

INTERNATIONALLY RECRUITED NURSES IN LONDON

Profile and implications for policy

James Buchan, Renu Jobanputra, Pippa Gough and Ruth Hutt

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The issues surrounding international recruitment and the migration of health workers have generated huge media attention. However, relatively little primary research has been done in this area. Based on a survey of international nurses in London, this paper reports on the country of origin, demographic profile, motivations, experiences and career plans of the 380 respondents. The paper also outlines the overall trends in the numbers of nurses coming to the United Kingdom, examines the policy context in which international recruitment activity has been conducted, and looks at the impact of the United Kingdom's Code of Practice on international recruitment.

Published by:

King's Fund
11–13 Cavendish Square
London W1G 0AN
www.kingsfund.org.uk

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Charity registration number: 207401

First published 2005

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ISBN 1 85717 533 6

A catalogue record for this publication is available from the British Library.

Available from:

King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Michael Monaghan
Typeset by Peter Powell Origination & Print Limited
Printed in Great Britain by the King's Fund

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About the authors

James Buchan is a Visiting Fellow in Health Policy at the King's Fund. James is also a Professor in the Faculty of Health and Social Sciences at Queen Margaret University College, Edinburgh. He has worked as a senior human resources manager in the NHS Executive in Scotland and as a human resources adviser at the World Health Organisation. His research interests include health care labour markets, policy issues related to internationally recruited health care workers, and trends in the NHS workforce.

Renu Jobanputra worked on this project as a Researcher at the King's Fund. Her background is in health economics, and prior to joining the King's Fund she held research posts at the Office of Health Economics and the National Institute for Clinical Excellence. Renu's current policy interests include workforce, finance and funding of health care, and performance assessment. She is now working as a Senior Researcher in Health Policy at the Healthcare Commission.

Pippa Gough leads the King's Fund's work on health workforce research and policy development. As a Fellow, she contributes to King's Fund leadership programmes and provides management consultancy to health and social care organisations and systems, with a special interest in workforce. Pippa has a particular interest in the workforce implications of new ways of delivering care, particularly those that are not hospital based. Prior to joining the King's Fund, she held a number of national nursing posts.

Ruth Hutt is a Visiting Research Fellow at the King's Fund. Her background is in public health, and she has a clinical background in nursing. Ruth's current policy interests include long-term conditions, demand management, population health and workforce issues.

Acknowledgements

This research would not have been possible without the active contribution of many London-based international nurses, and the support of the Royal College of Nursing.

Introduction

The NHS and other health sector employers in England have been active in the international recruitment of health professionals in recent years. As a result of planned and funded expansion of the NHS there was an urgent need to scale up the numbers of nurses and doctors working in the service. The NHS has been successful in increasing the numbers being trained, and in attracting back returners who were not practising, but there has also been an explicit policy emphasis on international recruitment as a method of 'growing' the NHS workforce (Department of Health 2004). This increase in active international recruitment has reflected a situation in which the NHS and other health care employers in the UK have had to recruit internationally because of skills shortages in the UK.

The issue of international recruitment and migration of health workers has generated huge media attention in the UK and elsewhere, primarily because of concern about the impact on source countries in the developing world. Much of this reporting has, however, been merely anecdotal. There has been relatively little primary research on this issue, and most of what has been published either focuses on assessing the impact of international recruitment in terms of trends in cross-border flows of health workers, or reports on small-scale focus-group interviews (see, for example, Daniel *et al* 2001; Allen and Larsen 2003)

There is much written about the 'push' and 'pull' factors stimulating health professionals to move and migrate, but little of this is evidence-based, and not much is known about the profile, motivations, and plans of the health professionals who have actually made the international move.

The main objectives of this paper are to report on the country and demographic profile, motivations, experiences and career plans of recently recruited international nurses working in London, and to give a detailed insight into why they have come to the UK, and what are their future intentions. In order to put these findings in context, the paper also outlines the overall trends in numbers of nurses coming to the UK, and examines the policy context in which international recruitment activity has been conducted.

Previous analysis of unpublished postcode data suggests that a much higher proportion of international nurses work in London than elsewhere in the UK (Buchan 2003). This is in part likely to be a reflection of the general trend for migrants to gravitate towards London as the major port of entry to the UK, but also indicates a situation where NHS employers in London report much higher levels of job vacancies than elsewhere in the country. Long-term nurse vacancy rates in the NHS in London are 3.8 per cent, which is twice the average for England (Department of Health 2005), and London-based employers have tended to be particularly active in using international recruitment to fill vacancies.

England has also been prominent in international recruitment since it is the only country that has issued a detailed Code of Practice on international recruitment, which is designed to limit the adverse impact of NHS recruitment on the developing world (Department of Health 2004). This paper also examines the impact of the Code.

Methods

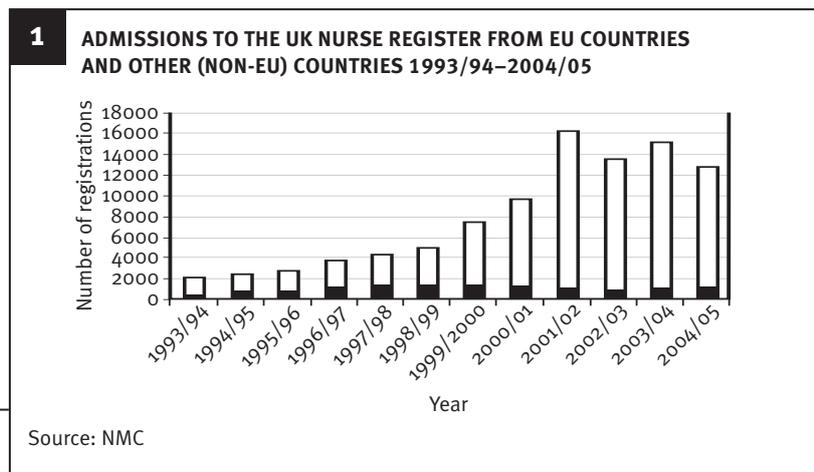
To provide background data on trends in inflow of nurses to the UK, annual registration data from the Nursing and Midwifery Council (NMC) was analysed. All nurses working in the UK must be registered with the NMC; newly registered 'home' and international nurses are identified separately on the register, so that it is possible to assess the relative size of each source.

The questionnaire was checked for cultural and linguistic relevance and sent as a pilot to 100 nurses in August/September 2004. Some minor modifications were made to the questionnaire and it was then sent in October to the home address of a random sample of 1,000 nurses who were international members of the Royal College of Nursing (RCN) and who reported a London address. The RCN is the largest professional association of registered nurses in the UK representing more than half of all nurses working in the UK. These nurses had been members of the RCN for no more than two years before the survey was conducted. A reminder was sent in November. There were 60 undelivered or returned (addressee moved away) and 380 usable returns giving a response rate of 40 per cent.

