**Overseas recruitment activities of NHS Trusts 2015 – 2018: Findings from FOI requests to 19 Acute NHS Trusts in England.**

#  Abstract

Migrant nurses form an increasing proportion of the nursing workforce, with the United Kingdom [UK] being the third most popular destination for overseas nurses in the world. The migrant nurse workforce is highly susceptible to policy changes at the macro or professional level of the donor and recipient countries. Freedom of information requests were issued to 19 National Health Service [NHS] Trusts in England to determine their involvement in overseas nurse recruitment activity from 1998 onwards.These indicate a notable shift away from active European Union [EU] recruitment and towards overseas countries particularly the Philippines and India. Reasons given were: Diminishing returns from EU sources, high attrition among EU nurses, and the introduction of English language tests for EU nurses in July 2016. This led to Trusts revisiting their recruitment strategies by increasing more direct/less resource intensive methods, and expanding their focus outside of the EU. Trusts frequently utilised private recruitment companies for their recruitment drives, including consulting and influencing the Trusts’ workforce strategies. Policy adjustments have numerous influences on the composition of the overseas nursing workforce. Whilst the NHS continues its efforts in expanding its international nursing workforce this should not be at the expense of ethical and sustainable recruitment practices, which may be compromised indirectly as a result.

#  Keywords

Overseas nurses, international recruitment, migration, Freedom of Information, NHS, Brexit.

1. **Introduction**

 The global mobility of nurses and other healthcare workers has shown a significant rise in recent decades, alongside a more general rise in labour migration. Between 1990 and 2013, the number of international migrant workers tripled to 150.3 million. This movement was largely from developing to developed nations and mainly to meet the service sector requirements of the advanced economies (International Labour Organisation [ILO], 2015). While the international migration of nurses is not a new phenomenon they, and other healthcare workers, have formed an increasing share of the healthcare workforce in Organisation for Economic Co-operation and Development [OECD] nations. Between 2000/01 and 2010/11 the share of overseas nurses grew from 11% to 14.5% due to chronic nursing shortages and recruitment problems across the developed world, which are recurrent and long-term issues (OECD, 2015). One difference facing the developed world today is that unlike previous shortages that were primarily due to increasing demand or decreasing supply, both demand and supply side factors now contribute equally: A declining supply of nurses cannot meet increased demands driven by rises in hospital admissions and treatment, and population ageing (Oulton, 2006). Overseas recruitment to meet these shortages has long been a key strategy of healthcare systems. While the United States [US] remains the largest overall importer of foreign-born nurses with 44% of the total working in that country, the UK is also a major importer. Despite having a much smaller population than the US (66 million compared to 325.7 million in 2017) it is the third most popular destination country for nurses (after Germany) with 10% of all foreign-born nurses practising in the UK (OECD, 2015).

Given the prominent roles that overseas nurses play in providing healthcare in the UK any changes that impact on their supply is likely to have serious consequences for the NHS. This article will examine changes in the composition of its international nursing workforce in recent years, situating those changes in the context of both the EU referendum result in June 2016, and recent changes to health and immigration policies that shape and regulate those flows. We present primary data from health authorities using Freedom of Information [FOI] requests to explore the focus of their recruitment drives from 2015 onwards, and the decision-making processes made by health providers regarding what countries to target and why.

The issue of how, and from where, the UK will meet its future nursing requirements has achieved added urgency in the context of Brexit. At the centre of the Government’s recent 10-year plan for the NHS, which will provide an extra £2.5 billion of spending in the next five years is a commitment to address the 36,000 unfilled nursing posts nationally and to increase staffing levels (The Kings Fund, 2018). The causes of this shortage are well known – the post recession impact on NHS finances; a surplus of nurses leaving the profession (though 3,880 more nurses and midwives joined than left the nursing register between September 2017 and September 2018); an ageing workforce, and a fall in nursing students following the scrapping of bursaries in 2016.

