by considerable margins.

Table 2: Trends in the NHS Workforce 1997- 2007

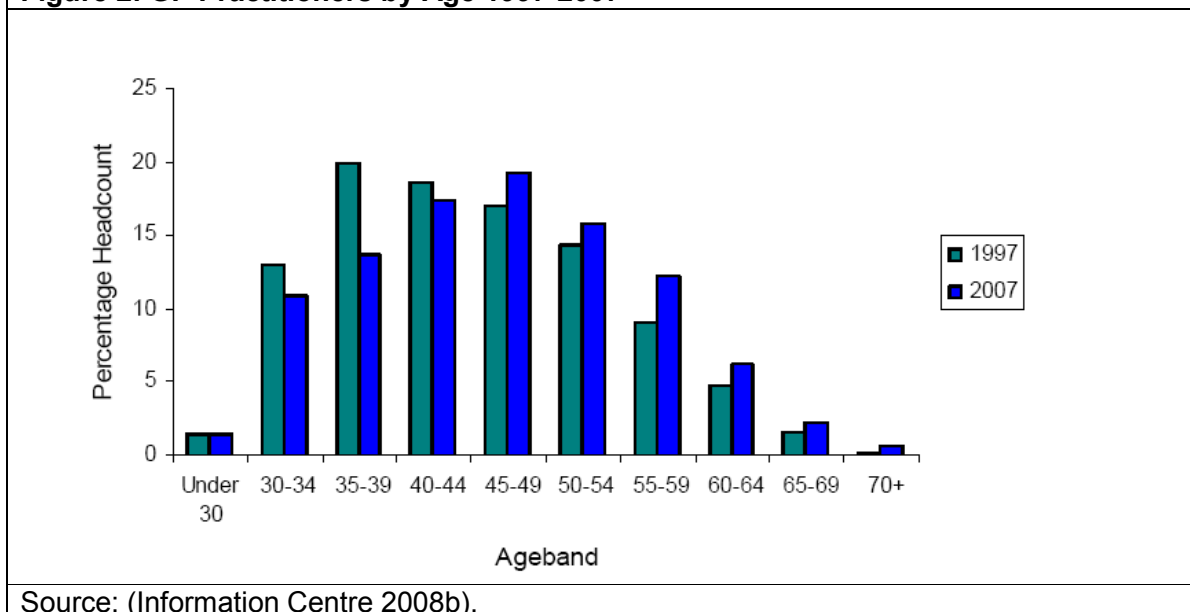
Year	All medical & dental staff employed within HCHS	Consultants	GPs excluding retainers and registrars	Qualified nursing, midwifery & health visiting staff	Qualified scientific, therapeutic and technical staff (ST&T)
1997	57,099	19,661	26,359	246,011	81,601
1998	58,746	20,432	26,455	247,238	84,560
1999	60,0338	21,410	26,558	250,651	86,837
2000	62,094	22,186	26,557	256,276	89,632
2001	64,055	23,064	26,628	266,171	93,085
2002	68,260	24,756	27,833	279,287	98,397
2003	72,260	26,341	27,624	291,925	102,912
2004	78,462	28,141	28,308	301,877	108,585
2005	82,568	29,613	29,248	307,744	113,214
2006	85,975	30,619	30,931	307,447	114,492
2007	87,533	31,430	30,936	307,628	117,107
Percentage Increase 1997-2007	53%	60%	17%	25%	44%

Source: (Information Centre 2008abc).

- *Gender:* Women make up 81 percent of the non-medical workforce (Figure 1) and across the NHS this proportion is increasing. For example women now comprise 39 percent of all medical and dental staff in England, an increase of 62 percent since 1997 (Information Centre 2008a) and comprise 42 percent of the workforce in General Practice.
- *Ethnicity:* The proportion of Black and Minority Ethnic (BME) in 2007 in England in the medical and dental workforce was 39 percent (29 percent in 1997). For the non-medical workforce ethnic minority backgrounds represented 15 percent of the workforce, compared to eight percent in 1997.

Figure 1: Non-medical staff by gender in England (2007)

- *Age.* The public sector workforce is older than the private sector. Three quarters of public sector workers are over 35 years-old, compared to just over 60 percent in the private sector, and there are far fewer young workers (under 24 years-old) compared to the private sector (Hicks et al. 2005: 23). A similar pattern is evident in the NHS and many professions face increasing levels of retirements, for example, GPs (Workforce Review Team 2008) (see Figure 2).

Figure 2: GP Practitioners by Age 1997-2007

Source: (Information Centre 2008b).

- Part-time employment:* The health sector employs a higher proportion of part-time workers (people working less than 30 hours a week) compared to the whole economy. Labour Force Survey data indicate that in 2006-07, the NHS across the UK employed 64 percent of staff (excluding medical staff) on a full-time basis and 36 percent on a part-time basis. The lowest level of part-time working was in London (29 percent) (NHS Review Body 2008:17).
- Trade union membership.* Labour Force Survey data for 2006 indicates that trade union membership (59 percent) was three times the level of the private sector (17 percent). In the health and social work industry which is a broader category than just health, 43 percent of UK employees were trade union members (Grainger and Crowther 2007). Longitudinal data derived from the authoritative Workplace Employment Relations Series (WERS) indicates that the health sector has the lowest union density within the public sector with continuous decline between 1980 and 2004 from 85 percent to 48 percent union density, although membership density among professionals is much higher than among manual and administrative grades (Bach et al. forthcoming).

1.6 Role of migrant labour within the health sector

Data sources and overall trends

There are several overviews which examine the contribution of the migrant workforce, but they are a little dated (Institute for Public Policy Research 2005; Royal Society of Arts 2005; Skills for Health 2006). The most widely used source of data is the professional registers. Registration data is usually up-to-date and provides information about the country in which the individual qualified (rather than necessarily where they were born). Registration data provides trends over time and indicates the relative importance of migrants as a proportion of that occupation. The main disadvantage of registration data is that it only provides a proxy measure of employment because it registers intention to work rather than actual employment. Non UK-trained nurses may register, but then not subsequently take up employment in UK nursing. By contrast, the Labour Force Survey provides data on the nationality of the UK and immigrant population and workforce in the UK, but when the sample is disaggregated by occupation (even using Standard Occupation Classification (SOC) 4-digit codes); the number of observations is often very small.

Work permit data indicates that around 3,280 work permits were granted to health professionals (mainly doctors) and 11,110 to associate health professionals (mainly nurses) in 2005. In line with registration data (discussed below), there has been a general upward trend among doctors being granted work permits since 2000, while for nurses there has been a sharp decrease since 2003-04 (OECD 2007) related to the removal of nurses from the shortage occupation list. Home Office (2007) data on the A8 countries indicates that between May 2004 and December 2006, 530 hospital doctors, 340 dental practitioners, 950 nurses and 410 nursing auxiliaries/health care assistants registered in the Work Registration Scheme. Relatively small numbers of health and medical occupation workers are listed in the Accession statistics for Bulgaria and Romania. Between October and December 2007 there were 20 approvals of work permits from Romania and 5 from Bulgaria, but this data is not comprehensive (see Home Office 2008).

