International Recruitment of Nurses: Policy and Practice in the United Kingdom

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Objective. To synthesize information about nurse migration into and out of the United Kingdom in the period to 2005, and to assess policy implications.

Principal Findings. There has been rapid growth in inflow of nurses to the United Kingdom from other countries. In recent years, 40–50 percent of new nurse registrants in the United Kingdom have come from other countries, principally the Philippines, Australia, India, and South Africa. Outflow has been at a lower level, mainly to other English-speaking developed countries—Australia, the United States, New Zealand, Ireland, and Canada. The United Kingdom is a net importer of nurses. The principal policy instrument in the United Kingdom, the Code of Practice on International Recruitment, has not ended the inflow of nurses to the United Kingdom from sub-Saharan Africa.

Conclusions. Given the increasing globalization of labor markets, it is likely that the historically high levels of inflow of internationally recruited nurses to the United Kingdom will continue over the next few years; however the “peak” number reached in 2002/2003 may not be repeated, particularly as large-scale active international recruitment has now been ended, for the short term at least. New English language tests and other revised requirements for international applicants being introduced by the Nurses and Midwives Council from September 2005 may restrict successful applications from some countries and will also probably add to the “bottleneck” of international nurse applicants. Demographic-driven demand for health care, combined with a potential reduction in supply of U.K. nurses as many more reach potential retirement age means that international recruitment is likely to remain on the policy agenda in the longer term, even with further growth in the number of home-based nurses being trained.

Key Words. Nurses, recruitment, United Kingdom

This paper reports on international migration and recruitment of nurses to the United Kingdom in the period up to 2005. The paper outlines the health and labor market context in the United Kingdom, examines the dynamics of the U.K. nursing labor market by assessing “flows” of nurses to and from the

United Kingdom, and discusses the impact of the main policy instrument—the Department of Health Code of Practice on international recruitment. The United Kingdom has been prominent in international nursing labor markets recruitment—both because it has explicitly used international recruitment as a policy response to home-based staff shortages, and because it is the country that first introduced an “ethical” code to underpin recruitment activity. With its postcolonial legacy, the United Kingdom also has a strong historical, educational, and migratory connection to a range of English-speaking countries in Africa and Asia, which distinguishes it from the United States—the other main destination country for English-speaking nurses.

This paper focuses on the flows of registered nurses. The United Kingdom no longer trains second level (“enrolled”) nurses, and recruitment and registration from other countries is focused on registered nurses. “International” nurses in the context of this paper are those who were trained in countries other than the United Kingdom, but now have U.K. registration enabling them to practice in the United Kingdom.

THE U.K. CONTEXT

This section discusses the main drivers that have led to the United Kingdom being an active recruiter in international nursing labor markets. The United Kingdom comprises four countries—England, Northern Ireland, Scotland, and Wales. The main focus of the paper is on England, the largest of the U.K. countries. While there are health policy variations and policy divergence in the four countries, all nurses are registered to practice at U.K. level, and most aspects of HR policy are similar across the United Kingdom. The United Kingdom has a population of 56 million, and most health care is organized and delivered through the National Health Service (NHS).

The U.K. NHS is funded from taxation and free at the point of delivery. As with any health care system, the NHS is a labor-intensive service industry. The NHS workforce is large, with more than one million mainly unionized staff working in several hundred hospital and primary care units. There is some private sector health provision, mainly in care homes and nursing homes, with a small independent acute sector that provides elective care.

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The Labour government, which first took power in the United Kingdom in 1997, was committed to significant expansion in the NHS, including planned year-on-year funding increases of approximately 7 percent in real terms. It identified a lack of staff capacity as a major blockage on planned expansion of services. The Wanless report, which reviewed NHS funding, stressed that “the UK does not have enough doctors and nurses . . .” (Wanless 2001). The response by U.K. governments was an explicit commitment to “grow” the NHS workforce, made highly visible by establishing specific staffing growth targets, such as the target set in the year 2000 for “20,000 more qualified nurses by 2004.”