Adding to this shortfall is the 96% drop in new nurse applicants from the EU. This was widely reported in nursing journals, the BBC and other news media as a direct consequence of the EU referendum accompanied by dire predictions about patient care and safety (O’Dowd, 2017; Siddique, 2017). The referendum result in 2016 has polarised political debate and civil discourse in the UK and discussions around its impact have been marked by four related trends that themselves reflect wider changes in contemporary public discourse. First, increasing disagreement regarding facts and their interpretation; second, blurring of the distinction between opinion and fact; third, the increasing relative volume and influence of opinion and personal experience over fact, and finally declining trust in previously respected sources of factual information (Kavanagh and Rich, 2018). Since December 2017 the number of people considering the NHS to be the biggest issue facing the UK has risen 10 points to 55% replacing Brexit as the number one concern overall. It is perhaps inevitable therefore, that these two issues would become intertwined, with the NHS deployed for political ends by both sides in the EU debate (Ipsos MORI, 2018).

The potential consequences of the referendum result on European nurses’ willingness to remain working in the UK should not be underestimated. Between April 2017 and March 2018 the number of nurses and midwives from the EEA [European Economic Area] leaving the nursing register rose by 29% (881 nurses). Brexit was cited as one of the top three reasons by 47% of those leaving (The Nursing and Midwifery Council [NMC], 2018a). This is especially pertinent given that the supply of nurses has not kept pace with demand, especially since the Francis Report in 2013 and the drive for higher staffing levels that resulted (NHS Improvement, 2016). Nevertheless, the reasons for overseas nurses leaving the register is a separate issue to trends in overseas nurse recruitment, and is beyond the scope of this paper. With reference to the latter, correlation is not causation. There are several reasons for being cautious of one-dimensional explanations for the fall in EU nurse recruitment, and neglect a range of intervening factors. The drivers of international nurse recruitment; the ways in which healthcare providers are reorienting their recruitment strategies, and the potential outcomes for the UK’s nursing workforce provides an important case study for health providers and policy makers internationally. This is particularly so given significant changes in political priorities and attitudes towards globalisation and migration in Europe and the USA in recent years, two of the major importers of international nurses (Moon and Toohey, 2018).

 **2. Nurse migration to the UK**

One reason for being cautious of mono-causal explanations is that it is premature to extrapolate a long term and/or permanent decline from short-term trends given fluctuations in the supply of overseas nurses in the post-war period. The NHS has been reliant on non-UK nurses to meet its workforce needs since its creation, although the location and extent of its non-UK recruitment activities has varied over time.

The creation of the NHS in 1948 increased demand for nursing staff in the UK, to which international recruitment became part of a solution (Snow and Jones, 2011). Pre-existing colonial nursing networks and pipelines had originally existed in commonwealth countries originally for warfare purposes, and were used for the continuation of nurse recruitment for the NHS into the post-war period (Calenda, 2014). By the 1950s and 1960s Irish and Caribbean nurses were a significant contributor to the NHS workforce (Mackintosh, Raghuram and Henry, 2006) and in 1968 30% of all nurse training positions were filled by those from commonwealth countries (Bivins, 2017)

The significant contribution of overseas nurses from Malaysia, Hong Kong, Africa, the Philippines, and particularly from the Caribbean continued into the early 1970s before recruitment was halted in the 1970s and 1980s (Adhikari and Grigulis, 2014). That 30% of student nurse places were occupied by those from commonwealth countries in 1968 (Bivins, 2017) and 12% in 1977 (Snow and Jones, 2011) is also indicative of a change of approach not just towards the nationality of nurses targeted for recruitment and when, but in the UK’s approach to training them. Whereas it was once the case that nurses were trained and then employed by the NHS, now nurses are recruited having already been trained by their own countries generally at their own expense.