Medical staff

In the 1950s, acute staff shortages encouraged medical staff immigration mainly from South Asia, especially India (Decker 2001; Kyriakides and Virdee 2003; Robinson and Carey 2000). In the 1970s, foreign trained doctors comprised about a quarter of the UK workforce (Mejia 1978) compared to around a third now. The GMC registration data (Table 3) indicates the proportion of non-UK qualified doctors within the workforce. Non-EEA doctors have made a vital contribution to the workforce, but the government is now actively seeking to discourage

International Medical Graduates (IMGs) from entering the UK by 'temporarily' restricting their access to post-graduate medical education because of the drive towards self-sufficiency and the assumption that EEA recruitment can substitute for non-EEA recruitment (Department of Health 2008). This decision is controversial and is subject to judicial review. These trends are starting to be reflected in GMC data (Table 3).

Table 3: New Registrations of doctors in the UK (based on place of primary medical qualification) 1998-2007

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
UK	4,010 (44%)	4,242 (50%)	4,214 (50%)	4,462 (51%)	4,288 (42%)	4,443 (29%)	4,658 (37%)	5,164 (34%)	5,620 (48%)	6,133 (55%)
EEA	1,590 (17%)	1,392 (16%)	1,192 (14%)	1,237 (14%)	1,448 (14%)	1,770 (11%)	2,419 (19%)	4,103 (27%)	2,994 (25%)	2,446 (22%)
Rest of the world	3,580 (39%)	2,889 (34%)	2,993 (36%)	3,088 (35%)	4,456 (44%)	9,336 (60%)	5,683 (44%)	5,825 (39%)	3,163 (27%)	2,609 (23%)
Total	7,363	8,523	8,399	8,787	10,192	15,549	12,760	15,092	11,777	11,188

Source: (General Medical Council, Personal communication).

Nonetheless, there are more than 20,000 doctors trained in India on the UK register, around 10 percent of the total stock. There are also an estimated 11,000 African doctors registered in the UK mainly from South Africa (approximately 7,500) and Nigeria (approximately 1,900). Other important source countries include Pakistan and Egypt (Buchan and Dovlo 2004; Connell et al. 2007). In terms of the EEA, an analysis conducted before the entry of the European Union (EU) accession countries indicated that doctors from Germany, Greece, Ireland, Italy and Spain were the main source countries registering with the General Medical Council (Nicholas 2004). Since 2005, the GMC recorded an increase of around 25 percent in the number of registered doctors from A8 and A2 countries. Around 1,500-2,000 doctors from Poland registered annually (2005-2007) and the Czech Republic and Hungary also recorded doctor registrations of between 500-1,000 per year (see Pollard et al. 2008: 36-37).

In England, around a fifth of GPs contracted to the NHS received their primary qualification abroad, divided between the EEA (five percent) and elsewhere (16.5 percent) (Appendix 1). There has been a relatively large increase (from a low base) of EEA qualified GPs. This contrasts with the situation for Hospital and Community Health Services (HCHS) medical staff.

Not only has there been very rapid growth in non-EEA qualified medical staff, but also it is evident that non-EEA medical staff are concentrated in Staff Grade and Associate Specialist (AS) grades (Appendix 2). This data confirms the picture revealed by other studies (Oikelome and Healy 2007). These grades used to be termed 'non-career' grades because they do not incorporate postgraduate training leading to consultant posts. Associate Specialists work within a particular specialty and may work without direct supervision, but they are attached to a clinical team led by a consultant in their specialty. UK qualified doctors are reluctant to enter these grades, as are non-UK qualified doctors, but the latter are disproportionately employed in these grades. There are currently plans to close the AS grade to new entrants and establish the grade of 'specialty doctor' with improved salary prospects. These measures are intended to boost morale and motivation among these non-consultant career grade doctors (NHS Employers 2008). NHS Trusts have also created trust grade posts to meet service needs, which have non-standard terms and conditions. These posts, which are often filled by migrants, are not protected by national terms and conditions of employment and may incorporate worse terms and conditions of employment (British Medical Association 2007).

Nurses

There has been a long history of international recruitment of nurses in the NHS which originates from the UK's imperial history and the British Colonial Nursing Service (Solano and Rafferty 2007). In the 1950s, severe nurse shortages led to recruitment from the Commonwealth and former colonies which continued until the late 1960s (Carpenter 1988). The Nursing and Midwifery Council (NMC) provides annual statistics on the number of nurses and midwives on the register, together with the numbers entering and leaving the register, providing a good indication of trends in the number of overseas (EEA and Non-EEA) nurses registering to practice in the UK. In 2007, there were 686,866 nurses on the register. During the 1990s, until 1998, there was a sharp fall of around 35 percent in the number of new entrants to the UK from UK sources before increasing by more than 40 percent during the last decade. It was in this intervening period that overseas registrations filled the shortfall in terms of initial registrations.

As Figure 3 (below) indicates, active recruitment by the NHS and independent sector from the late 1990s led to a sharp rise in registration from non-EEA qualified nurses. In the peak year of 2001-02 the number of non-EEA nurse registrants exceeded those from the UK. The key source countries have been India and the Philippines (see Table 4), but active overseas nurse recruitment has now virtually dried up and it is almost certain that data for 2008 will indicate a further fall in non-EEA registrations. This stems from the expansion of UK educated nurse

training and the removal of Band 5 and 6 nursing posts (the main entry level nursing posts) from the Home Office shortage occupation list in 2006. Removal from the shortage list makes it more difficult for employers to recruit non-EEA nurses and also sends a signal to overseas nurses that there are fewer opportunities in the UK labour market (for detailed analysis of trends in the nursing workforce see Buchan and Secombe 2004, 2006ab).

Figure 3: Admissions to the UK Nurse Register from the UK, EEA and Non-EEA countries 1998 - 2007