The main driver for NHS reform has been the NHS Plan, and within it, there has been a commitment to increase NHS staffing. This was set out in a series of specific targets, such as 7,500 more consultants and 2,000 more general practitioners, and 20,000 extra nurses by 2004, from a year 2000 baseline. Most of these targets (particularly those for nurses) have been met or exceeded through investment in retention practices (e.g., flexible working), increased training, and active international recruitment. The United Kingdom therefore stands out as a country where active international recruitment of nurses, and other health professionals, was an explicit national-level government policy response to the need to increase staffing levels in a public sector, government-funded health care system. This again distinguishes it from the United States, where there is not the same scope for coordinated national policy-led recruitment activity.

The NHS has achieved significant staffing growth since 1997. The overall NHS workforce in England (whole time equivalent) grew from 846,000 in 1997 to 1,071,000 in 2004. In the case of the main health professional occupations of doctors, nurses and midwives, and allied health professionals, there was growth of about one quarter in the size of these workforces in the NHS over the time period (see Table 1).

THE STOCK OF NURSES AND MIDWIVES IN THE UNITED KINGDOM

There are approximately 670,000 nurses and midwives on the U.K. professional register. Any nurse who wishes to practice in the United Kingdom must be registered, so this provides a measure of the total potential working population of nurses. Reregistration is required every 3 years, so the register is updated. Of the nurses on the register, about 400,000 are employed in the

Table 1: Number and Change in NHS Staff by Selected Occupation, NHS England, 1999 and 2004, September (Headcount)

	1997	2004
All employed staff (including GPs)	846,289	1,071,203
All doctors	84,758	109,224
Qualified nursing	256,093	315,440
Qualified allied health professionals	36,917	48,338
Managers	21,434	36,007

Source: Department of Health Statistical Bulletin 2004/2005.

Figures are rounded.

NHS, and perhaps 100,000 in other jobs and sectors (Buchan and Seccombe 2003).

International nurses (i.e., nurses trained in countries other than the United Kingdom, but now registered to practice in the United Kingdom) work both in the NHS and in the private sector. The Department of Health in England does not collate data on nationality or country of training of nurses. It is therefore not possible to assess accurately the number of international nurses working in the NHS. The only information available on the “stock” of international nurses in the United Kingdom is from a previous study, which used postcode data to “map” the location of international nurses registered in the United Kingdom (Buchan 2003).

The study reported that in October 2002, there were 4,053 European Union (EU) nurses reporting a U.K. address, and 38,096 other overseas (OS) nurses reporting a U.K. address, giving a total of 42,149 international nurses currently reporting an address in the United Kingdom (*Note:* The rapid inflow in international nurses since 2002, which is discussed later in this paper, means this will be a significant underestimate of current stock). This represents approximately 7.5 percent of all U.K.-based nurses for whom there were complete address details.

The same study found that OS and EU nurses have a “younger” age profile than U.K.-educated nurses. One in three of OS nurses and of EU nurses are under age 30, compared with only one in 10 of U.K.-educated nurses. OS nurses have a significantly higher profile of male registrants—15 percent, as compared with 10 percent for the U.K. average.

Further analysis of postcode data for some of the urban areas in England highlighted much higher proportions of OS/EU nurses in London. In October

2002, one in four (28 percent) of all registered nurses in Greater London was from OS or the EU.

There is little evidence available on the attitudes, experiences, motivations, and career plans of international nurses in the United Kingdom. Most research that has been published is anecdotal or based on relatively small focus groups drawn from one nationality (see, e.g., Daniel, Chamberlain, and Gordon 2001; Allen and Larsen 2003; Gerrish and Griffith 2004), and much media attention has focused on problems experienced by international nurses who have been given misleading information by recruitment agencies or have been exploited by employers (see, e.g., *Nursing Times*).

A recent survey of 980 international nurses in London (380 responses, 40 percent response rate; Buchan, et al. 2006), which, as noted above has the highest proportion of international nurses does provide some relevant information. Nursing is mainly a female occupation in most countries. Over 90 percent of U.K.-trained nurse are female. There was a higher proportion of male nurses in the international nurse respondents, with 84 percent being female. Two-thirds (66 percent) of respondents reported they were married. Three-quarters of respondents (76 percent) who reported that they were married or had a partner also reported that they were currently living with their spouse/partner in the United Kingdom; one-quarter (24 percent) reported that their spouse/partner was living in their home country.