 **2.1 Current Trends in international nurse recruitment**

Increased investment in the health system in the late 1990s and early 2000s saw recruitment efforts outside of the UK and Europe grow significantly, with the Philippines and India being of particular interest. Such was the success of these efforts that in 2000/1 more overseas nurses joined the NMC register than UK nurses, 44% of whom were from the Philippines (Carlos, Roxas-Reyes and Suzuki, 2017). Yet this level of overseas activity could not be maintained in the face of stricter migration regulations, and by 2004 active recruitment from these countries ended with non-EU international recruitment tailing off in the late 2000s. Instead, the focus of attention turned towards the EU, and by 2008/9 more nurses were joining from the EU than outside it. Between 2009 and 2015 the percentage of foreign born nurses fluctuated between 11.5% and 13% but while non-EU nurses comprised 11.6% of the UK’s nursing workforce in 2009 compared to 1.3% from EU countries, by 2015 the former comprised a declining share at 8.2% while the latter had grown to 4.5% of nurses (Maranzagov, Williams and Buchan, 2016). European countries, particularly Portugal, Ireland, Italy, Greece and Spain (the PIIGS) who were experiencing national economic crises were specifically targeted for nursing recruitment with Italy, Spain and Portugal being the most targeted countries in 2014 (NHS Employers, 2015).

Further reason for scepticism in the face of single cause explanations is that they gloss over the national and occupational complexity of EU recruitment trends, which present a more mixed picture. Although EU nurses and other healthcare workers have formed a growing and increasingly vital part of the NHS workforce in recent years, the NHS as a whole is 29% less reliant on EU staff and 70% more reliant on non-EU overseas staff than the wider UK labour market. Filipino nurses outnumber those from 24 EU nationalities combined, and while there are more Polish and Italian nationals working in the NHS since the referendum there are fewer Spanish nationals. There have been increases in doctors and scientific and professional staff from the EU but fewer nurses (Tinsley, 2018).[[1]](#footnote-2)

Moreover, what has received little attention has been the introduction of English language tests to EU nurses, which came into effect within a few weeks of the referendum on the 18th July 2016 (NMC 2015). This change, which effectively ended a two tier and (for non-EU overseas nurses who had been required to take the test) discriminatory system, was announced in 2015 prior to their introduction. This was followed by a rapid fall in requests for application packs from prospective EU nurses from nearly 3700 in January 2015 to 453 in December that year (Buchan, 2017). A decline in EU applications due to these new English language requirements had been forewarned by the Migration Advisory Committee [MAC], and was expected to reduce the EU nurse supply further than was occurring already (MAC, 2016). In evidence to the Health Committee, Jackie Smith Ex-Chief Executive and Registrar of the NMC noted the spike in EEA applicants prior to the introduction of the tests and sharp drop afterwards, adding that it was not possible to disentangle the influence of Brexit from that of the new tests (Parkin and Bate, 2018).

Supply side explanations are rooted in rationalist, economistic approaches that view trends in labour migration as the aggregated outcome of potential workers evaluation of the barriers to entry, as well as the opportunities, costs and benefits of migrating to particular destinations. From this perspective, the possibility of more stringent entry requirements combined with uncertainty and anxiety post-referendum made the UK a relatively less attractive destination for potential EU nurses. However, labour mobility is driven and patterned from the demand side, and influenced by a broader range of social, political, and institutional determinants than purely supply side factors (Bodvarssen and Van Den Berg, 2013). Despite the globalised and interconnected nature of contemporary societies, migration is mediated in a myriad of ways in both source and receiving countries not least by the immigration and employment policies through which receiving countries regulate, direct, and channel migration. The findings below suggest that in the NHS Trusts discussed, demand-side factors have played a key role in determining the make-up of their international nursing workforce in recent years. While the wider political and policy environment framed their decision making, individual Trusts target source locations depending on the success or otherwise of previous recruitment drives, evidence from other health Trusts, and on information and advice from recruitment agencies concerning where and how to focus their recruitment drives. It is likely therefore that these factors have also played an important role in explaining the fall in new nurses being recruited from the EU.