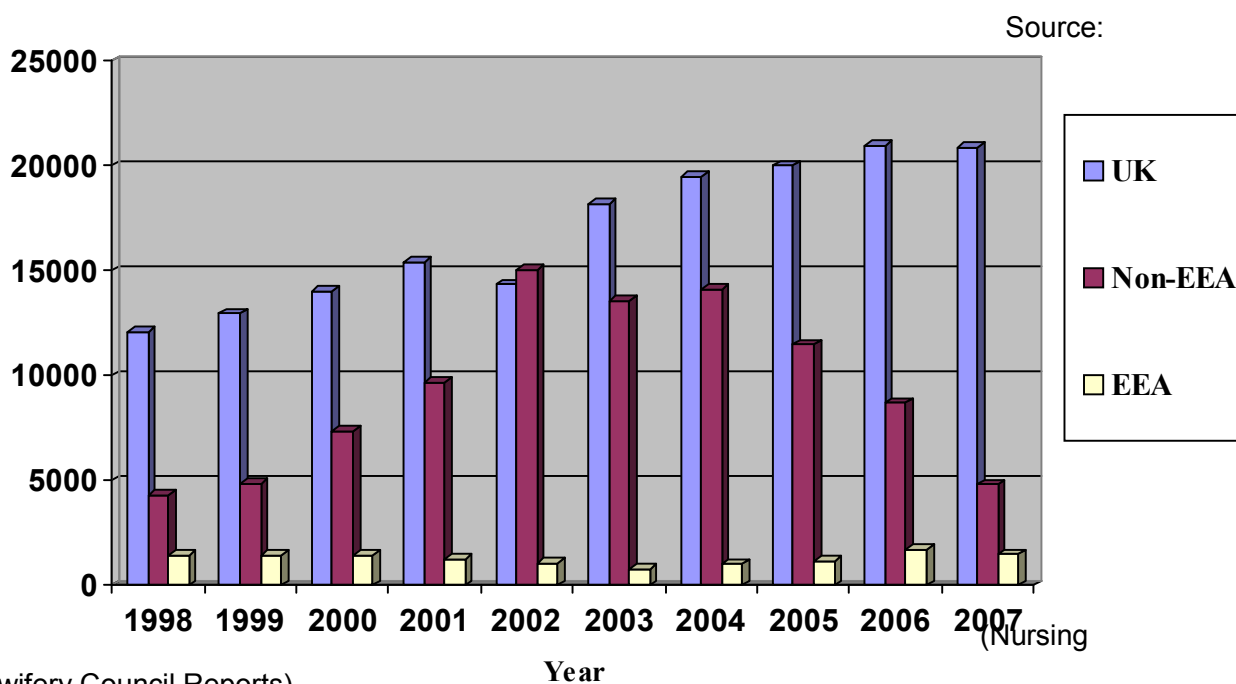


Table 4: Overseas (non-EEA) trained nurses registered per year in the UK 1999-2007. Listed by 20 most numerous source country registrations in 2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
<u>Country</u>									
India	30	96	289	994	1,830	3,073	3,690	3,551	2,436
Philippines	52	1,052	3,396	7,235	5,593	4,338	2,521	1,541	673
Australia	1,335	1,209	1,046	1,342	920	1,326	981	751	299
Nigeria	179	208	347	432	509	511	466	381	258
Pakistan	3	13	44	207	172	140	205	200	154
Nepal	-	-	-	-	71	43	73	75	148
Zimbabwe	52	221	382	473	485	391	311	161	90
China	-	-	-	-	-	-	60	66	80
New Zealand	527	461	393	443	282	348	289	215	74
Ghana	40	74	140	195	251	354	272	154	66
Zambia	15	40	88	183	133	169	162	110	53
South Africa	599	1,460	1,086	2,114	1,368	1,689	933	378	39
Kenya	19	29	50	155	152	146	99	41	37
Canada	196	130	89	79	52	89	88	75	31
Saudi Arabia	-	-	-	-	22	23	-	-	28
Sri Lanka	-	-	-	-	23	36	47	n/a	28
Mauritius	6	15	41	62	59	95	102	71	27
USA	139	168	147	122	88	141	105	98	21
Sierra Leone	-	-	-	-	-	-	24	n/a	n/a
Total*	3621	5945	8403	15,064	12,730	14,122	11,477	8,709	4,830

* Aggregate individual country figures do not equal total non-EEA initial registrations as some countries are omitted from this table.

Source: (Nursing and Midwifery Council, various years).

It should be noted from Figure 3 that the number of EEA registrations remains low and has been around 1,000-1,500 for the last few years. In 2007, around a third (578) of EEA registrations were from Poland (Nursing and Midwifery Council 2007). Considering the expansion of the EEA and the volume of immigration from the EEA in other sectors, this is an important distinguishing feature of the health sector, and in general, outflows of nurses (and to a lesser extent doctors) from Estonia, Poland and Lithuania have been lower than anticipated (Buchan and Perfilieva 2006). Language barriers are an important reason for difficulties in gaining registration. In addition, uncertainties about the level of nurse training in many A8 countries make it difficult for nurses to gain recognition for their qualifications because they are not compliant with EU directives, although this will alter over time (Hasselhorn et al. 2005; Zajac 2004). Some nurses also report difficulties in obtaining the requisite documentation about their qualifications from

their home country (Charlton 2004). Consequently many accession state nurses are working as health care assistants. For example the independent sector organisation, Westminster Health Care, initially recruited 200 Polish citizens to work in care assistant roles (Cole 2005).

Finally, it is important to note that in comparison to nurses, non-UK midwives have constituted a very small proportion of the recent additional stock of midwives in the UK. Under five percent of overseas midwives (around 80-90 per year) gain approval to undertake an NMC approved adaptation place, and not all of these gain NMC registration. The difficulty is that international midwifery training is rarely compliant with UK standards (Royal College of Midwives 2005). It is unlikely that in the short-term international recruitment could play a major role in alleviating any workforce pressures, which are most prevalent in the South East. There is some uncertainty about whether current expansion of the midwifery workforce is sufficient to meet increased demand, as discussed in 'Maternity Matters' (Department of Health 2007).

Other occupational groups

There has been far less research and analysis of the contribution of other occupational groups to the UK health sector. In particular, there is a large gap in our knowledge of the migration patterns of health sector scientists. Key points about other groups include:

- *Pharmacy:* The OECD (2007) notes that the share of foreign-born pharmacists in the UK workforce (and other OECD countries) is lower than for doctors and nurses. This is attributed to the need to pass law examinations in addition to possessing a pharmacy degree. Pharmacy is distinctive because the majority of pharmacists work outside the NHS. The most authoritative analysis of the UK pharmacy workforce is being undertaken by the Centre for Pharmacy Workforce Studies, University of Manchester (www.manchester.ac.uk/cpws) (Seston et al. 2007). Hassell (2007) estimates that 6.5 percent of pharmacists in the UK are non-UK qualified and this represents a small but growing proportion of the workforce. In recent years (2001-2005) the most important source countries in terms of new registrants have been Spain (>1000) and Australia (>600) with particularly marked growth from the EU (Chan et al. 2006).
- *Allied Health Professionals (AHPs):* These form part of the Scientific, Therapeutic and Technical (STandT group) but are analysed separately with the main therapy occupations comprising: Physiotherapists; Occupational Therapists; Speech and

language Therapists; Radiographers (diagnostic and therapeutic), Chiropodists/Podiatrists and Dieticians. There are currently 178,000 registrants on the Health Professions Council (2007) register, but it does not provide details of place of qualification. There was a significant inflow in the number of physiotherapists coming to the UK after 1997. Work permit data indicates that the main source countries were South Africa, Australia, New Zealand, Zimbabwe and India (Buchan and Dovlo 2004). More recently, graduate physiotherapists have faced difficulties gaining employment (Social Partnership Forum 2007).

2. Employer Demand: What skills are required in the health sector?

Virtually all health professions are degree level qualifications, although some professions enable progression from a lower starting level via assistant type roles. National Vocational Qualifications (NVQ) acquisition has been encouraged in the sector for some lower-level occupations, but the main requirements that employers seek from health professions are regulated by the individual regulatory body. These requirements focus on technical expertise, usually gauged by a combination of educational attainment, experience in appropriate training posts, demonstration of technical proficiency in supervised posts, and evaluation by (practical) examination. Other criteria to gain registration usually focus on 'good character' and 'good health.' Consequently, employers have limited discretion in the requirements they can establish for health professionals. Although precise regulations differ, registered professionals are required to:

- Comply with the standards of competence and conduct set out in their professional code of conduct. Breaches of the code can lead to being removed temporarily or permanently from the list of registered professions;
- undertake continuous professional development, demonstrate evidence of that learning, and subject themselves to periodic revalidation of their professional competences as outlined by the appropriate registration body, and;
- Communicate effectively in English. Non-EEA qualified health professionals are required to demonstrate English language proficiency and this is measured via the International English Language Testing System (IELTS).