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

Two-thirds (69 percent) of respondents were working in NHS hospitals in London, 13 percent were working in the independent sector, and 10 percent 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 sub-Saharan Africa (where many were working in the private sector), South Africa (where 40 percent reported they were working in the independent acute sector), and Australia/New Zealand/the United States (where some reported they were working directly for nursing agencies).

FLOWS TO AND FROM THE STOCK OF U.K. NURSES

This section examines trends in inflow and outflow of nurses to the United Kingdom by assessing registration data and by placing international flows in the broader context of other “home based” sources of supply of nurses. As such, it enables the relative contribution of international sources to be examined. The data highlight the rapid growth in inflow of nurses to the United Kingdom since the late 1990s, a direct consequence of the active recruitment policy sponsored by the Department of Health in England.

Meeting the NHS Plan nurse staffing targets has required a concerted effort across the range of potential initiatives:

- to increase the numbers of applicants accepted into preregistration nursing and midwifery education;
- to minimize the number of “discontinuations” (i.e., attrition) from those programs;
- to maximize recruitment of newly qualified nurses into the NHS;
- to improve retention of current staff (including provision of more flexible retirement);
- to maximize return to the NHS of the nonworking pool of nurses; and
- to actively encourage international recruitment.

The supply of “new” nurses from training in the United Kingdom has varied significantly over the last 15 years. The numbers leaving training and entering the U.K. register declined rapidly in the early 1990s, but began increasing a gain from 1997/1998 onward. The number entering the U.K. register from UK training in 2004/2005 was the highest it had been in the last 15 years (Table 2).

As well as new entrants from training, another source of nurse staffing growth has been “returners”—U.K.-trained and U.K.-based nurses who had left practice but have been supported and encouraged back to clinical work. There have been several thousand nurse returners per annum in recent years.

Registration data can be used to assess inflow of registered nurses trained in other countries. The international inflow of nurses to the United Kingdom has risen rapidly over the last 10 years, in part at least as the result of active recruitment supported by the NHS and by private sector employers. This process is often facilitated by recruitments agencies, either in the “home country” of the nurses, or working internationally. In the year up to March

Table 2: Initial Entries to the NMC Register from Preregistration Nursing and Midwifery Training in the United Kingdom, 1990/1991–2004/2005 by Country

	<i>England</i>	<i>N.I.</i>	<i>Scotland</i>	<i>Wales</i>	<i>U.K. Total</i>
1990/1991	14,786	659	2,537	998	18,980
1991/1992	14,184	726	2,513	846	18,269
1992/1993	13,931	717	2,485	936	18,069
1993/1994	13,992	707	2,334	915	17,948
1994/1995	13,997	585	2,060	769	17,411
1995/1996	13,527	581	1,920	842	16,870
1996/1997	11,208	492	1,802	708	14,210
1997/1998	9,416	437	1,688	541	12,082
1998/1999	10,184	421	1,789	580	12,974
1999/2000	11,048	363	1,909	715	14,035
2000/2001	12,501	379	1,771	782	15,433
2001/2002	11,712	393	1,786	647	14,538
2002/2003	NA	NA	NA	NA	18,216
2003/2004	15,862	457	2,331	812	19,462
2004/2005	NA	NA	NA	NA	20,588

Source: UKCC/NMC annual reports; disaggregated data not available for 2002/2003 and 2004/2005.

N.I., Northern Ireland.

2005, a total of 12,670 initial entrants were admitted from all OS countries (Figure 1).

The four most important source countries in 2004/2005 were India, the Philippines, Australia, and South Africa. In 2004/2005, India was the most important source country, as the numbers registered from the Philippines dropped from 4,338 to 2,521. Less than one in 10 of the new non-U.K. entrants was from the other countries of the EU. (*Note:* As noted above the vast majority of international nurse registrants are registered general nurses; there are relatively few midwives and specialist nurses).