# 3. Methodology

Since 2005, The Freedom of Information Act (2000) has allowed individuals the right to access information held by UK public authorities upon request, yet the Freedom of Information [FOI] request is still considered the preserve of the investigative journalist as opposed to the academic (Bows, 2017). Although research using FOIs as a method of data collection is growing very few research articles have been published in the UK which have utilised the FOI request as a method and it remains a powerful, yet underexploited tool within academia and healthcare related research (Fowler, et al., 2013). With overseas recruitment drives being decided and managed at Trust level any data regarding nurses joining the NHS through this route cannot be obtained through NHS digital or any other national level dataset. Therefore, to explore trends relating to overseas recruitment at the level of detail that NMC data could not provide we submitted FOI requests to nineteen Trusts, seventeen of whom employed the highest percentages of EU nurses in 2017 (Baker, 2018). Although research indicates wide differences between Trusts regarding their level of overseas nurse recruitment there are no significant Trust level factors making them more likely to internationally recruit from the EU than from outside of the EU (and vice versa) (Maranzagov, Williams and Buchan, 2016). Therefore Trusts who were actively involved in EU recruitment would also be likely to engage in overseas recruitment too. As these FOI requests were originally prompted by a larger research project exploring Filipino nurse migration to the UK, recruitment efforts in the Philippines was of particular interest.

The remaining two Trusts were known to us as currently engaging in overseas recruitment drives to the Philippines, and were also included. FOI requests typically and purposely discloses the institutions from which data was received. However, due to two of these Trusts being familiar to the authors a decision was made to not name the final list of Trusts to prevent disclosure of these two Trusts, and the overseas nurses who work there. The FOI request process was performed in two parts. The first requested data held on their nurse recruitment drive activity outside of the UK in a country, date, number recruited format from 1998 to the present day. If any notable changes were observed to have occurred in the recruitment activity in the data provided these Trusts were subjected to a second FOI. The latter request sought to obtain qualitative data indicating reasons for this. Ten Trusts provided further qualitative data on their recruitment drive activities.

# 4. Findings

## **4.1 Request for Trust-level overseas nurses recruitment activity 1998-Present**

A response rate of 100% was achieved for the first FOI request although not all provided data within the 20 working day deadline stipulated by the FOI Act (2000). Approximately one-third of Trusts (six of the 19) did not fulfil the request within the 20 day time frame, and one of these failed to provide this information prior to October 2018 – almost four months after the date on which the initial request was made. Although reasons were often not provided for the delay, one Trust attributed this to short staffing. To ensure the data was asaccurate as possible, a great deal of time was spent clarifying any responses that were not explicitly clear.

Despite records being requested as far back as 1998 the earliest record obtained dated back to 2008, with only three of the 19 Trusts being able to provide any data earlier than 2013. 2008 was an important turning point in nurse recruitment, which saw reduced overseas nurse recruitment in favour of those from the EU. The years 2008/9 marked a change whereby the majority of non-UK nurses joining the nursing register became predominately from within the EU rather than outside it (Maranzagov, Williams and Buchan, 2016). However, with 84% of the Trusts not holding a record of their recruitment drives between 2008 and 2013 when EU nurse recruitment was at its highest, and sparse records being held between 2013 and 2015, the findings are limited in their ability to identify any trends farther back than the last three years.

Poor recording of overseas recruitment drives by the Trusts was apparent. In addition to the lack of historical data pre-2015, few were able to provide all three points of data in the required format of: Overseas drive, month on which it occurred, and how many nurses were recruited as a result. Only six of the 19 Trusts were able to provide data in this format. Some were able to provide numbers and ethnicity of nurses who had been recruited via active recruitment drives abroad – although the dates provided were those when these nurses started work and were not associated with any particular drive. Additionally, some provided offers made to nurses recruited via these drives rather than those who had accepted and taken up posts. Offers made are likely to be higher than offers filled.

Some Trusts provided the country where overseas drives had taken place by year only. The frequency of recruitment drives in these countries, and how many nurses were recruited was not provided. Some Trusts just provided nurse ethnicity numbers on the months on which they joined. Although many of these nurses would have had to come via an active recruitment drive in the donor country rather than independently applying for these jobs via NHS jobs (due to the requirement of sponsorship etc.), recruitment from countries which are typically targeted for nurse recruitment does not necessarily mean that they were recruited via this method. Even within Trusts there was inconsistency in their reporting methods: Some used a mixture of the reporting methods above – such as providing location country of overseas drives (but no numbers) for earlier years, and more specific data for new starters in more recent years.

Owing to the heterogeneity of the data provided by the Trusts, direct comparison within and between Trusts was difficult. Comparison of some form was enabled by using the number of Trusts either performing overseas recruitment drives or recruiting ≥5 nurses of a single nationality between 2015 and 2018. As some Trusts held this in a month/calendar year format, and some by financial year, data is split to reflect this.

