

**ETHICAL INTEGRATION OF INTERNATIONALLY EDUCATED  
HEALTH PROFESSIONALS: ETHICAL AND REGULATORY CONTEXTS**

**THE UNITED KINGDOM**

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## Abstract

The UK health system has always relied on internationally-educated health professionals largely from Asia, Africa, Australia/New Zealand and the Caribbean. In recent years, however, inflows of such individuals to the various UK professional registers have reduced significantly; and the relatively small share of health professionals coming from the EU/EEA has increased. These trends reflect the impact of: a) general immigration restrictions and health professional registration changes from 2006, which have led to a collapse in numbers coming to the UK from outside Europe; and b) the fact that EU/EEA health professionals are continuing to exercise their rights of free movement particularly following the recent EU enlargements in 2004 and 2007. This new situation contrasts with the early years of the last decade when the then UK government's policy of significant National Health Service (NHS) workforce expansion instigated a period of active international recruitment on an unprecedented scale. Overall, the key feature of the UK's mobility profile is the sheer range of countries – more than 150 worldwide - from which health professionals have migrated. Moreover, the sheer variety of professional cultures represented within the EU/EEA makes integration of health professionals from that source equally as challenging as for other ostensibly more significant movements from single-countries (e.g. India; The Philippines). Another key point here is that EU/EEA linked flows cannot be controlled by UK policy makers (whereas non-EU flows can be influenced by immigration regulations). There are several quality/safety concerns associated with this including: a) the fact that because of EU-level free movement agreements, professional regulators cannot test for English language competence as a pre-requisite for registering individuals from the EU/EEA; b) the need for EU mobility legislation to require Continuing Professional Development (CPD); and c) the need for more effective cross-border information sharing to restrict movement of “unsafe” individuals. The integration of internationally-educated health professionals has also challenged UK workforce planners and it is only very recently that attempts have been made to link planning and immigration policy (e.g. in relation to the shortage professions list). National-level mechanisms to manage movement of internationally-educated health professionals include high-profile Codes of Practice on International Recruitment and bilateral agreements between the UK and several overseas governments. However, questions remain about the success of these policies. The extent to which the UK will now remain self-sufficient in health human resources; and whether “ethical recruitment” can ever really work is also questionable.

## **Introduction**

The UK has a history as a destination country for internationally-educated health professionals going back to the 1950s and earlier. From the late 1990s, however, the UK government's policy of significant National Health Service (NHS) workforce expansion (DH, 2000) instigated a period of active international recruitment on an unprecedented scale (Young et al, 2008; 2010). The policy of active international recruitment was subsequently wound down from 2006 and more restrictive general immigration and professional regulation rules were introduced. The general immigration rules have been further tightened following the change of political party in government in 2010. These changing policy approaches are a key element of the UK experience. The other aspect of the UK story is the increasingly complex picture of migration patterns, in particular the shift towards relatively more significant flows from the European Union (EU) and European Economic Area (EEA)<sup>1</sup>; although most internationally-educated health professionals registering in the UK still come from non-EU/EEA sources.

This paper will first summarise migration flows inferred from professional registration data for the health professions of interest: medical doctors, nurses and midwives, dentists, pharmacists and allied health professionals (AHP) including physiotherapists, occupational therapists (OTs) and speech & language therapists (SLTs). The paper then outlines the UK's approach to the integration of internationally-educated health professionals, with particular emphasis on: the changing nature of international recruitment policy, immigration rules and professional regulation requirements; the particular free-movement rules surrounding migration within the EU/EEA; and the responses required of workforce planners and individual employers to the challenges involved in integrating an internationally-diverse workforce into the NHS.

## **Internationally-Educated Health Professionals in the UK**

The UK health system has always relied on immigrants. Foreign-educated medical doctors accounted for 36.8% among all registered doctors in 2008 of which approximately a quarter came from the EU/EEA and three-quarters from the rest of the world. The share of foreign-educated nurses/midwives was smaller but still represented more than 12%. The main countries of origin have been – for example: India, Pakistan, Nigeria and South Africa, and Australia for medical doctors; and Australia, New Zealand, South Africa, Nigeria, Zimbabwe, and the West Indies for nurses, with the addition of India and The Philippines following active international recruitment. Most midwives migrating to the UK are from African countries such as South Africa, Zimbabwe and Nigeria. By contrast in pharmacy, dentistry and the AHPs the majority of individuals on/applying to the professional registers have been UK-educated. Where individuals are internationally-educated, most in pharmacy have been from a country with a reciprocal arrangement such as Australia and New Zealand. For AHPs the majority of international applications have been from Australia, India and South Africa

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<sup>1</sup> In the context of the EU, a further distinction can be made between the pre-2004 member countries or the EU15 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Portugal, Spain, Sweden, The Netherlands, and the United Kingdom), and those countries that joined in 2004 (Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) and 2007 (Romania and Bulgaria), which are collectively referred to as the EU12. The EEA is the wider entity that, in addition to EU countries, includes Iceland, Norway and Liechtenstein; and as Switzerland follows EEA training requirements it is also treated as EEA. Individuals from EEA countries have similar rights to work in the UK as EU citizens.