Figure 2 highlights the relative importance of U.K. and international sources in contributing to new entrants to the U.K. nurse register. In the early 1990s, about one in 10 “new” entrants was from international sources. In recent years, this has risen to 40–50 percent of new entrants per annum. This figure clearly highlights the move away from “self-sufficiency” during this period, as national policy stimulated active international recruitment to support staffing increases.

English-speaking nurses have a range of career opportunities in Organisation for Economic Co-operation and Development (OECD) countries in

Figure 1: Admissions to the U.K. Nurse Register from European Union (EU) Countries and Other (Non-EU) Countries, 1993/1994–2004/2005.

North America and Australia/New Zealand, as well as in Ireland and the United Kingdom. The United Kingdom has exploited its market advantage in recruiting English-speaking nurses from Africa and Asia, but is a target for

Figure 2: International and U.K. Sources as a Percent of Total New Nurses Admitted to the U.K. Register, 1989/1990–2004/2005 (Initial Registrations).

increased recruitment activity from OECD countries attempting to solve their own nursing shortages. The U.K. nursing press is carrying more nursing job adverts from employers in other developed countries than in previous years. Historically, there has also been a tradition of U.K. nurse emigration to North America and Australia/New Zealand.

Some estimate of outflow of nurses from the United Kingdom can be determined using data held by the NMC on verifications reported to other countries. Whenever a U.K.-registered nurse applies for registration in another country, that country's registration body should contact the NMC for verification of the nurse's details.¹

In 2004/2005 a total of 8,044 verifications were issued, with Australia, the United States, New Zealand, and the countries of the European Economic Area (EEA, primarily Ireland), being the main destination countries/areas. Overall trends in outflow, as measured by verifications, are shown in Figure 3. The number of verifications issued declined in the first half of the last decade, but there was then a rising trend since the mid-1990s, and the numbers appear to have stabilized.

Some indication of the net flow of nurses to and from the United Kingdom can be determined by comparing NMC data on new registrants from

Figure 3: Annual "Outflow" of Nurses from U.K.-Total, and Number to the United States.

Figure 4: Net Flow of Nurses to/from the United States, as Measured by UKCC/NMC Registration Data, 1993/1994–2004/2005.

other countries (inflow), with verification data from the same source (outflow). Figure 4 shows the net effect of combining these two data elements. By this measure, the rapid growth in inflow since the mid-1990s has shown that the United Kingdom has moved from a position of net balance, to becoming a net importer.

Overall, it is important to note that most inflow of nurses to the United Kingdom has been from Australia and a range of developing countries, whereas most outflow has been to other developed countries. The United Kingdom tends to be receiving nurses from English-speaking developing countries in the “new” Commonwealth in Asia and Africa (plus the Philippines), whereas “losing” nurses to English-speaking developed countries in the old Commonwealth (plus Ireland and the United States).

THE IMPACT OF THE DEPARTMENT OF HEALTH’S CODE OF PRACTICE

The Department of Health in England has attempted to limit the potential negative impact of active international recruitment on developing countries

by introducing a Code of Practice for NHS employers. The Code has a broader resonance for policy than its U.K. impact, as it was the first country-level policy instrument that was designed to moderate international recruitment activity. There have been more recent debates at the World Health Assembly about some type of international code; any other development in this area should learn from the U.K. experience.

The Department first established guidelines in 1999 (Department of Health 1999), which required NHS employers not to target South Africa and the West Indies. It then introduced a Code of Practice for international recruitment for NHS employers (Department of Health 2001). This Code was strengthened and extended in 2004, and now also covers recruitment agencies, temporary staff working in the NHS, and private sector organizations providing services to the NHS (Department of Health 2004). The Code “promotes high standards of practice in the ethical international recruitment of health care professionals. All employers are strongly commended to adhere to this code of practice” (Department of Health 2004).

The foreword to the Code notes that “the international mobility of health care professionals is a well established practice that has been going on for many years. More recent times have seen an increasingly large-scale, targeted international recruitment approach by many developed countries to address domestic shortages. This can benefit the health care professional in terms of enriching experience and a chance to increase their quality of life. However, concerns related to the impact this may have upon the health care systems of developing countries also need to be addressed” (Department of Health 2004).