Skills escalator

Apart from professional registration, the main approach of the NHS to identify and encourage skill acquisition stems from the skills escalator concept which was one of the 'four pillars' that was intended to make the NHS an employer of choice. Employers were expected to benefit because skills development would improve recruitment and retention and also facilitate role redesign (Department of Health 2002). These principles were embodied in the Knowledge and Skills Framework (KSF) which was implemented as part of the Agenda for Change pay modernisation process. The KSF was intended to bolster staff development and ensure that pay progression was based on staff achieving the knowledge and skills required in their post. Each job within Agenda for Change has a KSF post outline that sets out the dimensions, levels and indicators that the postholder is expected to achieve to undertake his or her job effectively and to gain incremental progression. The KSF is based on an annual developmental review process and this leads to the generation of an agreed Personal Development Plan (PDP) for each staff member.

The implementation of the KSF has lagged implementation of other elements of pay modernisation and has not been effectively implemented. The 2007 national staff survey indicated that only 61 percent of respondents had received an appraisal or performance development review in the previous 12 months, a slight improvement on 2006 (58 percent). Of these, 40 percent had received a KSF development review and the remainder had received some other type of appraisal. Moreover there has been a slight downward trend in accessing training, with over a quarter stating that they had not received the training identified in their Personal Development Plan (PDP) (Healthcare Commission 2008: 11-12). The NHS Review Body (2008: 74) also expressed disappointment at the slow implementation of the KSF. The reason for its slow implementation relates to its perception among managers that it is too complicated and/or time-consuming and that because salary increments are virtually automatic, the KSF is irrelevant. Despite these difficulties, the skills escalator concept has encouraged some modest improvements in skills acquisition for ancillary staff and health care assistants (Cox 2007). These groups have traditionally received very few opportunities for learning and career development (Fryer 2006).

Apart from technical proficiency, the relative importance of 'soft' skills to the delivery of effective health care and the extent to which these are innate attributes or can be developed via training

has been much debated (Grugulis 2007). For example, there has been consideration of the degree to which nurses have the time and inclination to demonstrate 'caring' qualities (Brown and Kirpal 2004). At the core of care is the interaction between an individual patient and a plethora of health professionals. There has been awareness within the nursing sector that increased technical proficiency may distance nurses from direct bedside care, thereby undermining notions of 'holistic' and 'patient-centred' care (Bach et al. 2008; Witz and Annandale 2006). Concerns about role drift (meaning that core professional duties are being delegated to assistants and technicians), is a common source of anxiety among nurses, allied health professionals and pharmacists (McKenna et al. 2007).

Finally, the development of a stronger managerial ethos in the health sector has encouraged a shift away from an exclusively professional defined norm of competence towards more customer-orientated requirements (McBride et al. 2005). This is reflected in waiting time targets that professionals are required to achieve and the emphasis on servicing internal and external customers. Many professionals are willing to accept these new requirements, but Lord Darzi (2007: 5) commented that some staff do not feel they are,

listened to and trusted. They do not feel that their values – including wanting to improve the quality of care – have been fully recognized.

These concerns have led to tensions between medical and managerial staff (Hunter 2006) and a concern that many medical staff are disengaged and alienated from current health policy (Horton et al. 2007). Overall, the main focus in the sector is on technical proficiency, but employers are also interested in the possession of appropriate experience, good communication skills and practical ability, indicating a broader perspective on the skills that matter in the delivery of effective health care.

3. Labour supply

In aggregate terms, the NHS workforce is more in balance and is moving towards self-sufficiency to a greater extent than in the past decade. There has been significant expansion in the number of UK trained health professionals. For example, there has been a 12 percent expansion in the number of nurses in training between 2003/04 and 2005/06, reflected in the number of initial NMC UK registrants (Figure 3). The number of medical school places has been expanded and it is estimated that the number of medical school graduates in England will

rise from 4,091 in 2004 to 6,062 in 2011 (Workforce Review Team 2008). Although the main focus has been on increasing training commissions, attempts have also been made to attract staff back into nursing. The Department of Health has undertaken a series of campaigns to encourage returners via 'Return to Practice' courses, but data is not collected on how many returners subsequently take up and remain in NHS employment (Buchan et al. 2003).

3.1 Influences on the supply of migrant health professionals

In addition to employer demand discussed below, if opportunities exist in the UK health sector, what are the main influences on migration? There is a wide-ranging literature on 'push' and 'pull' factors that encourage migration, not least wage differentials (Vujicic et al. 2004). Factors that are frequently discussed relate to the inadequacies of the working environment in the home country, including the impact of HIV/AIDS and other influences such as war and civil unrest (Physicians for Human Rights 2004; World Health Organisation 2006). Nurses from Africa and the Indian sub-continent come to the UK because of their fluency in English and familiarity with British culture because of well-established migration pathways. Those from the Philippines and South Asia are aware of a wider range of destinations and are influenced by the relative difficulty of registration and examination requirements. The UK is often viewed as a possible step towards the United States as the ultimate destination. The UK has the advantage over the Gulf States of not treating nurses as 'guest workers' (with no employment rights) (Smith et al. 2006: 30-31).

Remuneration

The scope to enhance earnings has been mentioned as a key reason for migration among nurses coming to the UK. The balance between the desire for material advancement and a focus on accessing training and development opportunities differs by nationality, which has been partly attributed to differing family expectations about the size of remittances (Smith et al. 2006). Even if health professionals believe that they earn enough to meet their current financial needs in their home country, they often cite the inability to ensure the long-term security of their family and children, for example an inability to purchase property, as a motivating factor (Mensah et al. 2005: 28). In general terms and especially following pay modernization, health professionals, notably medical staff, are comparatively well paid. Even prior to the implementation of the consultant contract, in 2004, average pay in the UK for specialist doctors as a ratio of Gross Domestic Product (GDP) per head is higher than many other OECD countries (National Audit Office 2007a: 38). Along with these findings it needs to

be noted that many non-UK qualified health professionals experience downward occupational mobility and deskilling on entering the UK labour market (Smith et al. 2006). Responses from overseas doctors in the UK indicated that almost half (45 percent) had experienced a reduction in their grades on migration (63 percent for those from India). Nonetheless, this did not preclude 45 percent of the sample sending home remittances. On average, remittances comprised six percent of their income earned in the UK (Kangasniemi et al. 2007: 918).