(Young et al. 2009); with physiotherapists accounting for most of the small number of EU/EEA-educated AHPs that move to the UK (Petchey and Needle, 2007). The exception is dentistry where more individuals on the register are from the EU/EEA than the rest of the world (14.9% compared with 11.4% in 2008) (Young 2011). The other key feature of the UK's mobility profile is the sheer range of countries – more than 150 worldwide - from which health professionals migrate.

In recent years there has been a significant reduction in inflows of internationally-educated health professionals to the various UK professional registers. In addition, the relatively small share of health professionals coming from the EU/EEA has increased. These trends reflect the impact of: UK immigration and professional registration changes from 2006, which have led to a collapse in numbers coming to the UK from outside Europe; and the fact that EU/EEA health professionals are continuing to exercise their rights of free movement particularly following the recent EU enlargements in 2004 and 2007 (see Table 1 for numbers of new registrants before and after these changes). Amongst medical doctors, for example, non-EU/EEA inflows accounted for 64.2% of new registrants in 2003 compared with 24.1% in 2008 (Young 2011). Similarly for nurses/midwives between 8,000 and 15,000 non-EU/EEA-educated individuals were added to the register annually in the early years of the last decade. This figure has now fallen to less than 1,000 per annum in 2010. Put another way, in 2009/10, 78% of total international nurse registrants were from the EU, compared with less than 7% in 2001/2 (Buchan and Secombe 2011). In dentistry 36.1% of new registrants were EU/EEA-educated compared with 19.9% from the rest of the world in 2008 (Young 2011). Although the EU15 still accounts for most EU/EEA health professionals registered overall, the EU12 is rapidly catching up in the context of new inflows. In 2008 alone, for instance, the EU15 and EU12 accounted respectively for 1166 and 970 new registrant medical doctors. Also in 2008, 932 new registrant nurses/midwives were from the EU12 against just 437 from EU15 countries (Young 2011) (see Table 1 for detailed trends). Overall, Germany is now the most significant EU15 source country for health professionals in terms of numerical totals on the various professional registers, followed by Italy, Greece and Spain. By far the largest recent increases have come from Poland (the EU12 country most targeted for active international recruitment), but others including Bulgaria and Romania that only entered the EU in 2007 are also becoming increasingly significant in relative terms (EMN 2006; Pollard et al 2008). During this time, certain professions (e.g. dentistry) have also become relatively more reliant on European migrants; and others (e.g. midwifery; general medical practice) now need EU/EEA recruits due to the professional regulation requirements restricting other sources (Young et al. 2009).

## **Policy, regulation and interventions**

*International Recruitment and Immigration Policy* – The UK has had several distinct approaches to internationally-educated health professionals in recent years. This is in the context both of general immigration and the way in which health professionals specifically have been dealt with within the immigration system. Four “policy periods” are identifiable (Table 2):

- From 1998 to 2006: “Active international recruitment of health professionals and general immigration openness”
- From 2006 to 2008: “International recruitment wound down, plus tighter general immigration rules introduced”
- From November 2008: “Further tightening of general immigration rules which also affects health professionals”

- From 2010 onwards: “Another phase of general immigration rule tightening which also affects health professionals”

From 1998-2006, policy centred on the then Labour government’s ambitious plan of NHS investment and related workforce expansion targets. These could not be met on the timescale required through growth of domestic training capacity alone (DH 2000). This led to the UK’s high profile recruitment policy and its openness to immigration across the health professions (Table 2 column 1). It was in this context and the situation of economic growth at the time that the UK also opened its borders to health workers from the 10 countries that joined the EU in 2004. No restrictions were placed on immigrants from Malta and Cyprus reflecting the UK’s historical ties with those countries. Those from the remaining EU10 countries in Central and Eastern Europe had only to register with a Worker Registration Scheme (WRS) and work legally for 12 months (with no more than 30 days break) to obtain a residence permit confirming their right to live and work in the UK. Such policy attitudes contrasted with most of the EU15 where more restrictive transitional arrangements were employed for the 2004 EU joiners (MAC, 2009a).