Results

Trends in inflow of nurses to the UK

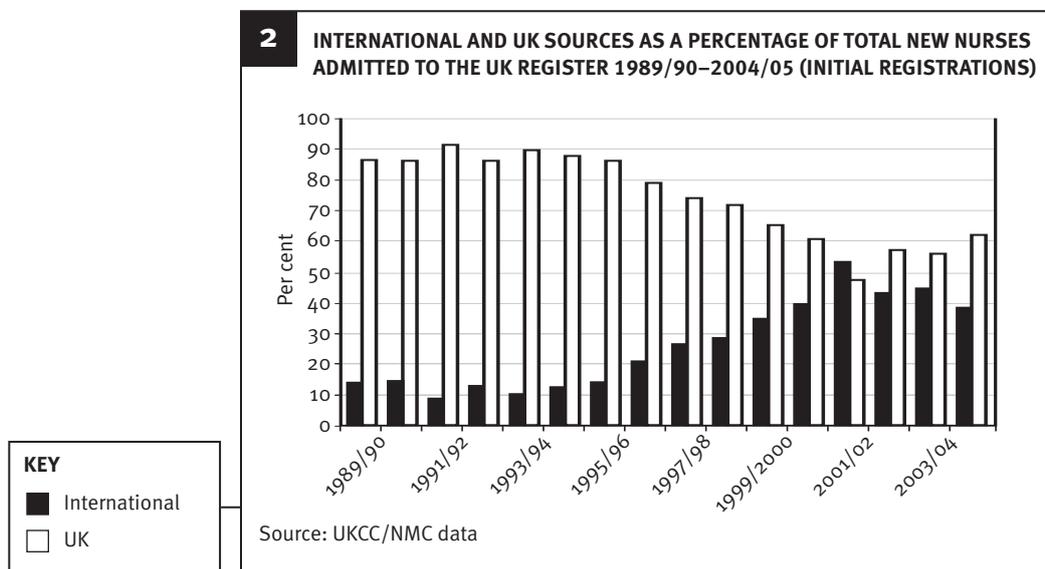
In recent years there has been a rapid growth in the numbers of nurses from other countries registering to practise in the UK. Data from the NMC register can be used to assess trends in the numbers of non-UK nurses entering the UK. (There are limitations in using NMC data to monitor the inflow of nurses to the UK, since these register the intention to work in the UK, rather than the actuality of working. Overseas nurses may be registered, but not move to the UK, or they may move to the UK but not take up employment in nursing.) The key indicator is the level of initial admissions to the NMC register of nurses and midwives originally trained and registered outside the UK. In the year up to March 2005, a total of 12,670 initial entrants were admitted from all overseas countries (Figure 1).



Most of the growth has been from countries outside the European Union (EU). The most important source countries in recent years have been the Philippines, India, South Africa, and Australia. The vast majority of nurses coming to the UK are from English-speaking countries of the Commonwealth, with the addition of the Philippines. Since April 1997 there has been an aggregate total of more than 80,000 overseas nurses admitted to the UK register.

The rapid growth in the importance of overseas countries as a source of new nurses for the UK is highlighted in Figure 2 (see p 6), which shows the relative contribution of UK and of overseas sources of 'new' nurses since 1989/90. In the early 1990s, overseas countries were the source of about one in ten nurses entering the UK register. The overseas contribution rose rapidly in the late 1990s, both in terms of numbers and as a percentage

of total new entrants. In the past four years, overseas countries have, on average contributed about 45 per cent of the annual number of new entrants, but this has come down from a peak of over half in 2001/02.



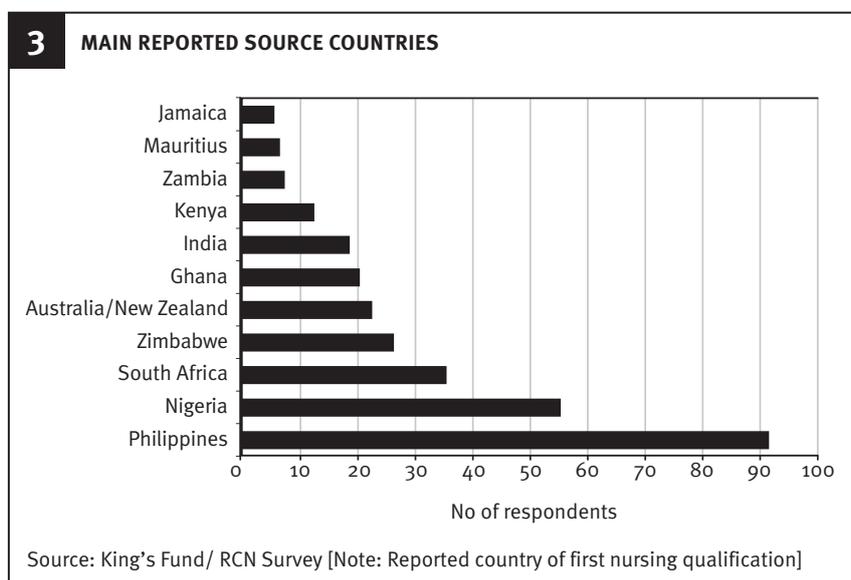
While NMC data can assist in tracking overall trends in the numbers of international nurses becoming eligible to practise in the UK, there are no complete and accurate published data available on where these nurses are located within the UK, or what type of work they are undertaking. Overall, about three-quarters of all working nurses in the UK are employed in the NHS, the remainder working in the independent (that is, private) sector, in nursing homes and in the relatively small, independent, acute hospital sector (Buchan and Seccombe 2003). Both the NHS and the independent sector have been active in recruiting internationally, but it is not known in any detail where the level of use of international nurses is most prominent. The NHS in England does not record how many international nurses it employs, despite a recent recommendation by a House of Commons Select Committee (House of Commons International Development Committee 2004).

It should also be noted that there is a significant backlog of international nurses awaiting full assessment of potential for registration so that they can practise in the UK. In July 2005 it was reported that the NMC estimated that there were ‘37,000 overseas nurses already in the UK who are unable to start work because they cannot find supervised practice placements’ (Parish and Pickersgill 2005).

The profile of the surveyed international nurses

The objective of the survey had been to target nurses who had arrived in the UK within the past few years. Most respondents (77 per cent) reported that they had first arrived in the UK after 2001, and nearly all the nurse respondents (96 per cent) reported that they had first arrived in the UK after 2000. All but one reported that they had first worked as a nurse in the UK after 2000. The survey respondents therefore represent a population that had spent four years or less in the UK. Given the significant increase in the number of international nurses arriving in the UK since 2000, shown in Figure 2, this is not surprising.

The 380 respondents comprised a population with more than 30 different countries of training. The Philippines, Nigeria and South Africa were the three most commonly reported countries of training (Figure 3).



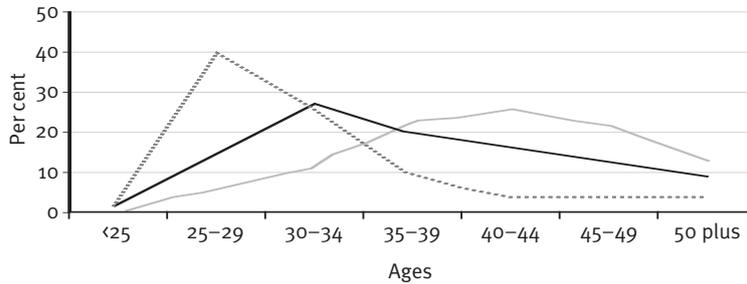
Most respondents reported that their country of training was the same as their previous country of location, with the exception of some Filipino and Indian nurses who reported that they had previously been working in the Middle East.