Training and professional development

For health professionals, professional development is an integral component of individual career planning and progression. Among doctors in New Delhi, the availability of training opportunities not available in India was the most important factor motivating out-migration. Gaining more academic qualifications and exposure to advanced professional infrastructure were viewed as crucial for long-term career advancement (Khadria 2004: 22). A similar emphasis on training opportunities was the primary reason (cited by over three-quarters of doctors) in a survey of non-EU doctors in the NHS (George, Rozario et al. 2006). Kingma (2006) reports similar priorities among nurses with a strong emphasis placed on the scope for learning opportunities. This includes access to specialist training or the chance to use technologies that are not routinely available in the home country.

Role of recruitment agencies

The role of recruitment agencies as a stimulus for labour supply is becoming increasingly acknowledged (Connell and Stilwell 2006). Analysis of almost 400 migrant nurses in London indicated that almost two thirds were recruited by agencies to work in the UK (Buchan et al. 2005). The recruitment agency assists the nurse to gain a work permit and to find a placement (which can be very difficult) which they have to complete before they are able to work as a registered nurse. This places many nurses in a highly dependent position, for example their accommodation is provided by their employer, making them vulnerable to exploitation. The fees charged by recruitment agents are substantial. In Ghana, agents charge about £2500-£3500 to assist nurses moving to the UK which excludes accommodation, visa fees and air fares (Mensah et al. 2005: 17-18). Consequently, the recruitment of nurses has become more formalised and commercialised, but although the direct costs of out-migration have increased substantially, this has not discouraged it.

4. Migration and Labour Demand

Although there is a strong legacy of the use of migrant labour in the health sector, the significant flow of migrants since 1997 has been stimulated by *active* government policy (Bach 2007). The key drivers have been the following:

- The Labour government's 'NHS Plan' for England established targets for workforce expansion. Taking account of staff shortages and lags in training health professionals, international recruitment was the preferred strategy to ensure rapid workforce growth. Workforce targets were exceeded (Health Committee 2007).
- Consultant medical staff in a number of specialist areas, GPs, nurses, midwives, dieticians and Biomedical scientists were the main occupations included in the Home Office shortage occupation list, forestalling the resident labour market test. It signaled that the UK was seeking non-UK qualified health professionals.
- The Department of Health established an institutional infrastructure to facilitate recruitment activity. An NHS Director of International Recruitment was appointed supported by International Recruitment Coordinators. The number of staff recruited internationally comprised a key component of each Workforce Development Consortium's performance framework. These coordinators and staff in Spain and elsewhere aided NHS trusts in their recruitment efforts. Financial support was made available, enabling managers to travel to the Philippines in particular, to recruit batches of 50-100 nurses at a time. The Department of Health actively marketed the NHS through its website and entered into bilateral agreements to promote recruitment activity (see Appendix 3).

Vacancies

Overall, the Doctors' and Dentists' Review Body and the NHS Review Body concluded in 2008 that at present there were no overall problems with recruitment and retention among their remit groups, although there were some difficulties with particular specialisations and in certain regions. These conclusions are based on the Office of Manpower Economics data (see OME website). The NHS Information Centre (2008d) collates vacancy data from the NHS in England (as at 31 March 2007). Although the data have been registering a fall in vacancies in England

over the past five years, NHS vacancy data have been widely criticised not least because they only record information on posts that have been vacant for three months or more (thereby depressing vacancy rates) and because they do not capture the use of bank/agency staff or the freezing of posts (NHS Review Body 2008: 40 - 42). Moreover the data is categorised by health authority 'London' and 'North East,' for example, which incorporates a number of different labour markets. At the same time when broken down by occupation, the number of vacancies can be small (for example, in Dietetics, 30 vacancies are listed in England). With these caveats in mind two points are evident:

- *Region:* Irrespective of professional group, it is invariably London and the South East that have the highest vacancy rates. The West Midlands and South West generally have the lowest vacancy rates.
- *Occupation:* Consultants have the highest overall vacancy rates (1.2 percent), but there are wide variations between region and specialty. Accident and emergency (3.2 percent), psychiatry (2.6 percent) and pathology (two percent) all have vacancy rates above two percent. Among the nursing, scientific and therapeutic occupations, overall vacancy rates are lower. Within these groupings some of the highest vacancy rates are among the following:
 - Nurses: community learning disability nurses (1.8 percent);
 - AHPs: operating theatre staff (1.6 percent); registered pharmacists (1.4 percent); orthoptics (1.3 percent) and dietetics (1.1 percent);
 - Scientific professions: cardiology (1.8 percent); other physiological sciences (1.7 percent); rehabilitation engineering (1.5 percent); other life science (1.5 percent).

In addition to the occupations discussed below, recruitment and retention issues are often mentioned in relation to pharmacy, radiography and biomedical scientists (see, for example, Suff 2005), but given the range of health professions in the sector and variations between regions and grades, this analysis is not comprehensive. The main points to emerge from the Review Bodies and elsewhere (Bloor et al. 2006; Royal College of Nursing 2007; Workforce Review Team 2008) relate to:

- *Attrition:* The number of UK qualified health professionals has increased, but attrition rates among students are high. Data released to the *Nursing Standard* indicated that 26

percent of nursing students left their courses early in 2006 which has been partly attributed to high levels of student debt (Waters 2008). The National Audit Office (2007b) concluded that completion rates for 'subjects allied to medicine' progressing from first to second year was below the average for all subjects in 2004-05. Medicine and dentistry had the highest completion rates.

- *Graduate unemployment:* In particular occupations there are indications that not all graduates can gain employment in the short-term, and there is a concern about over-supply. The risk is that new graduates may exit the health sector workforce and this could exacerbate shortages in the medium to long-term. The most clear cut case is physiotherapy which arises from high levels of non-UK qualified physiotherapists entering the UK labour market and expansion of training commissions. The government's Social Partnership Forum (2007) published 29 recommendations to maximize employment opportunities for graduate healthcare professionals. These recommendations included exploring whether UK graduates could be gainfully employed in other countries that are experiencing shortages.
- *Variations between occupations and specialisations:* Even if aggregate supply is more in balance than in recent years, some occupations and specialties are more frequently mentioned as 'at risk' in terms of short-to-medium term supply than others. In terms of their significance for the health workforce considerable analysis relates to:

General Practitioners: The National Audit Office (NAO) concluded that although 'good progress' had been made on increasing the number of GPs, it was too early to comment on retention. Some GPs reported that it was more difficult for younger GPs to become partners, but at the same time the 'new generation' favour a more flexible career (NHS Employers 2007: 3). Concerns about GP supply relate to reductions in GP registrar posts, changes in medical training (the move to 18 month GP training), insufficient training posts to maintain supply, and an increase in retirees. Health policy changes (for example, shift to the community and increased demand) could lead to supply-side difficulties which may be alleviated in part by skill-mix change and more medical trainees being redirected into GP training (Workforce Review Team 2008).

Nurses: Nursing forecasts indicate a leveling off of supply and then a fall in nurse numbers (partly because of the ageing workforce). International recruitment from outside the EEA has sharply decelerated. It is often more experienced nurses (Band 6 and above) rather than newly-qualified nurses that the NHS has difficulty recruiting and retaining. Particular specialties, such as theatres and paediatrics are often mentioned as confronting recruitment difficulties. Overall, the contribution of non-UK registered nurses to recent health sector workforce growth cannot be overstated, with more than 90,000 new registrants (around 45 percent of all new entrants to the NMC register). This flow has been jeopardised by the alterations in work permit regulations (Royal College of Nursing 2007). It is uncertain if the inflow from the EEA can substitute for non-EEA nurses in terms of numbers or desired employer competencies.