In 2006 active international recruitment was wound down and immigration rules for non-EU/EEA health professionals were tightened as policy-makers realised that UK training expansion was coming on stream (DH 2006a; DH 2006b; NHS Employers, 2006). Employer organisations now had to recruit resident workers (or EEA nationals) before looking to other candidates; and several health professional categories were removed from the shortage occupations list (which officially indicates whether or not there are enough resident workers in the UK to fill the available jobs in a particular sector) (Table 2 column 2). Arrangements for Bulgarian and Romanian immigrants were also more restrictive when those countries entered the EU in 2007 than for the 2004 EU-joiners. Individuals had to be able to support themselves and family without help from public funds (i.e. social security); and had to apply for prior permission to work from the UK Border Agency. Again, however, once they have worked legally as an employee for 12 months without a break Bulgarian and Romanian workers have full EU free-movement rights (MAC, 2008).

Further changes came for non-EU/EEA nationals in 2008/9 with the “biggest shake up of the [UK] immigration scheme for 45 years” (NHS Employers, 2008 p.1). This saw the streamlining of the employment categories that afforded eligibility for non-EU/EEA immigration (from 80 routes into five Tiers) within a new points-based system; and further tightening of the shortage occupations list (Table 2 column 3). In addition, employing organisations now needed a sponsorship licence to recruit skilled/temporary migrants - which, for example, affected health professionals wishing to take up short-term clinical attachments (DH 2008; MAC, 2009a).

With the change of government in 2010, from Labour to the Conservative/Liberal Democrat Coalition, immigration policy has again been reviewed. A number of new changes have been introduced governing the way that individuals from outside the EU/EEA can work, train or study in the UK (Table 2 column 4). Many of the changes (e.g. closure of and/or numbers caps on certain immigration routes/Tiers in the points based system) are already in place with the intention being “to ensure that net migration reduces between 2010 and 2015 to the levels previously seen in the 1990s” (NHS Employers 2011a) (see also NHS Employers 2010). Further consultations are also on-going regarding: limiting rights of settlement to live in the UK arising from immigration through the different Tiers; and new recommendations further to tighten the shortage occupations list by raising it to a higher skills level (UKBA 2011). The response both from NHS Employers (representing local NHS organisations) and the professional bodies however stresses the importance of continued immigration to maintaining

provision of health services and the sustainability of, for example, medical training within the UK system (GMC 2010a; NHS Employers 2011).

Immigration arrangements remain less restricted for EU/EEA citizens. The WRS, for example, has now closed (from May 2011) because under the terms of the EU Treaty of Accession the UK cannot apply transitional restrictions on EU-joiners for longer than seven years. Individuals from the 2004 joiner countries therefore now have access to the UK labour market on exactly the same terms as other EU nationals. Restrictions still apply however to Bulgarians and Romanians and may be extended to 2013. In addition, the current coalition government firmly intends to apply transitional controls on labour market access to nationals of any country joining the EU in the future.

*Professional Regulatory Arrangements* - In 2006, at the same time as international recruitment policy was wound down, the professional registration bodies also tightened their requirements for non-EU/EEA health professionals (Table 3 column 1). They saw this as in line with their role of ensuring quality and patient safety in the face of the large-scale migration of earlier years. The changes they made included more stringent language requirements for non-EU/EEA nurses, the removal of top-up courses for midwives lacking UK-equivalent qualifications and the removal of reciprocal recognition for Australian and New Zealand pharmacists and AHPs (NMC 2005a; WRT 2009a; 2009b; 2009c). Certain profession-specific restrictions (e.g. additional adaptation requirements or minimum times to have been in practice) were also placed on Central and East European health professionals applying for UK registration from the EU12 countries after 2004 and 2007.

In contrast, there are few restrictions on other EU/EEA educated individuals moving to the UK (Buchan, 2006) (Table 3 column 2). This is because the EU/EEA actively promotes free movement of health professionals through a system of mutual recognition of professional education, training and qualifications based on EU-level Directives (Box 1). Two types of Directive are in place. Medical doctors, dentists, general nurses, midwives and pharmacists are covered by what are termed Sectoral Directives. Harmonization of education/training and skills means they are entitled to automatic registration by their UK regulator (and equivalents in other EU/EEA member states). Others including specialist nurses and the various AHPs (e.g. physiotherapists, OTs and SLTs) are covered by the General Directive (Petchey and Needle, 2008). Under this, recognition is decided case by case – i.e. those with qualifications and experience equivalent to UK qualifiers can be registered but for others a period of adaptation may be required. Unlike health professionals from non-EU/EEA sources, no EU/EEA-qualified individual has to prove language proficiency in order to register. More recently, another EU Directive 2005/36/EC aimed to reduce regulatory barriers to free movement still further. Amongst other things, it allowed professionals registered in another EU/EEA member state to practice in the UK for a limited period each year *without* registering with a UK professional regulator (Box 2).