For the purposes of country and regional comparison, some of the data analysed in this paper is presented in regional aggregate form, in five regional categories, by country of training: the Philippines; India/Pakistan/ Mauritius; South Africa; other sub-Saharan African countries; Australia/New Zealand/United States of America (USA). These five regional categories account for 349 of the total of 380 respondents.

While there is often an assumption that younger nurses are more likely to be internationally mobile, the age profile of respondents varied markedly by regional grouping. Sixty per cent of the nurses from sub-Saharan Africa, over 40 per cent from South Africa and India/Pakistan/Mauritius were aged 40 or older; the youngest age profile was reported by the nurses from Australia/New Zealand/USA, with more than 60 per cent being aged 34 or younger. Figure 4 (see p 8) highlights the significant variation in age profile between the relatively 'younger' Australia/New Zealand group, and the older profile of nurses from sub-Saharan Africa.

Nursing is mainly a female occupation in most countries. However, the proportion of females is slightly lower in the international respondents than in the home-trained UK population of nurses – 84 per cent compared with over 90 per cent. Two-thirds (66 per cent) of respondents reported they were married. Three-quarters of respondents (76 per cent) who reported that they were married or had a partner also reported that they were currently living with their spouse/partner in the UK; one-quarter (24 per cent) reported that their spouse/partner was living in their home country.

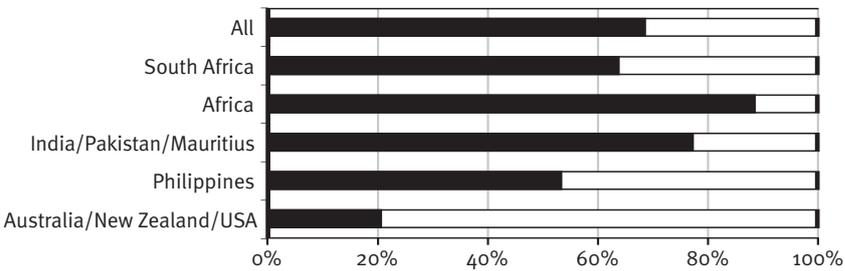
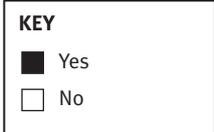
4 AGE PROFILES: ALL INTERNATIONAL NURSES; AND THOSE FROM AUSTRALIA/NEW ZEALAND AND SUB-SAHARAN AFRICA



Source: King's Fund/RCN [Note: Africa excludes South Africa]

Two-thirds of respondents (66 per cent) reported having children. Most respondents from sub-Saharan Africa (88 per cent), India/Pakistan/Mauritius (77 per cent), South Africa (63 per cent) and the Philippines (53 per cent) reported having children. Only 22 per cent of respondents from Australia/New Zealand/USA reported that they had children. Of these respondents, 61 per cent had children living with them in the UK and 39 per cent reported children living in their home country. (NOTE: Some respondents reported having children both in the UK and in their home country.)

5 DO YOU HAVE CHILDREN (RESPONSE BY MAIN REGIONAL GROUPINGS)?



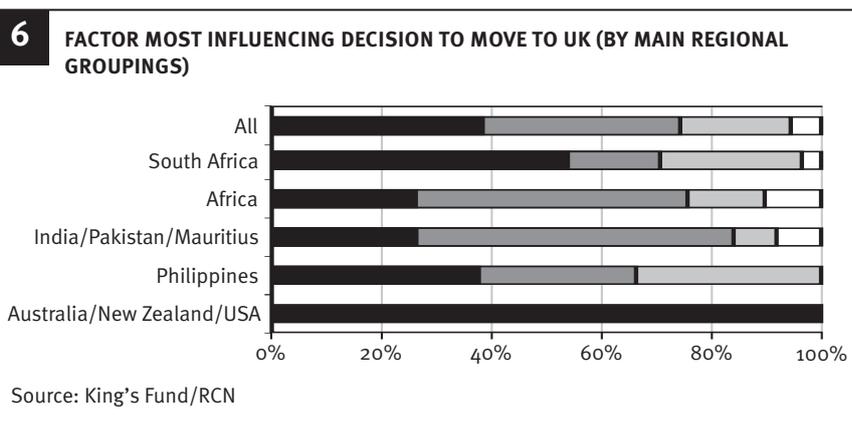
Source: King's Fund/RCN

Nearly all of the respondents (92 per cent) are qualified and registered to practise in general adult nursing: 10 per cent are registered to practise in mental health nursing, while small numbers reported registration as learning disabilities nursing, children's nursing or midwifery. (NOTE: Some respondents are registered to practise in more than one field.)

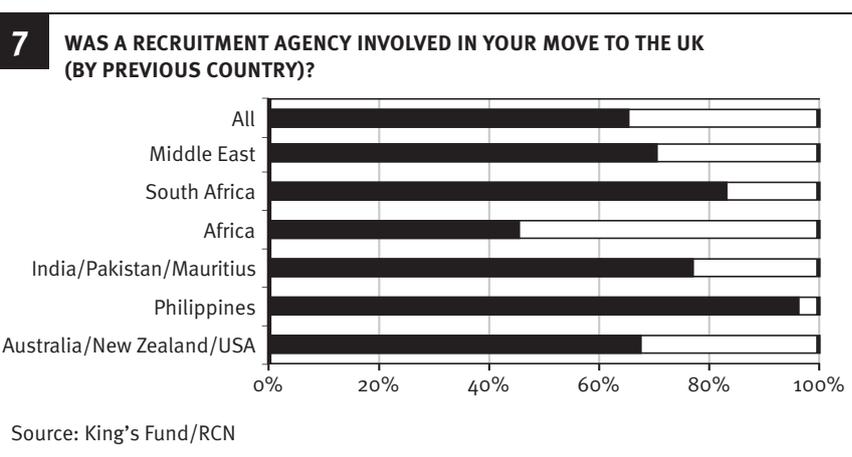
Coming to the UK

Respondents were asked to indicate what had most influenced them in deciding to come to the UK (see also Allen and Larsen 2003). The key results are shown in Figure 6. The responses highlight some variation by region of origin. All of the nurses from Australia/New Zealand/USA indicated that the main reason that they were in the UK was personal, linked to travel and experiencing a different way of life. The results from the other regional groups dispel the myth that nurses only move for financial reasons – many

report that the factor that most influenced them to move was professional development. Some nurses from Africa and India/Pakistan/Mauritius reported social reasons as being the main driver – primarily linked to joining family already in the UK. No nurses from the Philippines reported this reason for coming to the UK. This is unsurprising as there is no history of migration from the Philippines to the UK – and the post-colonial ties that exist between the UK and Anglophone areas of Africa and Asia are absent.



Two-thirds of all the respondents indicated that a recruitment agency had been involved in their move to the UK – relatively fewer nurses who had previously been located in sub-Saharan Africa had made use of an agency, but nearly all Philippines-based nurses (96 per cent), South African nurses (83 per cent), and most nurses who had worked in the Middle East and in India/Pakistan/Mauritius reported that a recruitment agency had been involved in their move. Filipino nurses were most likely to report that the agency was based in their home country (that is, the Philippines), while for nurses from the other regional groups the agency was more likely to have been international, or based primarily in the UK.