4.1 Employer preferences and experience

There is little evidence to suggest that employers in the sector have a *positive* preference for migrant workers, with few mentions of 'work ethic' and other points that are often discussed in relation to migrants in the hospitality sector, for example. Employers have sometimes expressed a preference for 'home grown' nurses (Smith et al. 2006: 37) and current government policy emphasises self-sufficiency, in part because it is seeking to avoid unemployment among UK qualified health professionals. Nonetheless, there are a range of benefits that accrue to employers in recruiting migrant labour.

Filling vacancies

The primary motivation has been to address skill shortages and fill vacancies. Geographical locations with the highest vacancy rates for nurses have made greatest usage of non-UK trained nurses. London has a disproportionate number of non-UK trained nurses, and in conjunction with the South East, they employ approximately 40 percent of those in the UK (Batata 2005). Employers, especially in the independent sector, indicated that international recruitment was a relatively straightforward and cost-effective method to address their staffing requirements compared to other recruitment and retention approaches methods (Buchan 2003: 22).

Unpopular specialties, grades and shift patterns

The use of migrant health professionals to work in unpopular specialties and localities is widely documented. In medicine, it has been the specialties of elder care, accident and emergency and psychiatry that have been viewed as lower status specialties and which have employed the greatest proportion of non-EEA qualified doctors (Decker 2001). The sub-consultant career grades which do not ensure the financial rewards or status of consultant posts are dominated by non-EEA qualified doctors (British Medical Association 2007). A survey of Staff and Associate specialists indicated that they earned more, worked longer hours and had less autonomy than their UK-qualified comparators (Oikelome and Healy 2007). Overseas doctors struggle to gain the same training as provided to their home country counterparts. For some doctors this arises because of a lack of understanding of the structure and organisation of training, however, for many others it reflects the view that overseas doctors' careers and training needs are systematically ignored (Unwin 2001; British Medical Association 2004). It has also been noted that non-EEA staff fill particular organisational slots. Among nurses, the Royal College of Nursing (2007) reported that who they termed 'internationally recruited nurses' were much more likely to work permanent night shifts while O'Brien (2007) emphasised that non-EEA nurses were expected to undertake less technical direct-care duties.

Rewards and managerial control

Although the sector is highly unionised and the NHS uses a national structure of pay and conditions, limiting the scope for the worst forms of exploitation, a common experience among overseas nurses has been the lack of recognition of their skills and previous experience. This has encouraged a feeling that their competence as a nurse was being questioned (Royal College of Nursing 2003; Smith et al. 2006). Similar concerns were raised by South African nurses working in a UK trust hospital, who felt their training and skills were being wasted (Hardill and MacDonald 2000: 689). This lack of recognition can result in a sense of injustice because the tasks allocated and the pay received do not correspond to experience. Because of their dependence on their employer for their work permit and also their reliance on their employer to gain their professional registration, nurses feel insecure and anxious during their adaptation (Winkelmann-Gleed and Seeley 2005: 959). In some cases, employers, especially in parts of the independent sector, have not provided adequate training to enable nurses to gain registration enabling them to be employed on lower paid Healthcare Assistants' (HCA) grades (Royal College of Nursing 2003). Consequently migrant labour may provide additional flexibility and a higher level of dependence on the employer.

5. Alternatives to migration in response to labour shortages

Since around 2003-04, there has been a shift in government emphasis towards 'self-sufficiency.' A number of other initiatives have been taken at national and local level. These have been primarily to improve recruitment and retention and to ensure that the NHS is an employer of choice, but they have also reduced the focus on migrant labour. The main attention has focused on:

Raising wages

Cumulatively *Agenda for Change*, the new GP contract and the revised consultant contract have contributed to a significant increase in the NHS paybill. In 2005-06, the average pay of consultants was £109,974, an increase of 27 percent in three years (National Audit Office 2007). For GPs, pre-tax take home pay in England increased by 58 percent from £72,011 in 2002-03 to £113,614 in 2005-06 (National Audit Office 2008). The impact of *Agenda for Change* is harder to assess because it covers all non-medical staff and therefore there are 'winners' and 'losers,' and the implementation process has generated many grading appeals. The NHS Review body (2008: 113) concluded that:

On comparative earnings, there is no evidence that our remit group has done better than average in recent years when compared to other, similar, workers, notwithstanding the introduction of AfC. AfC has led to significant above average pay increases for some groups within our remit, but this is not the case for our remit group as a whole.

The NHS also has the opportunity to target wage increases on a national or local basis. At trust level, local agreements existed prior to *Agenda for Change* (Bach 2004) and many of these agreements have been continued, for example, using local pay supplements to boost recruitment and retention. *Agenda for Change* includes provisions for the establishment of recruitment and retention premiums to address labour market difficulties among specific occupational groups and high cost area supplements. The NHS Review Body (2008: 57-58) has been cautious about using these provisions, but it has proposed a bonus payment ('golden handcuffs') for newly qualified pharmacists that remain in the NHS for five years. The Treasury has expressed interest in making public sector wages more sensitive to local labour markets,

and some evidence suggests that the competitiveness of nurses' pay does vary between geographical locations (Elliott et al. 2007).

Skill-mix measures and assistant roles

The government has been critical of professional role demarcations and has emphasised new ways of working to encourage organisations to use fully the talents of their unregistered workforce. In general, the response of professions is more positive when they view assistants as complementary to their own role rather than as a potential threat and substitute to their own job (Bach et al. 2007). The NHS has therefore made concerted attempts to increase the utilisation of non-registered health workers. The most high-profile cases include the enhanced role of health care assistants, the development of maternity support workers (NHS Employers 2007) and the use of support workers in the therapy and scientific professions (see, for example, Ford 2004). It is not straightforward, however, for many of these groups to become registered professionals, and uncertainties remain as to whether support workers reduce the workload of registered professionals (Bridges and Meyer 2007; McKenna et al. 2007). Overall there is sustained interest in altering skill-mix in the health sector.

Widening and extending labour supply

The NHS has promoted 'grow your own' strategies to widen the pool of potential applicants for professional roles (Malhotra 2006). Cadet schemes have been used to increase recruitment into nursing or similar training by encouraging young people with few formal academic qualifications to pursue nursing or an Allied Health Professional career. It is estimated that well established schemes encourage about sixty percent of cadets to progress into pre-registration nurse training, while many others remain as HCAs (Norman et al. 2007). The NHS has also moved towards electronic recruitment through NHS Jobs (www.jobs.nhs.uk). Although this creates difficulties for Human Resources in dealing with the volume of applicants, it has also extended the reach of NHS recruitment. Ashford and St Peter's Hospitals NHS Trust filled six hard-to-fill radiography posts with overseas workers recruited via NHS jobs (Suff 2006).