The fact that professional regulators cannot test for English language competence as a prerequisite for registering individuals from the EU/EEA is a major concern for many in the UK. This is particularly the case for doctors and nurses, where the view is that migrants can feel competent in general with English, but that does not mean that they automatically have “the right” English to work effectively in the health service (Anon 2010; 2011; Beckford 2011; NMC 2005b; NMC 2009). In addition, the UK, like other EU/EEA states has its own particular ethos and system of healthcare delivery that has emerged as a result of cultural and historical factors, which are often intangible and difficult to quantify. There are therefore additional concerns about the “real” equivalence of education and training (Allen and Carter, 2007; Cowan, 2006; Wang, 2007; Young et al, 2009). Recognising potential difficulties

within these areas is vital: first, to ensure the individual patient experience is safe and of high quality; second, to enable NHS organizations to get maximum value from employing EU/EEA migrants; and third, to assist individual professionals to gain positive benefits from moving to work in the UK. Although dedicated support has been in place, it has often been in the context of particular recruitment campaigns (Ballard et al, 2004b; Porter and Powell, 2005). The knowledge learnt has often been lost because the NHS lacks an infrastructure to share experience about how best to ensure language competency, and deliver professional/clinical induction and support both for EU/EEA migrants and other internationally-educated health professionals (Bola et al 2003; Close 2002; Illing et al 2010; Winkelman-Gleed and Seeley 2005; Young et al, 2010). Perhaps most significantly, the sheer variety of professional cultures represented (from 31 countries) makes the integration of EU/EEA educated health professionals equally if not more, challenging than for other ostensibly more significant movements from single-countries like India and The Philippines (Young et al, 2009).

Other quality/safety concerns include: a) the need for EU mobility legislation to require Continuing Professional Development (CPD) to ensure the continuing fitness and suitability to practice of potentially mobile health professionals; and b) the need for more effective cross-border information sharing between regulators to restrict movement of “unsafe” individuals within Europe (BMA 2009; Griffiths 2002; Hazell 2009; Mead 2003; NMC 2005b). The reported view of the UK professional regulators is that quality assurance arrangements are currently inadequate (Meikle 2011; Young et al, 2009). Such opinion has been reinforced by: various high profile cases where, for example, mistakes have been made by doctors practising in the UK by virtue of qualifications gained elsewhere in the EU (Meikle 2009; Meikle and Connolly 2009); and the example of so called “flying doctors” who have their main job elsewhere in the EU but come to the UK to provide locum cover (e.g. at weekends) (Harding et al. 2005; Sears, 2008).

All of these language and quality/safety issues are reflected in: a) the UK’s instigation of the cross-EU initiative on “Health Professions Crossing Borders” (AURE 2005; HPCB 2007)<sup>2</sup>; and b) the responses of the UK professional bodies (GMC 2010b; RCN 2011a) to the latest proposals intended to modernize the Professional Qualifications Directive (summarized in Box 2) and thereby stimulate even greater free movement of health professionals within the EU/EEA (EC 2011) (see also EHMA 2011; RCN 2011b). In the UK the latest development is an on-going House of Lords enquiry into the mobility of health professionals between EU member states: “The sub-committee has published written and oral evidence as it prepares what is expected to be an extremely critical report on the current arrangements” (Meikle 2011: 1) (see also Anon 2011a; 2011b). Of course it must also be noted that not all in the UK see a major problem here. The Health Professions Council (which regulates AHPs), for example, states on its website that it does “not have any evidence which would support that this [language skills] is a problem for the professions we regulate”. Again, “good employment practices, including robust arrangements for selection and induction” are seen as key “in making sure any professional is fit for the job they are doing and that patients and the public are protected” (HPC undated).

*Workforce Planning and Development* - Historically, medical doctors have been the health profession most covered by workforce planning, with others underserved by comparison (Buchan 2004). Even within medicine, however, the internationally-qualified contribution was not factored in adequately (Bloor et al. 2005). Instead planning models focussed on

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<sup>2</sup>See: <http://www.hpcb.eu/>

quotas for undergraduate education and post-graduate specialist and GP training - the aim being to achieve appropriate throughput to allow “the right numbers” onto the career ladder in different service/specialty areas. The thousands of internationally-educated doctors in NHS posts lacking the post-graduate training accreditation necessary to achieve promotion were therefore overlooked – regarded, some would argue, as a dispensable resource supplementary to the “main” medical workforce (Grant et al, 2004) (see also Allan et al. 2004 and Smith et al. 2006 re. nurses). Another consequence of planning inadequacies is that little account was taken of the need to pace international recruitment and tailor it down as increased UK training numbers began to feed into the system in 2006 (Health Committee 2007; Young et al. 2008). Together with the coincidence of NHS budget cuts that year, this meant that large numbers of UK-qualifiers (nurses, medical doctors and allied health professionals) could not find work. This in turn triggered the rapid policy turn-around described above away from mobility, which caused significant uncertainty amongst affected groups of internationally-educated health professionals (Carlisle, 2005; Casciani 2006a; 2006b) (see also BBC, 2009 regarding impact of later immigration rule changes).