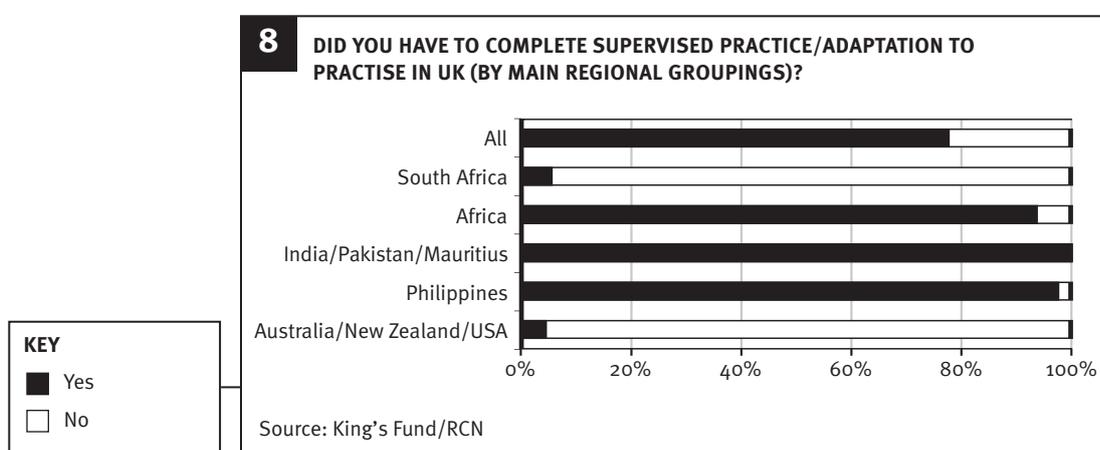


Nearly three out of every four nurses (72 per cent) who reported using an agency had to pay for at least part of the services provided by the agency (that is, the recruiting employer was not covering all the recruitment/registration/travel costs). Filipino nurses (74 per cent) and those from India/Pakistan/Mauritius were most likely to report that they had paid.

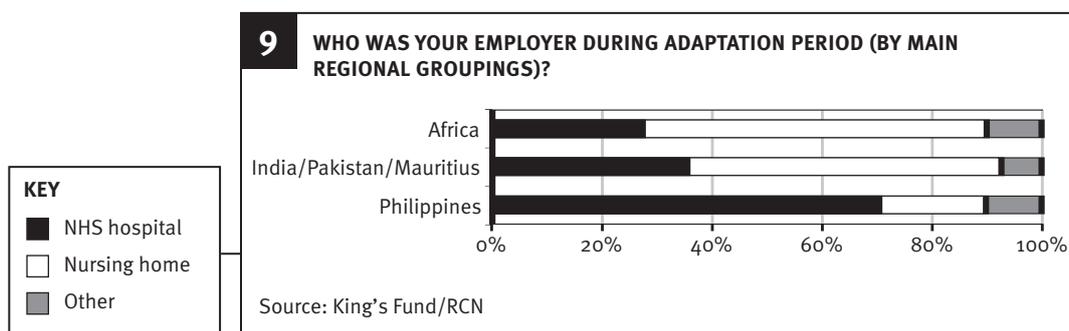
Most nurses from Australia/New Zealand/USA (78 per cent) reported they did not have to pay for any services provided by agencies. The most commonly reported payments were: direct fees to the agency; adaptation fees to the Nursing and Midwifery Council in the UK; and transport fees to travel to the UK to take up their job.

Supervised practice/adaptation

Three-quarters of the respondents (76 per cent) reported that they were required to complete a supervised practice course/period of adaptation in order to practise as a nurse in the UK. The requirement to undertake supervised practice/adaptation varied significantly depending on country of training (Figure 8). Nearly all the nurses from Australia/New Zealand/USA and from South Africa reported that they were not required to undertake a course prior to registration to practise in the UK, but all nurses from India/Pakistan/Mauritius and nearly all from the Philippines and sub-Saharan Africa reported that they had to take a course/period of adaptation.



In the majority of cases, this course was reported to have been taken while the nurses were working for private-sector nursing homes (nurses from India/Pakistan/Mauritius and sub-Saharan Africa) or in NHS hospitals (nurses from the Philippines).

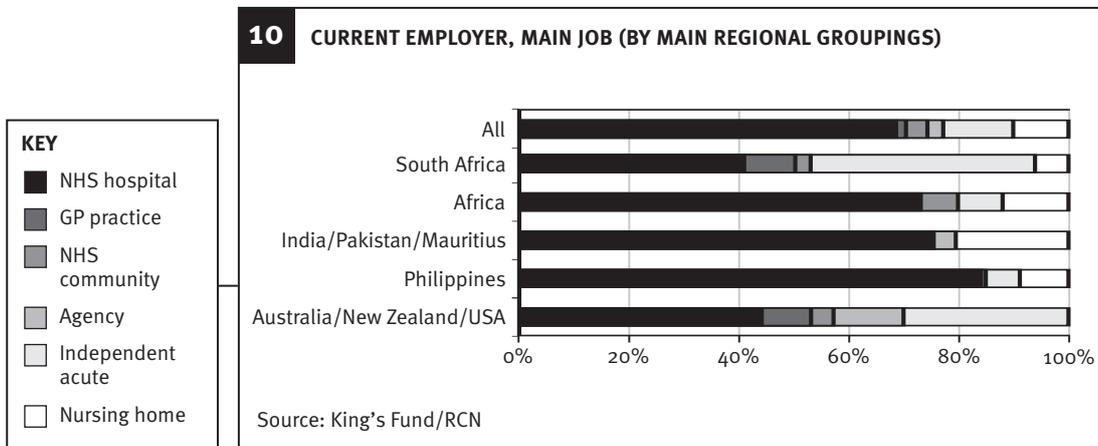


Most nurses reported that they had been paid a clinical grade A or B during adaptation/supervised practice (that is, they were paid at a rate equivalent to an unqualified nursing auxiliary). However, 30 nurses (23 from sub-Saharan Africa) reported they were not paid at all during adaptation and 23 (18 from sub-Saharan Africa) reported that they had to pay

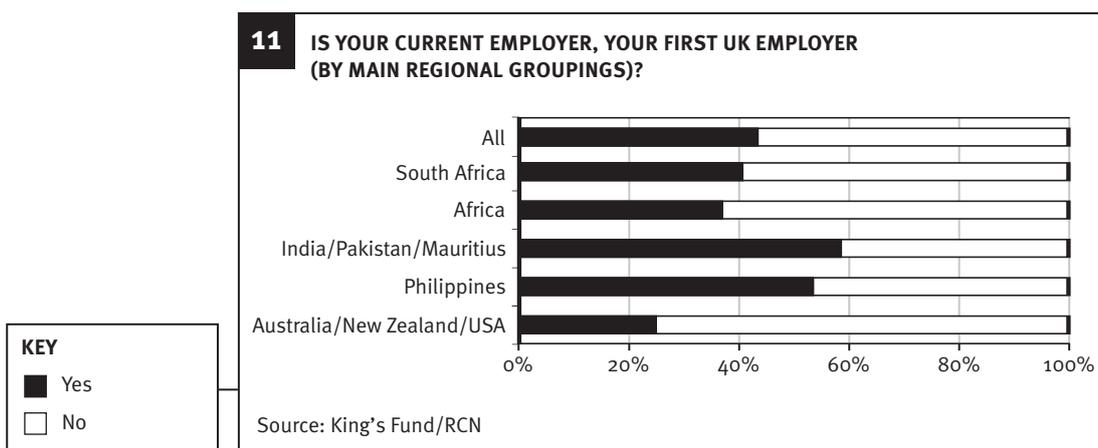
a fee while undertaking the period of adaptation. These nurses were mainly based in private-sector nursing homes.