At least 3000 refugees living in the UK are health professionals, and these skills are an under-utilised resource because only about 20 percent are practicing their profession. The main obstacles include the protracted registration process, the high cost of clinical attachments, lack of UK experience and unfamiliarity with the structures in the sector (King's Fund 2004). The experience of employment can also be discouraging as one refugee nurse explained:

What is hard for some nurses to swallow is not being paid less while in training or supervised practice, but when their 15 years of experience is not taken into account in the grading system. So even if you have had experience in your country of origin relevant to the job in this country you may have to start at D grade [the basic grade for newly qualified nurses]. There needs to be some recognition given to overseas experience (Employability Forum 2003: 4).

The NHS, the British Medical Association and the Royal College of Nursing have taken a variety of initiatives to publicise the problems faced by refugee nurses and doctors, to lobby for government action, and to assist them gain registration and find employment. The ROSE website (www.nhs.nhs.uk) is a key resource for refugee health professionals. The Royal College of Nursing was involved in establishing the Refugee Nurses Task Force and the British Medical Association convenes the Refugee Doctor Liaison Group.

Flexible working practices

The health sector, like the public sector in general, has adopted a variety of policies to encourage work-life balance. In addition to those already discussed, flexibility initiatives that are being actively considered include:

- measures to recruit and retain older workers and encourage workers to remain in employment beyond conventional retirement age;
- improved utilisation of temporary staff within the sector (see National Audit Office 2006);
- consideration of work guarantees for newly qualified NHS staff (Health Committee 2006: 86).

Offshoring

Because of the nature of health care as an interactive, face-to-face service there is little scope for offshoring direct patient care services. Some patients do seek treatment abroad (for example, dentistry) because of the cost or to circumvent waiting times in the UK. Several NHS trusts (for example, The George Eliot Hospital, Nuneaton) have offshored the typing of medical notes and other secretarial work to India and South Africa, but large-scale offshoring of medical services is not an immediate prospect.

6. Conclusions

The health sector has a long history of employing migrant health professionals. It reflects the historical under-investment in the sector's workforce and the scope to encourage doctors in particular, but also nurses and other migrant workers to come to the UK *to train* and work in the NHS. These migrant workers gained access to training and ultimately gained citizenship, although at a cost in terms of being channeled into the least popular specialties and locations, and experiencing widespread discrimination.

In 2008, the position is rather different. After 1997, the Labour government actively encouraged nurses and medical staff to come to the UK and the emphasis was on attracting *qualified* staff with much less attention placed on training staff from overseas. Within an overarching narrative of a mobile and global workforce, it was expected that these migrants would be more mobile than their predecessors and that decisions about their longevity in the UK would be made on a solely economic basis: their contribution to the UK economy. At the same time the UK has moved towards greater self-sufficiency in its health sector workforce and the shortages that existed in recent years have receded. The Department of Health has a clearly stated objective to ensure that UK qualified health professionals gain employment and that the investment in UK trained staff is utilised effectively. This policy agenda and its implications for non-EEA migrants have created some tensions with the Home Office (Health Committee 2008). In a context in which very limited restrictions on the EEA workforce are possible, it is unsurprising that the government is seeking to reduce migration of health professionals from non-EEA countries. It therefore envisages little role for non-EEA migrant labour in the immediate future. The Migration Advisory Committee, however, may want to take account of the following points in reaching their conclusions.

First, how robust are workforce forecasts for the sector? The quality of data is uneven and there has been little sense of ownership of workforce planning. In particular, there is little information about health professionals leaving the UK; verification data, for example, is very hard to interpret. Better monitoring and recording of the emigration of health professionals would be an important first step towards developing a more well-informed understanding of migration trends in the sector. More generally, information about some key occupational groups, for example, scientific professions is thin. The record of workforce planning in the sector is very poor and the NHS has experienced unexpected fluctuations in supply and demand for health services. In

particular, while it may be more straightforward to forecast the supply side, it is very difficult to anticipate all the influences on the demand for health services. The health sector context is becoming more volatile with a wider range of providers within the sector and more market-orientated funding. There is also uncertainty about the potential workforce consequences of the Darzi review. Moreover, all governments have confronted difficulties in turning their vision for health services into reality because of the lack of ownership among the workforce and other key stakeholders; policy does not always correspond with delivery.

Second, does the aggregate picture of low vacancies and no serious recruitment and retention problems tell the whole story? In a sector as large and complex as health, it is tempting but also misleading to focus exclusively on the aggregate picture. Health care delivery is a highly interdependent and complex supply chain, and the shortage of a particular occupational group or grade of staff can have consequences beyond the immediate workplace. For example, if independent sector nursing homes with their reliance on non-EEA staff are unable to recruit and retain sufficient nurses, this could generate bed blockages in the acute sector with knock on effects for the whole NHS.

Third, to what extent does an emphasis on the quantity of health professionals pay sufficient attention to the quality of those staff? In other words there is an assumption that a unit of 'nursing' from the Czech Republic, Ghana or the Philippines are equivalents, but the aspirations and training of migrants from these countries differ and the preferences of employers differs. More research is needed to understand employer preferences and what lies behind them. This is an important question because employers may not necessarily be willing to substitute EEA labour for non-EEA labour across all occupations as is assumed within government policy.

Fourth, what responsibilities does the UK have towards those health professionals that it has actively recruited in recent years? What signals does current UK policy send and does the approach to International Medical Graduates (IMGs) and other non-EEA health professionals contradict the basic tenets of the new points-based system to encourage skilled migrants to the UK? While government policy has a certain logic, it is difficult to gauge how employers are responding to the more restrictive requirements on recruiting non-EEA health professionals and whether they will be willing to undertake the resident labour market test to recruit and retain these staff. To the nurses, IMGs and other health professionals that are the recipients of this policy, it is often perceived as unfair and politically expedient. The danger is that if shortages

re-emerge in the years to come, to what extent will nurses from the Philippines and doctors from India, for example, be available to come to the UK when other countries will also be welcoming them across their borders?

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Appendix 1: Practitioners (excluding GP retainers and GP registrars) by country of primary medical qualification in England 1997-2007

England	Numbers & Percentages										
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Practitioners (excluding GP retainers and GP registrars)	28,046	28,251	28,467	28,593	28,802	29,202	30,358	31,523	32,738	33,091	33,364
Country of Qualification Group:											
UK	22,556	22,807	22,967	23,072	23,474	23,751	24,707	25,590	26,363	26,082	26,197
EEA	855	894	947	999	1,075	1,206	1,334	1,514	1,647	1,698	1,857
Elsewhere	4,635	4,550	4,533	4,522	4,253	4,245	4,317	4,419	4,728	5,313	5,510
Percentage breakdown											
UK	80.4	80.7	80.7	80.7	81.5	81.3	81.4	81.2	80.5	78.8	78.5
EEA	3.0	3.1	3.3	3.5	3.7	4.1	4.4	4.8	5.0	5.1	5.0
Elsewhere	16.5	16.1	15.9	15.8	14.8	14.5	14.2	14.0	14.4	16.1	16.5

Data as at 1 October 1997 to 1999 and 30 September 2000 to 2007

Figures exclude GP locums

The EEA (excluding the UK) includes Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Irish Republic, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Switzerland

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Source: (NHS Information Centre 2008b).