Such short-comings have since been recognised (Bosworth et al. 2007; Curson et al. 2008; Darzi 2008). Amongst other changes, a combined Workforce Review Team (WRT) was established which was responsible for identifying development priorities for all the health professions. Another WRT responsibility (together with NHS Employers and Skills for Health) was to provide evidence to the Home Office’s Migration Advisory Committee (MAC), which reviews the shortage professions list described above<sup>3</sup>. This arrangement meant that the integration of internationally-educated health professionals is more clearly linked to NHS workforce planning (see for example WRT 2009a; 2009b; 2009c; 2009d; 2009e). It also allowed for the needs of the UK’s constituent countries (e.g. Scotland) to be assessed separately from UK needs as a whole (DH 2009; MAC 2009b). A key point here is that EU/EEA linked flows cannot be controlled by UK policy makers (whereas non-EU flows can be influenced by immigration regulations). Therefore increasing migration from EU/EEA countries is arguably a bigger challenge for health workforce planning than the mobility patterns previously typical for the UK. Another problem is the lack of useful workforce data at EU/EEA level (EFPH 2003; EC 2008)

### *National Level “Ethical” Recruitment Policy*

National-level mechanisms to manage movement of internationally-educated health professionals include a high-profile Code of Practice on International Recruitment and bilateral agreements between the UK and several overseas governments. First introduced in England in 2001 (DH, 2001) and later revised to encourage independent sector as well as NHS sign-up (DH, 2004), the Code aims to prevent recruitment from over 150 countries experiencing health professional shortages. A separate Code for Scottish healthcare was launched in 2006 (Scottish Office, 2006). The list of countries from which recruitment is restricted includes developing economies in Africa, East and South Asia, the Middle East, the Caribbean, South America and the Pacific Islands. It also includes EU candidates and other countries in what might be termed “wider Europe” (i.e. Albania; Bosnia & Herzegovina; Croatia; Georgia; Macedonia; Moldova; Tajikistan; Turkey; Uzbekistan). Other countries including India, The Philippines and China have restricted recruitment to particular professional groups and/or geographical areas through bilateral agreements. Bilateral agreements were also signed in the context of the UK’s active recruitment policy in Europe between 2001/5, for example with Spain, Germany, Austria, Italy and Poland. Such

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<sup>3</sup> Some WRT responsibilities have now been subsumed within the recently established Centre for Workforce Intelligence (CfWI)

arrangements were later set within wider policy on international development (Buchan and Dovlo 2004; Crisp 2007; DfID 2007; DH and DfID 2008; Robinson and Clark 2008). The bilateral agreement with South Africa in 2003 reflected this approach as it focused on sharing expertise through time-limited placements of healthcare staff. Similarly, below national level there are Royal College sponsorship schemes for medical doctors; and exchange agreements and twinning or staff volunteering partnerships between local NHS organisations and bodies abroad (e.g. providers and regional governments) (Sloan 2005).

In terms of impact the evidence regarding all these mechanisms is equivocal (Buchan et al. 2008; DH and DfID 2008). By providing adaptation to the UK system but no longer-term job prospects, for example, some independent sector nursing homes encouraged so called “back door recruitment” which allowed the Code to be circumvented (Buchan et al. 2006). The assumption was that nurses would move into the NHS when they achieved full registration (Buchan et al 2008). In addition, although qualitative evidence suggests that NHS organisations and private agencies were influenced against targeting countries covered by the Code of Practice (e.g. in Africa and Europe outside the EU), individual applications for UK professional registration still continued in large numbers from those countries (Young et al, 2008). One view, therefore, is that the UK must move to a position of self-sufficiency in its production of health professional labour (Mellor undated). This is not least because of the need to reduce the “risks” (e.g. of migrants by definition being a less constant workforce given their potential to re-migrate). However, it is also because UK policy-makers want to be (seen to be) “doing the right thing” in relation to potentially vulnerable health systems that are the main UK migration sources (Jenkins 2004; Mellor 2003). Indeed it was this realisation – triggered by complaints from countries such as South Africa - that led to the Codes mentioned above and the subsequent linking of healthcare mobility to international development policy. Of course questions continue about how far the International Recruitment Code of Practice is being adhered to (NHS Employers 2011); the extent to which the UK will now remain self-sufficient in health human resources; and whether “ethical recruitment” can ever really work (Bundred and Levitt 2000; Deeming 2004; Khan 2005; Sartorius 2005).