The key points of the 2004 version of the Code are as follows:

- developing countries should not be targeted for active recruitment by the NHS unless the government of that country formally agrees (a list of developing countries is provided);
- NHS employers should only use recruitment agencies that have agreed to comply with the Code;
- NHS employers should consider regional collaboration in international recruitment activities;
- staff recruited from abroad have the same legal protection as other employees;
- staff recruited from abroad should have same access to further training as other employees.

As such it is important to stress that the Code is not intended to prevent flows of individual nurses from developing countries, and it does not cover all employers in the United Kingdom. Private sector employers are not required to comply (unless they are involved in providing services to the NHS) and the Code does not prevent health professionals taking the initiative to apply for employment in the United Kingdom, or to come to the United Kingdom for training purposes.

Given these limitations, the Code has not stopped all migration of health workers from developing countries on “the list.” NMC data show that in 2004/2005 more than 3,000 nurses entered the U.K. register from developing countries on the so-called “banned” list, accounting for at least one in four entrants from non-EU countries, and with little change in that proportion in the previous 4 years.

Longer-term trends in entrants to the United Kingdom from selected sub-Saharan African countries also highlight that there has been little sign of any consistent trend of reduction in inflow of nurses from these countries since the 1999 guidelines and 2001 Code was introduced.

Figure 5 shows the number of entrants to the NMC register from selected countries. South Africa and the West Indies were noted in the 1999 guidelines, and all the countries illustrated in the figure were covered by the 2001 Code, so no active NHS recruitment should have been occurring after November 2001.

There has been year-on-year fluctuation in the number of entrants from these countries, with an overall rising trend until 2003/2004, and an apparent drop between 2003/2004 and 2004/2005, but with variations between countries. For example, South Africa was first a “no go” area for active recruitment from November 1999, yet inflow grew markedly after that date, and then fluctuated. The limitation of the registration data in assessing the impact of the Code is that it cannot be used to assess how many of these nurses were coming to the United Kingdom to work in the private sector (which is not covered by the Code), or had arrived in the United Kingdom at their own initiative.

The overall impact of the Code is difficult to assess, given data limitations, and the fact that the Code does not “ban” inflow, it moderates active recruitment. It has, however, acted as an important decision support framework for local NHS employers as they have engaged in international recruitment, providing them with good practice guidelines and with information on which countries are acceptable targets for international recruitment activity (Buchan 2003).

Figure 5: Trend in Annual Number of New Registrants on U.K. Nursing Register from Selected Countries, 1998/1999–2004/2005.

CONCLUSION

Given continued demand for nurses in the United Kingdom, the aging of the available stock, and the increasing globalization of labor markets, it is likely that the historically high levels of inflow of internationally recruited nurses to the United Kingdom will continue over the next few years; however, the “peak” number reached in 2002/2003 may not be repeated. Reduced requirements for “basic” entry grade nurses in the acute sector as more newly qualified nurses emerge from training in the United Kingdom has reduced demand, as has short-term financial difficulties in some NHS-employing organizations in England. International recruitment activity in the short term will now focus on “hard-to-fill” posts. New English language tests and other revised requirements for international applicants, which were introduced by the Nurses and Midwives Council in September 2005, may restrict successful applications from some countries and have added to the “bottle-neck” of international nurse applicants (Nursing Standard 2005). However,

demographic-driven demand for health care, combined with a potential reduction in supply of U.K. nurses as many more reach potential retirement age means that international recruitment is likely to remain on the longer term agenda, even with further growth in the number of home-based nurses being trained in the United Kingdom.

ACKNOWLEDGMENT

The author acknowledges support from the Nuffield Trust in preparing this paper; the author alone is responsible for the content and conclusions.

NOTE

1. The NMC data indicate an intention to nurse in other countries, it does not necessarily record an actual geographical move. There will also be some double counting when a nurse applies to move to more than one country, and some of the outflow will be of foreign nationals who, having undertaken pre- or postregistration nurse education in the United Kingdom, return home.

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