Appendix 2: Hospital and Community Health Service Medical Staff by grade and country of qualification 1997-2007

England at 30 September each year	numbers										
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All grades Qualified In United Kingdom	43,839	44,890	45,813	46,936	47,918	48,697	50,312	52,620	53,494	55,445	57,116
Consultant	16,635	17,225	17,894	18,594	19,588	20,195	21,362	22,452	23,057	23,194	23,436
Associate Specialist	404	426	453	483	544	590	679	772	873	923	994
Staff Grade	764	917	1,070	1,232	1,344	1,398	1,445	1,532	1,469	1,509	1,435
Registrar group	7,720	7,845	8,154	8,137	8,290	8,464	8,664	9,839	9,992	10,529	16,279
Senior House Officer	8,856	9,182	9,477	9,865	9,967	10,404	10,485	10,732	11,002	9,722	2,354
Foundation Year 2	-	-	-	-	-	-	-	-	-	2,729	3,709
House Officer and Foundation Year 1	3,028	3,173	3,122	3,297	3,176	3,205	3,344	3,612	3,889	4,243	4,528
Hospital Practitioner	686	672	683	693	741	779	820	816	797	712	690
Clinical Assistant	4,143	3,970	3,800	3,545	3,346	2,901	2,602	2,286	1,976	1,603	1,448
Other Grades	1,601	1,480	1,160	1,090	902	761	711	577	439	281	243
All grades Qualified In other EEA Country	4,148	4,109	4,208	4,065	4,215	4,500	4,723	5,033	5,424	5,629	5,627
Consultant	992	1,083	1,165	1,279	1,397	1,531	1,684	1,883	2,076	2,228	2,360
Associate Specialist	60	60	62	63	67	77	104	120	134	152	172
Staff Grade	147	217	246	323	381	390	376	421	507	534	529
Registrar group	849	847	936	944	987	1,061	1,076	1,184	1,244	1,204	1,662
Senior House Officer	1,509	1,353	1,127	895	844	900	1,020	977	1,046	930	295
Foundation Year 2	-	-	-	-	-	-	-	-	-	166	256
House Officer and Foundation Year 1	264	224	368	281	238	249	205	210	201	225	185
Hospital Practitioner	21	23	24	22	22	28	26	29	36	38	32
Clinical Assistant	230	235	197	187	210	207	182	165	138	128	119
Other Grades	76	67	63	71	69	57	50	44	42	24	17
All grades Qualified outside EEA	15,282	15,849	16,363	17,157	18,181	20,180	22,053	25,491	27,742	28,337	27,955
Consultant	3,229	3,396	3,607	3,890	4,145	4,682	4,988	5,582	6,113	6,691	7,115
Associate Specialist	825	899	928	951	941	1,035	1,136	1,300	1,443	1,637	1,741
Staff Grade	1,549	1,968	2,329	2,804	3,078	3,300	3,262	3,330	3,351	3,676	3,676
Registrar group	3,067	3,156	3,299	3,377	3,654	3,925	4,388	5,485	6,421	6,716	10,413
Senior House Officer	4,213	4,239	4,208	4,321	4,578	5,361	6,707	8,385	9,061	7,724	2,809
Foundation Year 2	-	-	-	-	-	-	-	-	-	795	853
House Officer and Foundation Year 1	64	50	53	63	271	499	420	420	545	411	512
Hospital Practitioner	128	127	114	111	102	114	116	130	112	112	112
Clinical Assistant	1,398	1,291	1,188	1,063	941	834	705	617	528	484	447
Other Grades	809	723	637	577	471	410	331	242	166	91	77

¹ In November 2000, the General Medical Council introduced a new format for the GMC registration number that we use to identify individuals. As a result, we are better able to identify the country of qualification for newly qualified doctors, particularly those in the House Officer grade. The country of qualification figures for House Officers in 2001 and 2002 may not be directly comparable with earlier figures.

² The Modernising Medical Careers (MMC) programme has seen the introduction of new training grades, changes in categorisation and re-organisation of training staff. In 2007, these changes are reflected within the component staff of the doctors in training and equivalents group (particularly Registrar Group and Senior House Officers). For more information please see the analysis and commentary section of the bulletin (pages 1 to 4).

Source: (Information Centre 2008c).

Appendix 3: Characteristics of UK Migration Policy for Health Professionals

Permanent migration relevant for health professionals	Permanent Residence – indefinite leave to remain (after 5 years of legal residence with a work permit or a Highly Skilled Migrant Permit)
Specific conditions for health professionals	No
Temporary migration programmes Relevant for health profs #Y= Maximum duration LMT: Labour Market Test Quota	Work Permit: 5Y LMT (no labour market test if occupation included in skill shortage list – MAC to recommend shortage occupations from mid-2008) Highly Skilled Migrant Programme: 5Y (no job offer needed, points test and language requirement) Requirements for IMGs are changing in shift to Tier 1. Training and work experience 3Y non renewable no leave to remain (inc. medical training initiative) Student internship work permit 3 months (students will be Tier 4 from 2009) Note: Tiers 1 and 2 can lead to permanent settlement No
Shortage occupation list, specific mention of health professionals	Yes. Skill shortage occupation list contains some health professions. In July 2006 general nurses (Band 5 & 6) were removed from the list. In March 2008 38 healthcare-related occupations were removed from the list. These include: some consultant medical specialisms, general medical occupations (e.g. dietician, occupational therapy) and additional nursing related specialties (e.g. midwives).
Specific programmes for health professionals in underserved areas or particular regions	Fresh Talent: Working in Scotland Scheme: Allows graduates from Scottish universities (MSc or PhD) to stay in Scotland for up to 2 years without a job offer or any professional experience.
Bilateral agreements relevant for the recruitment of health professionals health	Recruitment agreements with China, Spain and India. Memorandum of Understanding with the Philippines. Agreement with South Africa for reciprocal education exchange of health workers.
Conditions on citizenship	No
Language proficiency test	Yes
Professional Examinations and Training programmes	Qualifications from Switzerland or EEA are recognised in accordance with the relevant EU directive (European Medical Directive). Special rules and restrictions apply to A2 countries. <i>Doctors:</i> with acceptable primary medical education and who pass the PLAB test can gain provisional or full registration depending on their postgraduate experience. <i>All doctors</i> are required to work initially (for a year) in an approved practice setting. The position of IMGs is in flux because the DH's guidance on IMGs is subject to legal challenge (see Health Committee 2008). <i>Nurses:</i> (people trained as doctors are not eligible) need equivalent training, 12 months of practice after qualifying (or 450 hours in the last 3 years) & to go through mandatory Overseas Nurses Programme (20 days protected learning and an appropriate period of supervised practice).
Regulation of agencies that recruit health professionals	Yes, Employment Agencies Act 1973; private recruitment agencies that supply the NHS required to comply with 2004 Code of Practice.
Code of conduct for international recruitment of health professionals	Yes, guidelines issued to NHS employers (1999) not to recruit actively from South Africa and the Caribbean. NHS employers (2001) required not to target developing countries except if a formal agreement existed. In 2004, further measures were taken to strengthen the code (see Bach 2007).

Source: (Adapted and updated from OECD 2007: 226-227).