Current employment

Two-thirds (69 per cent) of respondents were working in NHS hospitals in London, 13 per cent were working in the independent sector and 10 per cent were working in nursing homes. Very few respondents were working either for general practices or in NHS community nursing. In part this may be explained by the fact that some NHS community nursing posts require post-basic professional qualifications which are not available in other countries. Filipino nurses were most likely to be working in NHS hospitals, as were the majority of nurses from other regions apart from South Africa (where 40 per cent reported they were working in the independent acute sector) and Australia/New Zealand/USA (where some reported they were working directly for nursing agencies).



More than half of the respondents (57 per cent) had already made one move of employer since beginning work as nurses in the UK.



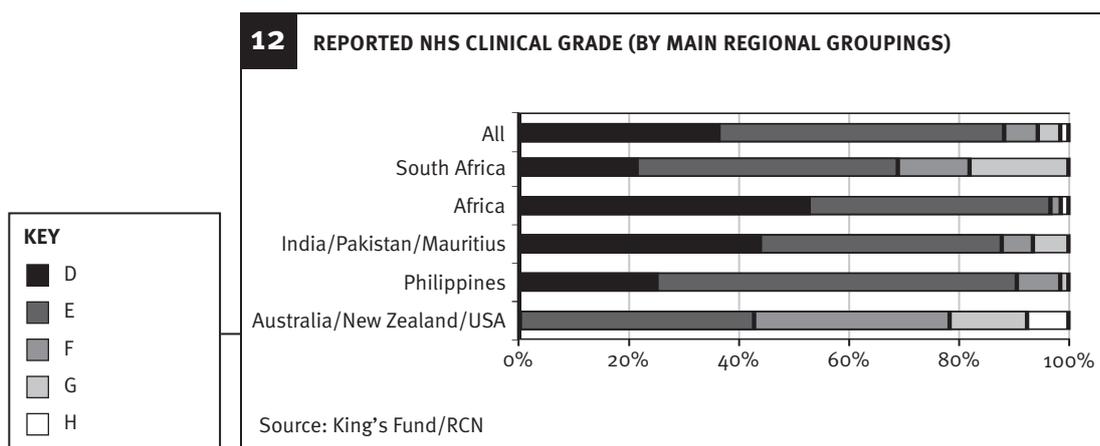
The main direction of employment mobility of these nurses has been from the private sector and nursing home sector to the NHS. Of those who have made a move, 75 per cent

reported that their first employment in the UK was as a nurse in the private/independent sectors.

Pay and grading

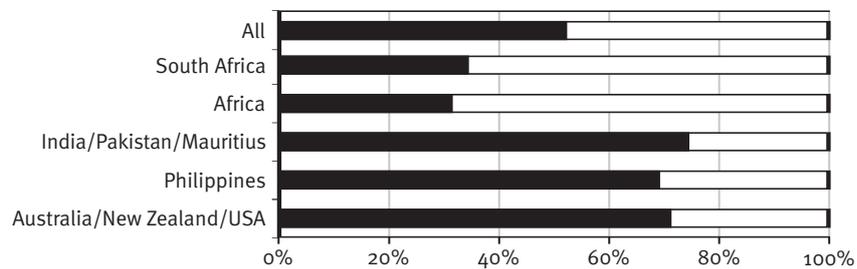
At the time of the survey, all NHS nurses working in clinical practice were paid according to a single national pay/grading system ('clinical grading'). This system is based on a grading structure from grade A (lowest) to grade I (highest). Three-quarters of respondents reported that they were paid on the NHS clinical grading system. (NOTE: Some private-sector employers also use the clinical grading system.) Data on reported clinical grade enable an assessment of variation in pay rates by different regional grouping.

Nearly all the respondents who were paid according to clinical grading reported that they were paid on either the lower clinical grade D (36 per cent) or grade E (51 per cent) (Figure 12). These are the two main grades for staff nurses. There was evidence of variation by region of training – more than half the nurses from sub-Saharan Africa (53 per cent) were graded at the lower level of D, as were nearly half of the nurses from India/Pakistan and Mauritius. Two-thirds (65 per cent) of Filipinos reported that they were graded at the higher level of grade E. None of the nurses from Australia and New Zealand reported that they were paid at grade D – more than half of this group were paid at the higher grade F or above.

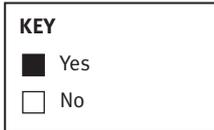


Respondents were asked to indicate if their current clinical grade was appropriate, given their role and responsibilities. Just over half (53 per cent) of those who were graded indicated that they believed their grade was appropriate, but this dropped to only 31 per cent of nurses from sub-Saharan Africa and 34 per cent of nurses from South Africa.

13 DO YOU CONSIDER YOUR CLINICAL GRADE TO BE APPROPRIATE, GIVEN YOUR ROLE AND RESPONSIBILITIES (BY MAIN REGIONAL GROUPINGS)?

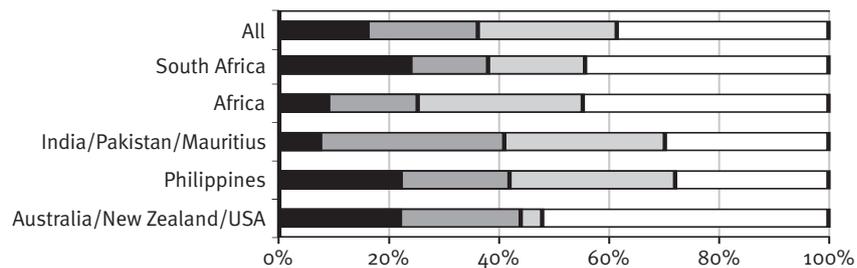


Source: King's Fund/RCN

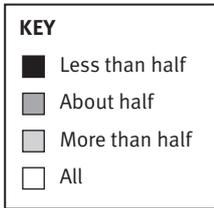


Most of the nurses were the major or sole 'breadwinner' contributing to household income. One-third (37 per cent) were contributing all of the household income, a further quarter (25 per cent) contributed more than half, and a further one in five (20 per cent) contributed about half (Figure 14).

14 WHAT PERCENTAGE OF TOTAL HOUSEHOLD INCOME DO YOUR EARNINGS AS A NURSE REPRESENT (BY MAIN REGIONAL GROUPINGS)?

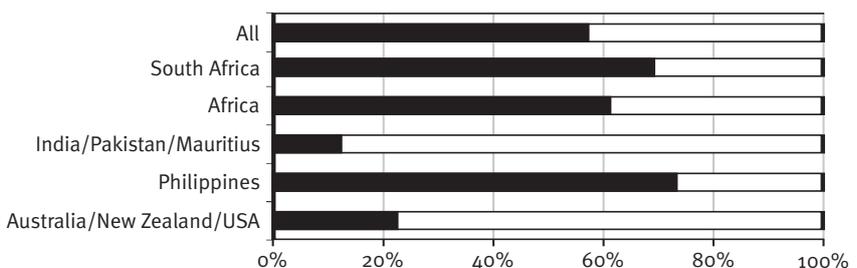


Source: King's Fund/RCN

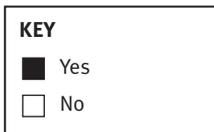


More than half of the respondents (57 per cent) reported that they regularly sent remittances to their home country. However, the pattern of remitting varied significantly by regional grouping (Figure 15). Three-quarters of Filipino nurses regularly remit money home, as do more than half of nurses from sub-Saharan Africa and from South Africa.