Figure one indicates that since 2016 many Trusts reduced their active recruitment drives within the EU, and yet again attention has turned to outside the EU. Whereas in 2015 the most common location for Trusts to recruit from was the EU, now the majority are conducting recruitment drives further afield. These findings are in line with national trends in recruitment. Recent NMC data indicates an 86% increase in non-EU international nurses joining the nursing register between April and June 2018 making a total of 69,425 non EU overseas nurses and midwives (NMC, 2018b).

### **Figure One**

**Figure Two**

## Figure two shows that just as 20 years ago, India and the Philippines have been the two most popular countries of choice for recruitment by these Trusts in the last few years, with India an increasingly large supplier. However, some Trusts are also diversifying their recruitment activities outside of the Philippines and Indian pipelines – the former having provided all of the non-EU international nurses to these Trusts in 2015 and 2016. The recruitment of nurses in Dubai and the United Arab Emirates [UAE] may indicate that the Middle East is a common destination in ‘stepwise’ migration, where nurses intend to accumulate experience and resources in one destination before moving onto their intended final destination (Carlos, 2013). Whilst Africa was included as a source of nurses in one Trust in 2017-2018, whether this was indicative of active recruitment drives in the continent remains unconfirmed. In the absence of recruitment drive data this Trust was instead able to provide nationality of new starters. Although this met the inclusion criteria above i.e. ≥5 nurses recruited in any one month, the raw data reflected small but regular numbers joining each month from five African countries over a five month period. Owing to their low numbers and absence of confirmation on recruitment drives at this Trust it not clear if these were as a result of active recruitment drives or due to other reason/s.

## 4.2 Request for reasons for declining EU recruitment activity

A second FOI request was issued to the Trusts who had appeared to shift their recruitment efforts away from the EU to non EU locations. The request itself asked: Why this was done, who made this decision and when, and why were the particular overseas countries chosen as replacements. Nine of the original 19 Trusts were issued this second request. One Trust had provided information as to why this change had occurred as part of the first request. Therefore over half were able to provide information as to why these trends may have been occurring. Unlike the first FOI which was descriptive and sought to capture general trends in recruitment activity these responses provided data which was more qualitative in nature, allowing the reasons for these trends to be explored at a level which could not be gained from descriptive data alone.

### **i: Less active recruitment due to diminishing returns**

In evidence to MPs on the Brexit Committee David Mortimer chief executive of NHS Employers stated that among other reasons, EU nurse applications had fallen because uncertainty was deterring both potential workers from coming to the UK and employers from recruiting in Europe (O’Dowd, 2017). Of the nine Trusts who answered the second FOI request, none mentioned either uncertainty or Brexit as a factor with only one stating that an active decision was taken to halt EU recruitment. Amongst the Trusts who maintained that EU drives have not been ceased deliberately or in their entirety, most did note a decline in activity and a reduction in suitable applicants from their EU recruitment pathways citing reasons such as:

*“We still recruit from the EU but not in the volume as in previous years.”*

*“Over the last few years the number of successful appointments from the EU has decreased.”*

*“{The} Numbers/ field of applicants was reducing/ less interest from EU.”*

Two Trusts noted that previous experience with EU drives had proven poorer than anticipated in terms of uptake, with one citing problems with attrition amongst EU nurses. This had been identified by the MAC in 2016 who noted that more EU than non-EU international nurses returned home within a few years, and that that overseas recruitment drives within the EU were ‘drying up’ due to recruitment drives having exhausted the pool of suitable EU applicants (MAC, 2016).

*“Previous experience of recruitment from EU produced fairly limited results.”*

*“The decision was made to re-focus resources to areas that are more successful and have a lower attrition rate.”*

Continuation of recruitment efforts in the EU due to diminishing returns, and fewer eligible candidates led to these drives being re-evaluated in terms of their return-on-investment capacity.

 *“The investment required for any overseas recruitment is substantial and the efficacy of that investment must be demonstrated”*

Consequently, active recruitment has been replaced with other forms of recruitment among those Trusts who responded.