## **Conclusion**

As the profile of internationally-educated health professionals described, the UK has always relied on internationally-qualified health professionals to help it address its workforce supply needs. In the past mobility has mainly been from outside Europe but European sources have recently started to become more important at least in relative terms. Practically from a UK viewpoint, the sheer variety of countries and professional cultures represented in migration figures makes effective induction and workforce integration measures a major challenge for NHS employers. Another practical question relates to the implications of international mobility for UK workforce planning, which to date has not factored the potential impact of return migration to source countries due to the lack of accurate information on outflows. There is also a continuing moral question regarding the ability of ethical recruitment policy to restrict negative impacts on source countries.

**Table 1: Health Professionals from UK, EEA and other world regions - Number of new registrants in 2003, 2004, 2006 and 2008**

<b>SOURCE – Primary Qualification of New Registrants</b>	<b>2003</b>	<b>2004</b>	<b>2006</b>	<b>2008</b>
<b>MEDICAL DOCTORS</b>				
No. All Sources	18,684	14,736	11,777	11,794
No. (%) UK	4,731 (25.3)	4,732 (32.1)	5,620 (47.7)	6,770 (57.4)
No. (%) EEA	1,956 (10.5)	3,674 (24.9)	2,994 (25.4)	2,181 (18.5)
No. (%) Rest of World	11,996 (64.2)	6,330 (43.0)	3,163 (26.9)	2,841 (24.1)
<b>OF WHICH:</b>				
EU15	1732	2437	1703	1166
EU12	175	1172	1251	970
<b>NURSES/MIDWIVES</b>				
No. All Sources	31696	34522	31342	25336
No. (%) UK	18212 (57.5)	19457 (56.4)	20946 (66.8)	21612 (85.3)
No. (%) EEA	889 (2.8)	1125 (3.3)	1833 (5.8)	1390 (5.5)
No. (%) Rest of World	12595 (39.7)	13940 (40.4)	8563 (27.3)	2334 (9.2)
<b>OF WHICH:</b>				
EU15	782	1007	940	437
EU12	84	87	848	932
<b>DENTISTS</b>				
No. All Sources	2030	2017	2412	2362
No. (%) UK	1119 (55.1)	940 (46.6)	1024 (42.5)	1039 (44.0)
No. (%) EEA	475 (23.4)	736 (36.5)	941 (39.0)	852 (36.1)
No. (%) Rest of World (a)	436 (21.5)	341 (16.9)	447 (18.5)	471 (19.9)
<b>OF WHICH:</b>				
EU15	nd	467	680	526
EU12	nd	0	551	399
<b>PHARMACISTS</b>				
No. UK-qualified (b)	nd	nd	1538	2316
No. EEA	443	278	501	413
No. Rest of World	159	91	524	nd
<b>OF WHICH:</b>				
EU15	443	248	278	190
EU12	---	29	220	220

Source: GMC, NMC, GDC and RPS (nd indicates no data provided for those years).

- (a) Rest of World here includes those who passed the International Qualifying Exam, which tests the knowledge/clinical skills of non-EEA dentists whose qualifications are not already recognised for full registration.
- (b) Figures for pharmacists exclude Northern Ireland; and since the RPS does not provide overall figures for all sources it is not possible to calculate the percentage of new registrant pharmacist from UK, EEA or Rest of World.