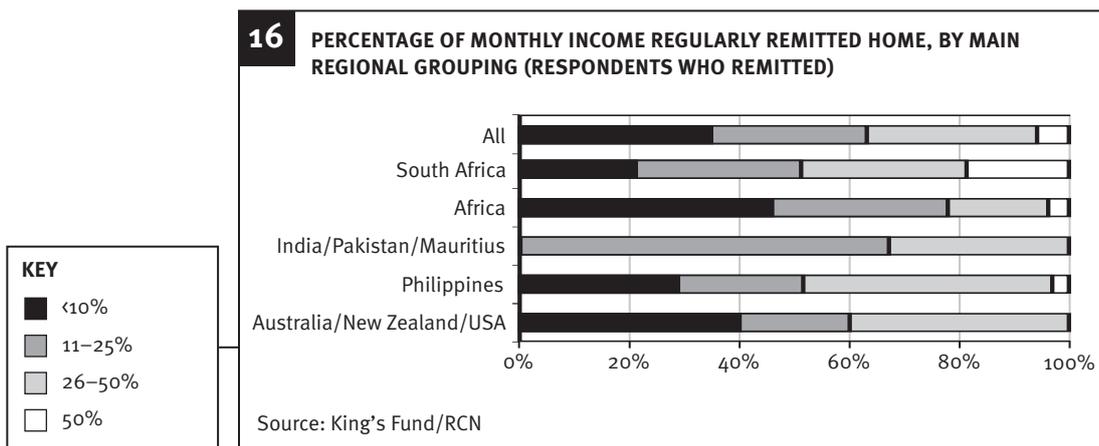
15 DO YOU REGULARLY SEND MONEY (REMITTANCES) TO YOUR HOME COUNTRY (BY MAIN REGIONAL GROUPINGS)?



Source: King's Fund/RCN



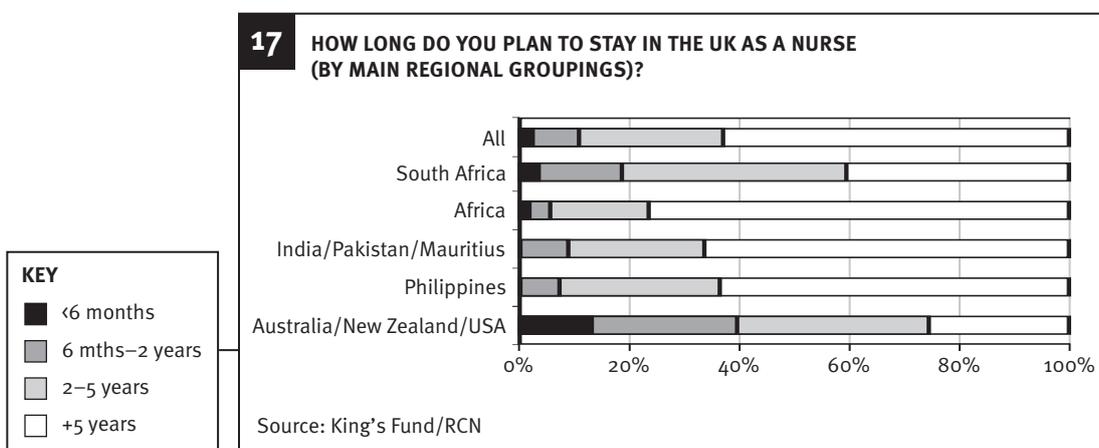
Nurses from Australia/New Zealand/USA and India/Pakistan/Mauritius were much less likely to report that they were remitting money. In the former case this may be linked to the fact that they are more likely to be single, and to be planning only a short stay in the UK (see Figure 17), while in the latter, it may simply be due to the fact that these nurses have their families with them in the UK. Nurses from South Africa and the Philippines were most likely to report that they remitted a high proportion of their income – in both cases, about half of respondents were remitting either between 26 per cent and 50 per cent or more than 50 per cent of their income.



The average full-time pay for a nurse in the UK in 2004 was approximately £UK24,500 (ONS 2005) (nurses in London will earn more because of a regional supplement).

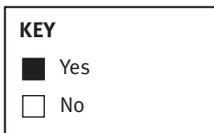
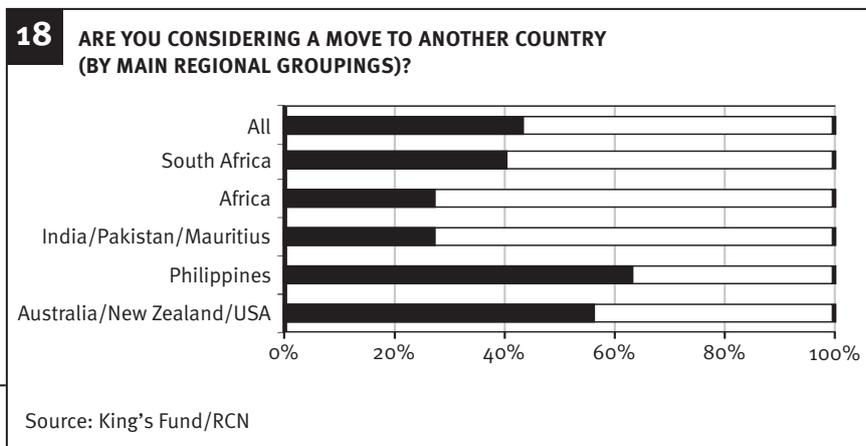
Career plans

Respondents were asked to indicate how long they planned to remain in the UK as a nurse (Figure 17). The majority (60 per cent) indicated that they planned to stay for at least five years, with a further quarter (25 per cent) indicating that they planned to stay between two and five years. Nurses from Australia/New Zealand/USA were least likely to be planning to stay long term and proportionally more South African nurses reported planning to stay 2–5 years than for longer periods. However, these responses must be assessed in the light of the findings, below, that many nurses were also considering the possibility of moving to another country.



Most respondents (83 per cent) require a work permit to work in the UK and nearly all (91 per cent) indicated that if their permit was extended they would wish to stay longer in the UK.

Respondents were also asked if they were considering a move to another country. Just under half (43 per cent) reported that they were considering a move (Figure 18). Nearly two-thirds of nurses from the Philippines (63 per cent), more than half of those from Australia/New Zealand/USA and 40 per cent of those from South Africa were considering a move. Nearly all of the Filipino nurses (83 per cent) who were thinking of moving reported that they were considering moving to the USA, while those from Australia/New Zealand/USA and those from South Africa were most likely to be considering moving ‘back home’. Overall, the USA was the most often reported potential destination, cited by more than half of the potential movers; Australia was the next most commonly reported possible destination.