### **ii: Shift to direct recruitment**

Conscious of costs, and faced with diminished returns on existing pipelines some Trusts have adjusted their methods of EU recruitment by recruiting directly via advertisements and online interviews:

*“We saw a reduction in the volume of suitably qualified and experienced nurses that we could interview, and the introduction in the use of SKYPE interviews or face to face interviews in the UK was more cost effective”*

*“The agency we were using did not have any candidates to send us. We therefore started advertising directly as opposed to via an agency.”*

How effective these cheaper, less resource-intensive recruitment methods proved to be could not be determined from the data gathered.

### **iii: Introduction of language tests**

Other Trusts specifically attributed the reduction in nurses eligible for recruitment to the introduction of language tests for EU nurses.

*“The candidates are no longer applying to work in the UK in any meaningful volume; due in the main to the NMC requirement for IELTS”*

*“The NMC English language requirements influenced the numbers of nurses who can meet the Registration requirements for EU nurses”*

*“We saw a reduction in the volume of suitably qualified and experienced nurses that we could interview….There was a significant reduction in the number of EU nurses passing the IELTS. We continue to recruit nurses from the EU, but only if they can demonstrate that have passed IELTS.”*

In response to a shrinking pool of suitable EU nurses and the impact of language testing, Trusts have started to look beyond the EU to meet their nursing requirements.

### **iv: Refocus on non-EU international nurses**

Concurrently, a shift towards India and the Philippines was occurring as these countries were not considered to possess the same language, attrition and supply barriers. For one Trust this was considered a complimentary strategy to maximise their supply of nurses rather than a replacement measure.

*“The Philippines and Indian campaigns are not an alternative option but are being used in conjunction with our local and EU campaigns.”*

Trusts noted their own positive experiences of recruiting from these countries, and due to positive feedback from other Trusts, recruitment agents and consultants.

*“…evidence from other Trusts who had previously travelled to the Philippines influenced some of our decision making concerning the volume of nurses available from outside of the EEA.”*

*“There were a high number of applicants interested in coming to the UK. A lot of other Trusts were recruiting from the Philippines and we had feedback it had been successful.”*

The final theme to emerge was the prominent role of intermediary agencies in the recruitment process, and in shaping workforce strategy at the Trust level.

**iv: The role and influence of private recruitment agencies**

One striking feature which emerged when enquiring how decisions were made was the extent to which Trusts outsourced not only their overseas recruitment drives, but their strategic decision making concerning which countries should be targeted and why to private recruitment consultancies or agencies.

*“India and the Philippines are the countries that were put forward by the recruitment agency based on our request to explore further recruitment options.”*

*“The Philippines was recommended by the recruiting company used as a good source of qualified nursing staff at the scale required by the Trust, based on recruitment campaigns held on behalf of other NHS Trusts.”*

The considerable role that recruiters play in shaping strategic issues in relation to workforce policy is perhaps unsurprising given the increasing role of market forces in the NHS, the lack of a national workforce strategy and the responsibility for different elements of workforce strategy being diffused among different NHS bodies. Some Trusts indicated that an evidence based approach underpinned recruitment decisions, although this was generated in partnership with, or conducted independently by, their private recruitment partners:

 *“We market tested with agencies who provide overseas recruitment support and took advice from those experts on the most effective countries for recruiting.”*

*“Any decisions regarding the methodology used for the recruitment are based on supply and demand and the methodologies used by agency supporting us with recruitment. We use an expert recruitment agency to advise on the best recruitment approaches, methods and sources”*

No scrutiny or oversight of this outsourced decision making process was evident at this latter Trust:

*“And {we} do not analyse their ways of achieving our goals.”*

The use of private recruitment companies has been regarded as a necessary evil in the hiring of foreign labour to do undesirable jobs, since doing so poses numerous challenges to those who seek and engage in their services (Martin, 2017). Relying on recruitment companies to both consult on and provide recruitment, raises a number of issues especially around conflicts of interest. These recruitment companies will be profit driven entities with a narrow focus and short term goals, which may not align with the long term, ethical and sustainable recruitment objectives that would be of most benefit to the NHS, and of least detriment to the donor countries. These issues also extend to the research and consultancy work that they provide. This is of particular concern in circumstances as above, where a Trust has no oversight into the methods being used by the recruitment consultancy to undertake this work for them. This makes the need for a coherent national workforce strategy for the NHS increasingly urgent, and it remains to be seen what the first attempt holds when the first 10 year workforce plan is published (originally scheduled for July 2018).