**Table 2: Timeline of Immigration and Mobility Policy for Health Professionals<sup>4</sup>**

1. 1998-2006 – Active international recruitment of health professionals and general immigration openness	2. Changes from 2006 – International recruitment wound down, plus tighter general immigration rules introduced	3. November 2008 to 2010 – Further tightening of general immigration rules which also affects health professionals	4. 2010 onwards – Another phase of general immigration rule tightening which also affects health professionals
<p>During this period <b>already qualified</b> health professionals from the EU and elsewhere were actively recruited under the auspices of bilateral agreements. Those targeted included: medical doctors (GPs and senior hospital doctors in shortage specialties); nurses (entry Bands 5/6 to more senior Bands 7/8 across all specialties); dentists; pharmacists; and AHPs. Countries targeted included: India, Philippines, Spain, Germany, Austria, Italy and Poland. Midwives were not targeted nationally, but local Trusts recruited in Germany, Scandinavia and Greece. Other countries targeted by Trusts included Australia and New Zealand.</p> <p>The UK also opened up to health professionals from the 2004 EU-joiners; and non-EEA migrants (e.g. junior doctors) were free to work or train in the UK.</p>	<p><b>Medical doctors and dentists</b> from outside the EEA now needed to meet the requirements of an employment category of the Immigration Rules (e.g. work permit provisions). Access to post-graduate training was restricted for non-EEA nationals unless they had trained at UK medical schools.</p> <p>Although senior <b>nursing</b> positions and shortage specialties remained on the shortage occupations list, entry grades were removed to ensure that UK resident nurses could find an NHS post. NHS organisations now had to advertise vacancies first and only if they were unable to fill the post could they turn to international recruitment. Non-EEA <b>midwives</b> continued to need a job offer to qualify under the overseas nurses and midwives immigration category.</p>	<p><b>Shortage Occupations List</b> – Only restricted specialties and grades of <b>medical doctors, dentists, nurses and pharmacists</b> are now on the list. <b>Midwives</b> are not included because “overseas recruitment is not [seen as] a sensible mechanism for alleviating shortages” – due to the particular (autonomous) nature of UK practice (MAC, 2009a, p.80).</p> <p><b>Other categories:</b></p> <ul style="list-style-type: none"> <li>▪ Non-EEA medical doctors applying for <b>specialty training</b> are now subject to the resident labour market test (i.e. employers must show that they cannot fill posts from UK/EEA candidates) (DH 2008).</li> <li>▪ Non-EEA nurses can only enter the UK as a <b>sponsored skilled worker</b> if they have a job offer from a licensed NHS sponsor.</li> <li>▪ Doctors undertaking the UK’s medical equivalence exam or a clinical attachment, and dental observer posts are <b>business and special visitors</b> - only granted UK entry for six weeks at a time, up to six months maximum.</li> </ul>	<p><b>Shortage Occupations List</b> – The MAC is currently consulting on the government’s proposal further to tighten the list. The NHS response stresses that several occupations should remain on the list including: medical consultants in various psychiatry fields, non consultant, non training posts in specialties such as anaesthetics, emergency medicine and paediatrics, specialist nurses in operating theatres, hospital based pharmacists (NHS Employers 2011b).</p> <p><b>Other categories:</b></p> <ul style="list-style-type: none"> <li>▪ Several routes in the points-based immigration system are now closed or are closing to new entrants.</li> <li>▪ A cap has been placed on the number of sponsored skilled workers from outside the EEA.</li> <li>▪ Foundation programme medical trainees are exempt from changes to their current immigration route, but will be affected by changes to Tier 1 (Post-study work).</li> <li>▪ Proposals around the medical training initiative (MTI) will be a key upcoming area of concern for the NHS.</li> </ul>

<sup>4</sup>Compiled from:

<http://www.nhscareers.nhs.uk> (Accessed 03/04/2007)

<http://www.nursinguk.nhs.uk/index.asp> (Accessed 22/11/2005)

<http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Specific-guidance> (Accessed 22/05/2009)

<http://www.ukba/homeoffice.gov.uk/workingintheuk/> (Accessed 22/05/09)

<http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment> (Accessed 06/09/2011)

**Table 3: Professional Registration Requirements<sup>5</sup>**

	<b>1. Health Professionals from Outside the EEA</b>	<b>2. EEA Health Professionals</b>
<b>Medical Doctors</b>	Since 2002 the General Medical Council (GMC) can grant full registration to doctors with World Health Organisation-recognised non-EEA primary medical qualifications. Doctors must also be on the GMC's specialist or GP registers to work as NHS hospital consultants (senior specialists) or GPs. The Post-graduate Medical Education Training Board (PMETB) confirms specialist/GP eligibility. To undertake UK post-graduate training doctors must pass the Professional Linguistic Assessment Board (PLAB) and International English Language Testing System (IELTS) exams (the latter at Level 7 in each section).	EEA doctors are eligible for immediate full GMC registration; also specialist and GP registration (provided their qualification is listed on the European Medical Directive and/or they submit appropriate evidence). EEA-qualified doctors who are not EEA nationals; and EEA doctors in specialties not considered equivalent first have to confirm registration eligibility with PMETB. EEA doctors are not required to pass a language test. However guidance recommends NHS organisations satisfy themselves of communication skills (e.g. at interview) provided assessment methods are consistent for all.
<b>Dentists</b>	To be eligible for registration with the General Dental Council (GDC), non-EEA dentists must pass the International Qualifying Exam and IELTS (with a minimum score of 6.5 in each section and an overall average of Level 7).	EEA dentists have automatic registration with the GDC provided their qualification has been gained within the EEA, however those from new member states joining in 2004/07 may have to satisfy additional criteria (usually to have practiced for three of the last five years).
<b>Nurses</b>	From 2006 non-EEA nurses must pass the Overseas Nurses Programme (ONP) before being registered with the Nursing and Midwifery Council (NMC). The ONP is a 20-day programme of protected higher education and supervised practice in a local Trust, but places are limited (Adaptation has always been required but the ONP introduced consistency) (NMC 2005a). Non-EEA nurses must also pass IELTS, with tougher requirements than before (WRT 2009a).	EEA-qualified nurses have automatic registration with the NMC however those from new member states joining in 2004/07 may have to undergo additional supervised practice/adaptation to satisfy registration criteria.
<b>Midwives</b>	Midwives must be NMC-registered and submit an Intention to Practice (ITP) form. From 2005/6 ITPs must be signed by a UK-based supervisor, which is difficult for non-EEA midwives. The NMC also ruled that only those with UK-equivalent qualifications are eligible for registration: there are no longer top-up courses for non-EEA midwives (WRT, 2009b).	EEA midwives are eligible for registration with the NMC. Since the changes (described opposite) which effectively restrict migration of non-EEA midwives to the UK, Europe is the main potential source of midwives to supplement the UK workforce if necessary.
<b>Pharmacists</b>	Non-EEA pharmacists must apply to the Royal Pharmaceutical Society (RPS) adjudicating committee for registration. They must have a qualification comparable to a UK degree and be eligible to register overseas. All must undertake accredited UK pre-registration training. Reciprocal arrangements applying to Australia and New Zealand were abolished in 2006 (WRT, 2009c).	EEA pharmacists are covered by mutual recognition policy and eligible for automatic RPSPB registration.
<b>Allied Health Professionals (Physios, OTs, SLTs and others)</b>	Non-EEA AHPs must apply to the Health Professions Council (HPC) for registration. The possible outcomes include: acceptance to the register; rejection due to insufficient basic levels of training and qualifications; rejection but with opportunities to join the Register following further training, experience or adaptation; and a request for further verification or invitation to attend a Test of Competence based on the particular professions' Standards of Proficiency.	EEA AHPs are not covered by mutual recognition policy so recognition by the HPC is on a case-by-case basis and an aptitude test and/or adaptation period in the workplace may be required

