



Main results from country studies: United Kingdom

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Background

- Health care in the UK is a mixture of public and private with over 85% of health care undertaken by the National Health Service (NHS), vast majority of funding comes from taxation
- The NHS is the world's largest publicly funded health service and the biggest employer in the UK, with more than 1.5 mio employees (just under half are clinically qualified)
- NHS 2007–8 budget equates to £1500 per capita
- The NHS deals with one million patients every 36 hours
- It is estimated that 87.4% of all expenditure on health in the UK was from the government. Health expenditure as a percentage of GDP was 7.7% in 2009



Recent policy periods in HP migration

- **1998- 2006:** Openness to mobility (NHS investments and related workforce expansions)
- **2006-Nov 2008:** Introduction of restrictions (due to effects of UK training expansion, immigration rules for non EEA HPs were tightened)
- **Since then:** Restrictions (related to non EU) strictly tightened, introduction of a point based system and streamlining of the employment categories which are eligible for immigration

International recruitment is now only seen as an option when all domestic recruitment opportunities have been exhausted



HP workforce policy players

- All health professionals in the UK are controlled by a regulatory council, which, *inter alia*, sets standards, oversees education, registers practitioners and deals with issues of malpractice
- 9 such bodies which all have procedures for registration, or temporary registration of non-UK trained practitioners
- Besides the councils, other policy “players” and main stakeholders are UK Government, NHS itself, professional representative bodies, trade unions and support associations for different migrant health professionals



Other influences

- Migration of HPs is an expressed concern in the UK
- The UK policy framework for migration of HPs is heavily influenced by international developments, including the Global Forum on Human Resources for Health
- Concern about migration also reflects the commitment expressed in the Millennium Development Goals
- **Crisp Report:** argued that the UK could do more by, *inter alia*, supporting the valuable work done by UK organisations and individuals in supporting health services and promoting health in developing countries (Government welcomed the Crisp report and reiterated that the UK would stronger support developing countries)



Migratory profile

- In the last decades, UK's health system has relied on foreign trained HPs to address its workforce supply needs
- In the past emigration has mainly been from none EU (Asia, Africa, Oceania), but European source countries have started to become more important (at least in relative terms)
- All world regions are represented in the UK HPs migration profile



Immigration

- There have been many studies citing data up to 2005 showing the migration of alarming numbers of health professionals from sub-Saharan Africa and other vulnerable countries into the UK, (despite the Code of Practice of the Department of Health).
- In 2005, the UK was a major destination for nurses from Zimbabwe, Malawi, Swaziland, Lesotho, and Ghana
- In the four years following the introduction of the NHS ban on recruitment, 6.104 South African nurses have registered to practise with the UK's Nursing and Midwifery Council
- Since 2005, more “home-grown” health professionals, more recruitment from the EC, changes in immigration policy and a reduction in the increase in staffing in the NHS

➡ Reduction in the immigration of non-EU foreign trained HPs



Immigration

- From 1988 to 2008, numbers of foreign trained physicians rose by more than 34,000 (34.5 % registered in 1988 to 36.8 percent in 2008)
- Nurses: 1988 only 2,808 (9.2 percent) of new registrants had qualified abroad in, compared with 4,099 (15.8 percent) in 2008
- EU15 still accounts for most EEA health professionals registered overall, but the new MSs EU12 are rapidly catching up.
- In 2008 alone the EU15 and EU12 accounted respectively for 1166 and 970 newly registered doctors.
- Also in 2008, 932 new registrant nurses/midwives were from the EU12 against just 437 from EU15 countries



Trends new EU MS

(10 Central/Eastern countries in 2004 and Bulg and Rom in 2007)

- Numbers of EU HPs registered in UK have increased following accession periods
- Trend will probably continue, i.a. due to the changes in immigration law
- The largest increase in numbers of doctors and nurses/midwives from new EU MS was observable for Polish HPs, but several other countries are also affected
- Effects on health systems in source countries?



Outflow data

- Lack of reliable data on outflows, thus the potential implications of return migration to source countries can not be assessed and be taken into account for health workforce planning
- Data on verification of qualification suggests that Ireland was the main EU destination country and important destination countries outside Europe are Australia, NZ, USA, Canada and the Middle East
- Lack of information about mobility of HP within the UK and between sectors



Workforce planning

- One of the biggest issues that emerged from the qualitative interviews was the *inadequacy of workforce planning* and the concomitant control exercised by the Royal Colleges
- The boom and bust in immigration was regarded as a function of the inability to identify workforce needs and plan appropriate training. This is aggravated by the control of the several Royal Colleges restricting numbers of trainees, ostensibly to maintain high salaries
- Respondents emphasized the restrictive practice and inhibitory role of the Royal Colleges
- Huge investments in workforce planning in the NHS, but it did e.g. not take drop out rates from training courses, birth rates, life expectancy and several other factors into account
- Informants reported that workforce planning did not work enough in synergy with education commissioning
- Perceived inflexibility due to workforce planning inadequacies, hospitals were devising new posts (e.g. “junior specialist doctor”, which is open for specialists worldwide)



Centre for workforce intelligence

- The *Centre for Workforce Intelligence* has recently been established, which will develop planning capacities at all levels and identify development priorities for the different profession (combined workforce review teams)
- HP mobility will be more closely linked to NHS workforce analysis
- BUT flows from EU countries can not be controlled by UK policy makers; only non EU immigration can be modified by immigration regulations)



IN THE NEXT 20 YEARS
THE NUMBER OF PEOPLE
IN ENGLAND WHO ARE 65
AND OVER IS PREDICTED
TO RISE BY 51 PERCENT*
AND THE DEMANDS ON
OUR HEALTH AND SOCIAL
CARE SYSTEM WILL BE
VERY DIFFERENT



WE NEED TO PLAN
FOR A WORKFORCE
THAT CAN MEET
THESE NEEDS

Ethical recruitment / Code of Practice

- The UK had codes of practice for several years, however the evidence about effectiveness is inconclusive. It suggests, though, that other countries might adopt them.
- The code is a step in the right direction, but more important training sufficient health workers in developed countries to avoid recruitment from developing countries
- Our interviewees were sceptical of the real impact of codes of practice, reflecting some of the literature that suggested they were systematically circumvented: " In practice, there are various arrangements to bring non-EU nationals to the United Kingdom for a period of training...."
- Several bilateral agreements have been signed (i.a. with the Philippines): In terms of impact, however, both on mobility and international development, the evidence is difficult to monitor



Main pull factors to UK

- Unemployment among HPs in source countries
- Political stability in UK
- Post graduate training capacities
- Family and social networks
- Language skills
- Economic and professional career opportunities
- In recent years: main facilitating factor has been the international recruitment policy



Need for deeper analysis

- Current trends in rising registrations from new EU MS need deeper analysis and in particular there is a need for (moral) debates around the EU dimension of the employment of foreign trained HPs, their impact on the NHS and in particular their negative impact on health systems in the source countries