#  5. Discussion

Acknowledging that the referendum result is impacting on EU nurses both joining and leaving the UK register needs to be tempered with recognition of the complex, multilayered processes and structures that shape flows of international nurses. Demand side factors such as the policy environment surrounding migration and employment; health-sector reforms such as the introduction of language tests, and the decisions of individual health Trusts themselves often acting on the advice of recruitment agents, may be more decisive in explaining the changing composition of EU and non-EU international nurses coming to work in the Trusts discussed here in recent years. The key question remains whether the UK can meet demands for nursing in the coming years. As this will not be met domestically in the foreseeable future much depends on future health and immigration policies remaining amenable to international healthcare workers. The NHS Long Term Plan notes the contribution of EU nurses and claims it will introduce a favourable immigration system for EU and non EU health and social care workers especially in shortage areas, while also implementing closer coordination between the NHS and government concerning staffing flows post Brexit. It also promises a ‘step change’ in international recruitment and expects to recruit several thousand international nurses a year over the next five years, setting out national arrangements for international recruitment.

The NHS Long Term Plan states that it will only “recruit from countries from whom it is ethical to recruit” (NHS, 2019 p.84). This reflects the UK’s code of practice, which is rooted in the belief that recruitment should not disadvantage source countries and should only occur where there are bilateral agreements in place. One recent policy shift that conflicts with these aims is the dropping of restrictions on UK registration for overseas nurses who have qualified for less than a year. While this may assist the UK in meeting its nursing targets it will likely have a detrimental impact in the Philippines. Despite producing a surplus of nurses oriented largely to the global market in healthcare workers, many hospitals especially in the provinces remain severely underfunded and understaffed due to internal and external migration, with 70% of nursing graduates moving abroad (Williams, 2017). Delucas (2014, p.77) highlights the devastating impact of the aggressive and relentless recruitment activities of economically developed nations on health care systems in the developing world, noting that “it is evident that most countries simultaneously import and export nurses, while poorer countries only export”. Particularly critical is a lack of skilled nurses with many hospitals relying on newly qualified nurses working (or volunteering or in some cases, paying to work) to gain the requisite experience before moving abroad. Potentially stripping the Philippines of this source of nurses contradicts the NHS commitment to ethical recruitment and, as Yeates (2010) notes inflicts further harm to their healthcare system by exporting the developed world’s healthcare crisis to the developing world.

Since 2017 further changes have been made to attract international nurses and healthcare workers to the UK and away from competitors. English language requirements have been made easier following widespread criticism of their unnecessarily high academic standards, with a lowering of the minimum International English Language Training System [IELTS] writing test from 7 to 6.5 and the introduction of the Occupational English Test [OET] as an alternative to the IELTS. With this test considered less arduous, albeit more expensive, there is potential for both EU and non-EU nurse recruitment to increase as a result of this policy change, depending on the post-Brexit immigration system and the policies which follow. The recent White Paper “The UK’s future skills-based immigration syst*e*m”sets out a number of proposals to liberalise and streamline the immigration system for highly skilled and skilled migrants. These include scrapping the cap on numbers in the existing Tier 2 Route, removing the resident labour market test, reducing bureaucratic hurdles, and lowering the skills threshold in Tier 2 to include intermediate skill levels (National Qualifications Framework [NQF] 3-5) (Her Majesties Government [HMG], 2018). One concern was the decision to keep the minimum salary threshold at £30,000. As the average starting salary for nurses is around £23,000 this would hinder overseas recruitment and nullify the decision to allow newly qualified international nurses to apply to the NHS. The Royal College of Nursing [RCN] has argued that nurses should be exempt, and has urged a focus away from salary levels and towards recognition of social value when issuing visas (Beaumont and Williams, 2017).