<sup>5</sup>Compiled from:

[http://www.nhs Careers.nhs.uk/img\\_qa.shtml](http://www.nhs Careers.nhs.uk/img_qa.shtml) (Accessed 03/04/2007)

[http://www.sts-mrc.org.uk/appeal\\_sheet6.html](http://www.sts-mrc.org.uk/appeal_sheet6.html) (Accessed 02/12/2004)

[http://www.rcn.org.uk/resources/international/noneu\\_nurses.php](http://www.rcn.org.uk/resources/international/noneu_nurses.php) (Accessed 22/11/2005)

<http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Specific-guidance> (Accessed 14/04/2009)

<http://www.pmetb.org.uk/index.php?id=certification> (Accessed 14/04/2009).

**BOX 1**  
**MUTUAL RECOGNITION DIRECTIVES FOR HEALTH PROFESSIONS**

**Sectoral Professions** (With year Directives introduced shown in brackets)

- Medicine – (1975 – modified further to simplify arrangements 1986 and 1993)
- Nursing - General Care – (1977)
- Midwifery – (1983)
- Pharmacy – (1985)
- Dentistry – (1978)

Directives have provided for: harmonisation of education and training; agreement on minimum educational and training requirements and a listing of qualifications that meet these; and automatic professional recognition of an individual holding a listed qualification.

**General System**

- Allied Health professions – e.g. physiotherapists, OTs, SLTs, radiographers, dieticians and others regulated in the UK by the Health Professions Council
- Nursing – specialisms such as mental health and learning disability

For General System professions, there is no harmonisation of education and training – i.e. recognition of qualifications has been on a case-by-case basis and EU member states have retained the right to require compensatory measures (a test of aptitude or period of adaptation up to 3 years).

Source: Young et al. 2009 - Compiled from: EC (undated a) *Professional Qualifications*. Available on website: [http://ec.europa.eu/internal\\_market/qualifications/index\\_en.htm](http://ec.europa.eu/internal_market/qualifications/index_en.htm) (Accessed 01/07/2008)

**BOX 2**  
**KEY CHANGES INTRODUCED BY EU DIRECTIVE 2005/36/EC**

- Under EU Directive 2005/36/EC any professional registered (for at least two years) in one EU/EEA member state now has automatic entitlement to provide, for a limited period each year, services in another member state **without registering with the appropriate regulatory body**. Thus a health professional from the EU/EEA wishing to work temporarily in the UK need only give a declaration, in advance, of an intention to work to the relevant competent UK authority (DfES, 2008).
- In addition, and particularly relevant to the AHPs which have not previously had sectoral mutual recognition, the Directive permits the formation of profession specific '**common platforms**' – i.e. where previously agreement on mutual recognition would have been needed between all 27 EU member states, voluntary agreements are now possible between fewer states (two-thirds of states where a particular professional is recognised), which predefine the necessary qualification criteria for registration. If such criteria are complied with there is no need for further compensatory measures (ER-WCPT, 2006). As Petchey and Needle (2007) notes the overall purpose of common platforms is to enhance professional mobility through increased transparency and decreased bureaucracy.

Source: Young et al. 2009

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