One reason why many nurses will have been considering a move is the influence of recruitment agencies, who continue to ‘tap’ this potentially mobile group of nurses. One-third of the respondents (32 per cent) had been contacted by a recruitment agency within the last six months and offered work outside the UK, including half of all the Filipino nurses (who were mainly being offered work in the USA).

Discussion

The survey of several hundred international nurses working in London has provided, for the first time, a detailed picture of their demographic profile, their motivations for working in the UK, their career plans and their pattern of remittances. The survey provides more insight into these issues than has been available before, and highlights a range of key issues which have implications both for broader-based UK national reliance on international recruitment of nurses, and local practice in retaining and motivating these nurses and treating them fairly.

The first point to note is that the sheer diversity of the countries from which nurses have been recruited has implications for policy and practice. The broad range of source countries for UK-based international nurses has been obvious in the NMC registration data from recent years, but this current survey highlights the extent to which different countries of training can be related to different demographic profiles and reported career intentions. While it may be misleading to generalise on the basis on source country, or grouping of source countries, there are marked variations in terms of respondent demographic profile, and of responses to some questions from some of the regional subgroupings. To focus policy attention or practice on all internationally recruited nurses as being 'the same', but somehow 'different' from all UK-educated nurses, is at best an oversimplification of a complex situation, and could be a dangerously misleading approach.

While it can be misleading to focus on generalities, it is clear that different types of internationally mobile nurses can be delineated within the survey: the young 'backpacker' nurse from Australia or New Zealand, who is planning a relatively short stay in the UK, has a different range of priorities and objectives from a Filipino nurse remitting money back to her extended family (and perhaps planning a move to the USA); both are different from an older South African nurse taking the opportunity of a few years in the UK for professional development before planning to return home.

Several key themes do emerge, which have implications for policy and practice in the UK. The data on broad age profiles of nurses, particularly the 'older' profile from Africa, have ended the myth that it is 'only' young nurses who are internationally mobile. Some of the mobile nurses are in their 40s or 50s and have many years' clinical experience. This reinforces the conclusion that the impact of out-migration on sub-Saharan countries is not just about numbers; it is also about a loss of experienced staff.

The demographic data also revealed, for the first time, that many nurses have their partner and/or children with them in the UK. This highlights the fact that not all have travelled leaving their spouse and other close relatives 'at home' – for some, in a sense, home has travelled with them. However, one in three nurses with children report that they have left some of their children back in their home country.

It was also evident from the responses to the survey that financial considerations are not the reported main motive for all international nurses to be in the UK; many have been attracted to the UK primarily for professional development reasons or to take the opportunity to travel.

The central role played by recruitment agencies in both stimulating and facilitating international recruitment was highlighted in the survey. Two-thirds of all respondents had used an agency and most had to pay for some of the services provided by the agency. Some of the nurses reported that they had been provided with misleading information by agencies about their pay and working conditions in the UK. Many of the nurses, when working in the UK, reported that they had been contacted by agencies with offers of work in other countries. Recruitment agencies providing staff to the NHS have recently been brought within the remit of the Code of Practice.

The regulatory requirements for nurses entering the UK are stringent and based on an assessment of each individual applicant (revised requirements are due to be implemented by the NMC in September 2005). Most international nurses from sub-Saharan Africa, the Philippines and India/Pakistan/Mauritius were required to complete a supervised practice course/or period of adaptation in order to practise in the UK; most had done so in private-sector nursing homes, and some nurses from sub-Saharan Africa reported that they had to pay for their adaptation, or received no pay during that period. While these regulatory requirements are in place to maintain standards and for public protection, the response from some of the nurses revealed that they have been exploited during their application and entry process.

This was associated with a form of 'back door recruitment' by the NHS, with many nurses reporting that they had initially worked in the UK for private-sector employers before moving to the NHS. In this situation the NHS is the end-beneficiary of recruitment practices which do not conform to its own Code, including active recruitment from the developing world by private-sector employers.

The survey evidence on remittances, although limited, does add new information on this important but under-explored issue. It is significant that most of the nurses reported that they were the sole or main contributor to family income. As reported above, more than half of the nurses reported that they regularly remitted money to their home country, with nurses from the Philippines and South Africa regularly remitting a quarter or more of their income. This represents a significant flow of money back to their home countries – several thousand pounds per year per nurse.

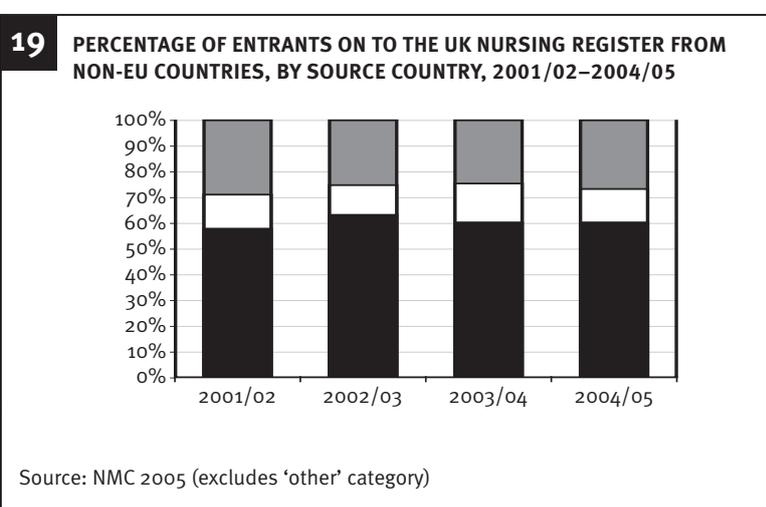
One critical issue for UK policy-makers is to determine if internationally recruited nurses will stay on in the UK, move back to their home country, or go on to another. Is London a gateway or a revolving door? The survey provides a mixed picture. The majority of the nurses were considering a long-term stay (five years or more) in the UK. In part this was dependent on the provision of an extension to their work permit. However, many nurses were also considering the possibility of moving on to another country; in particular, 63 per cent of Filipino nurses were thinking of a move. The USA was the most commonly reported country. The fact that these nurses have made at least one international move means that they are likely to have the propensity to move again. As such, retention efforts will have to take account of their career aspirations.

The Department of Health Code and ‘ethical’ recruitment

The UK policy context in which the survey evidence must be examined is codified within a so called ‘ethical’ approach. Recruitment of nurses from the developing world has been controversial, and the Department of Health in England has attempted to limit the potential negative impact. It first established guidelines in 1999 (Department of Health 1999), which required NHS employers not to target South Africa and the West Indies; this was followed by a Code of Practice of international recruitment for NHS employers (Department of Health 2001) which was later strengthened (Department of Health 2004). This Code requires NHS employers not to actively recruit from developing countries unless there is a government-to-government agreement that active recruitment is acceptable. At the time of writing, such agreements exist only with China, India, Spain and the Philippines – all other developing countries are effectively identified as ‘no go’ areas for NHS recruiters and agencies acting on their behalf.

The Code does not cover private-sector employers, and does not prevent health professionals taking the initiative to apply for employment in the UK, or to come to the UK for training purposes. Because the NHS in England does not record systematically how many international nurses it employs (Hansard 2004), it is not possible to verify the extent to which all NHS employers have complied with the Code, in terms of not actively recruiting from the developing world.

What is clear from NMC data is that, although there has been a decline in numbers, in 2004/05 more than 3,300 nurses entered the UK register from developing countries on the so-called ‘banned’ list – accounting for about one in four entrants from all non-EU countries. There has been little change in that proportion in the last four years (Figure 19).