On March 7th 2019, the government announced that nursing would remain on the shortage occupation list and would be exempt from the minimum income and maximum number restrictions, which other non-EU/EEA professions are subject to (HMG, 2019). Previously, the inclusion of nursing on the list in 2016 was done somewhat begrudgingly by the MAC, who cautioned against their inclusion. This was due to fears that overseas nurses were being exploited by the government as a ‘get out of jail free’ card in addressing a severe nursing shortage of its own creation, rather than considering alternative logical solutions such as pay increases and improved working conditions (MAC, 2016). The increasing reliance on non-EU international nurses, certainly in the short to medium term, appears to support these concerns.

Indeed, the role of overseas nurses in meeting demands for health care has significant international relevance given the 12.9 million shortfall in healthcare workers predicted by 2035, much of it in the developed world (Campbell, et al., 2013). Developed nations have embarked on a determined drive to attract nurses from developing nations through a process of “care resource extraction” (Parrenas, 2005). These include strategies to liberalise regulatory and certification processes, fast-tracking visa and job applications (Yeates, 2010) and via the growth of “migration institutions” such as nursing schools and recruitment agencies who control access to migration for nurses (Masselink and Lee, 2010). Qualitative findings from focus groups with UK based Filipino nurses as part of this study, indicate that the comparative ease of migrating to the UK to work is an important factor shaping migratory decisions. Stemming the further depletion of the developing world’s nurses and meeting ethical recruitment and sustainable workforce objectives requires an internationally coordinated approach to workforce planning. A variety of policy measures which improve working conditions, increase salaries and retain nurses in both source and recipient countries would do much to reduce demand for overseas nurses and meet the WHO’s Global Code of Practice on the International Recruitment of Health Personnel, which emphasises self-sufficiency (Little and Buchan, 2007).

Poor working conditions, low pay and a lack of career development are major stimuli for nurse migration from developing nations. In the Philippines, the Human Resources for Health Network (HRHN) have developed measures to mitigate the outflow of nurses covering policy and regulation of nurse education and training, supporting ethical recruitment and transnational agreements with destination countries, and strengthening professional norms and accountability (Dimaya, et al., 2012). However such policy instruments do not address under-investment in health in developing nations, which needs to be set alongside neo-liberal restructuring of the state and the structural adjustment programmes imposed on those nations that have often reduced their health budgets (Prescott and Nichter, 2014). Delucas (2014) argues that countries who consume the most resources should make larger investments in nurse training in their own countries and in those countries from where they recruit. To advance a more socially equitable and sustainable approach to international nurse recruitment, Delucas (2014) proposes an international summit with binding outcomes to reduce nursing demand from the developing world and replenish the human resources it is appropriating.

# 6. Conclusion

Claims about the impact of Brexit on the UK’s future nursing workforce are often based more on their proponent’s stance in relation to the referendum result than by an objective assessment of evidence. Discussions have become highly politicised and polarised, at times obscuring the range of demand side factors that play an important role in determining the flow of EU and non-EU nurses to the UK. The NHS Long Term Plan (NHS, 2019) acknowledges the disjointed nature of workforce planning and plans to align Health Education England [HEE] the organisation responsible for leading and coordinating healthcare education and training with NHS Improvement, which will lead on workforce issues. Whether this results in a more coherent and less fragmented approach remains to be seen, though the results of similar organisational restructuring in the past has not been encouraging.

The findings suggest that EU recruitment activities have not halted but have waned in previous years, and shifted from active to passive recruitment. This trend began prior to the referendum and was largely the consequence of a declining pool of suitable EU applicants, and the availability of alternative sources outside of the EU. The evidence presented here confirms the direction of future nurse recruitment outlined in the NHS’s Long Term Plan e.g. non-EU and predominantly from the Philippines and India. It is hoped that this pool of alternative labour will not prevent the government from improving the working conditions and pay of local nurses, or from addressing the high numbers leaving the profession. Likewise it is hoped that ethical guidelines governing nurse recruitment from developing nations are adhered to and recruitment strategies are transparent and accountable to prevent further depletion of nurses from poorer parts of the world, and the ensuing public health outcomes of this trend in source countries.

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