Given the increasing globalisation of labour markets, and the continued demand for nurses in the UK as a result of demographic change, it is likely that there will continue to be an inflow of international nurses over the next few years. The numbers entering are unlikely to be at the level of the peak year of 2001/02, and they are likely to be in response to more targeted recruitment aimed at shortage specialities in the UK. New entry requirements for international nurses, including tougher English language tests, are to be introduced by the NMC from September 2005, and this is likely to restrict successful

applications from some countries (*Nursing Standard* 2005). There is also likely to be some change of emphasis in source countries. While international recruitment activity, as indicated by NMC registrations, has been based on an increase in non-EU registrants, this may change with the accession of ten new countries to the EU in May 2004.

Conclusion

There are two critical ongoing policy questions for the UK, and any other country engaged in large-scale international recruitment: how 'ethical' is the practice, and how efficient is it (*see also Buchan et al 2005*)?

The primary ethical guide on UK international recruitment is the Department of Health Code on international recruitment. This only applies to NHS employment, and its impact is difficult to monitor because of an absence of complete data on NHS international recruitment practice. However, the study data on career history of the international nurses in London clearly demonstrated that many nurses were recruited initially by private-sector nursing homes in the UK, but moved quickly to the NHS on completion of their adaptation period in the UK. NHS employers in London were, therefore, the end-beneficiaries of private-sector 'back door' recruitment from countries that were on the NHS 'banned' list of developing countries. This does not contravene the Department of Health Code, but it does help to explain why there continues to be an annual inflow of several thousand nurses to the UK from developing countries on the list.

The issue of the efficiency and effectiveness of international recruitment rests partly on how long international recruits are retained within the NHS. The survey revealed that, while many international nurses are thinking about a long-term commitment to the UK, others are planning to go home and many are also considering moving on, often stimulated by contact by recruitment agencies.

Key lessons

There are a number of key lessons for UK policy-makers from the results of the study.

First, an active policy of international recruitment by health care employers in the UK has helped stimulate a huge growth in interest from nurses in many countries, now eager to come and work in the UK. This has led to an increase in the numbers of nurses in registration limbo – already in the UK, but unable to achieve full registration until they can complete adaptation requirements. This is the worst-case scenario for all involved – one country has 'lost' a nurse, the UK has not, yet, gained the nurse, and the nurse herself is prevented from making full use of her skills. The new NMC requirements in place from September 2005 could add to the time delay in full registration of many international nurses.

Second, bad practice in relation to international recruitment persists in some UK health care organisations, with some nurses still being exploited. Some of the surveyed nurses highlighted that they had been provided with misleading information by recruitment agencies about their employment prospects in the UK; others are charged for their

adaptation. Some believe they are undergraded in relation to their level of responsibilities – particularly those from sub-Saharan Africa.

Third, financial opportunities are not the only driver for nurses coming to the UK; while money isn't everything, it *is* important for these nurses that they feel they are being treated fairly and equally with home-trained nurses. Many of the nurses are in the UK for a range of reasons other than just earning more income, but most are the major or sole 'breadwinner' contributing to household income. Many regularly send home significant amounts of money.

Fourth, will these nurses stay put, go home or move on? The study paints a varied picture: some groups, particularly those from the Philippines, are weighing up the option of moving to the USA, while many of the surveyed nurses are also willing to make a long-term commitment to the UK. Many have their families with them.

Recommendations

It is in the interests of London, and the UK, that those nurses who have been recruited here stay as long as they wish – they are badly needed. However, unless we address the issues highlighted above, those thinking of moving on to another country are more likely to make the move, and some who are thinking of coming to the UK may select another destination country. We need:

- improved monitoring of numbers, locations and flows of international nurses in the UK
- an assessment of the impact of the Department of Health Code
- provision of sufficient adaptation places for international nurses in the UK
- provision of personal development plans to all international nurses
- equality proofing of implementation of the NHS pay system, Agenda for Change
- support and encouragement for international nurses who are planning to 'return'
- improved communication and co-ordination across UK government departments and other agencies involved in international recruitment and in international development.

First, we need better monitoring of how many international nurses are being recruited, and where they work. The Department of Health should implement House of Commons Select Committee recommendations (House of Commons International Development Committee 2004) and track the number of international nurses the NHS recruits and employs. It should also be more transparent about how many international nurses it plans to recruit over the next few years. This would help in assessing how important the overall contribution of international nurses will be over the next few years, and would enable an assessment of how near – or far – the UK is from self-sufficiency in training nurses and other health professionals.

The impact of the new 'strengthened' Code introduced in December 2004 (Department of Health 2004) should also be monitored, to assess its impact on recruitment agencies and the private sector.

The 'back door' recruitment via the private sector undermines the Department of Health Code of Practice on international recruitment; at the very least the NHS should commit to making available sufficient resources for the necessary number of adaptation and supervised practice placements within the NHS, rather than relying on nurses to pay for nursing home-based adaptation and then recruiting them soon afterwards.

Professional development opportunities are a major factor in attracting and retaining nurses. All UK employers should work with each international nurse to draw up individual career plans to ensure these nurses can work effectively and meet their career aspirations.

The implementation of Agenda for Change provides an opportunity to end any discriminatory practices if international nurses are being undergraded. Implementation of Agenda for Change should be monitored/audited to ensure that international nurses are not discriminated against, and that their nursing experience in other countries is properly and objectively assessed.

Another method by which the UK can engage more effectively in a truly mutual approach to international recruitment is to facilitate 'returners' who may wish to return to their home country after working in the UK for a few months or years. Some of the surveyed nurses reported the intention of returning voluntarily after they have achieved their goals in the UK. Where this is the case, the NHS and other UK employers should ensure that the return is supported, and that during their stay in the UK the clinical and professional development objectives of these nurses are met.

The process of return should be planned, with the involvement wherever possible of relevant organisations and employers in the returners' home country, so that these nurses can make a full contribution to health care in their home country. This is an area where the UK government can take a lead, ensuring that bilateral agreements have the return option detailed, and that NHS employers take account of the 'return' wishes of the international nurses that they employ.

There is also a need for better communication and co-ordination across the various government departments and other agencies that have an interest in the issue. In particular, the Department of Health, NHS Employers (who now have responsibility for international recruitment to the NHS), the independent health care sector, the Home Office, and the NMC should all be working to ensure that international nurses who are recruited and employed receive equal treatment and full and accurate information about recruitment processes and employment opportunities.

At a broader international level, these agencies should be liaising with the Department for International Development to identify and support approaches to UK international recruitment of health workers that are based on mutuality, are aligned with international donor activity rather than cutting across it, and that take account of the continuing potential of unco-ordinated international recruitment activity to cause irreparable damage to understaffed health systems in the developing world.

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The issues surrounding international recruitment and the migration of health workers have generated huge media attention. However, relatively little primary research has been done in this area. Based on a survey of international nurses in London, this paper reports on the country of origin, demographic profile, motivations, experiences and career plans of the 380 respondents. The paper also outlines the overall trends in the numbers of nurses coming to the United Kingdom, examines the policy context in which international recruitment activity has been conducted, and looks at the impact of the United Kingdom's Code of Practice on international recruitment.

