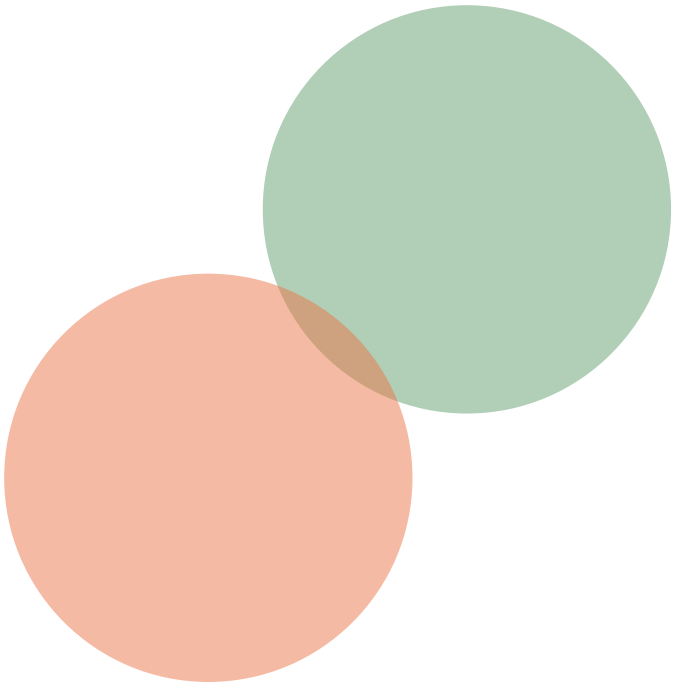
REAL Supply

TOPIC 3:
International migration of health and social care workforce

Authors:
Florin Vadean
Stephen Allan
Gintare Malisauskaite



University of York
University of Kent
University of Aberdeen
SPRE
Part of: The Health Foundation REAL Centre

Contents

Plain English summary

Context

The UK has long relied on international migration to fill gaps in its health and social care workforce. Training new UK professionals takes years, so recruiting workers from abroad has been a quick way to address shortages. However, experts warn that while immigration helps in the short term, a long-term solution requires better pay, working conditions, and funding for UK staff. This research looks at how many migrant workers are in the sector, where they come from, and the impact they have on healthcare and social care services.

Knowledge gap

There is limited research on the impact of migrant health and social care workers in the UK, especially on patient care, workforce stability, and regional staffing shortages. There is also little data on how well migrant workers integrate into the workforce, their career progression, and whether they face challenges like lower pay or poor working conditions. Another area lacking research is the reasons why UK-trained professionals are leaving for other countries and what could be done to retain them.

Value

Research on international migration of health and social care workforce provides essential evidence for policymakers to improve workforce planning in health and social care. Understanding the role of migrant workers in improving staffing and reducing vacancies, in particular in underserved areas, helps ensure services remain sustainable. Assessing the contribution migrant staff make to care quality could provide evidence of the importance of immigration policies in supporting health and social care provision. Moreover, evidence on labour market outcomes of migrant workforce can inform policies aimed at supporting their integration, preventing discrimination, and maximising their contribution to the UK health and social care sectors.

Impact

The findings can inform better workforce policies to maximise the contribution health and care staff are making to the sector. Insights into pay, working conditions, and migration trends can help improve job satisfaction and staff retention. Ultimately, this research can help create a more stable and effective health and social care workforce, benefiting both workers and the people who rely on these services.

Introduction

International migration to the UK has traditionally been a quite reliable source of health and social care workforce, filling in gaps in the local training and labour supply. In particular, in the short term, the size of the healthcare workforce cannot be increased through recruitment of UK nationals, as medical and nursing training takes several years (**Sumption and Strain-Fajth, 2023**). Nonetheless, as stressed by the **Home Office Migration Advisory Committee (2022)** while immigration policy can help with workforce shortages short-term, the long-term solution is in the design and funding of the system, including improving pay and employment conditions.

This pathfinder presents the migrant stocks and flows of health and social care workforce in the UK. Moreover, it discusses existing research on the drivers of international migration decisions, the labour market outcomes of overseas recruited health and social care staff, and their impact on health and social care service supply and quality. The main aim is to identify evidence gaps that could inform policy decisions for a more sustainable health and social care supply in the long-term.

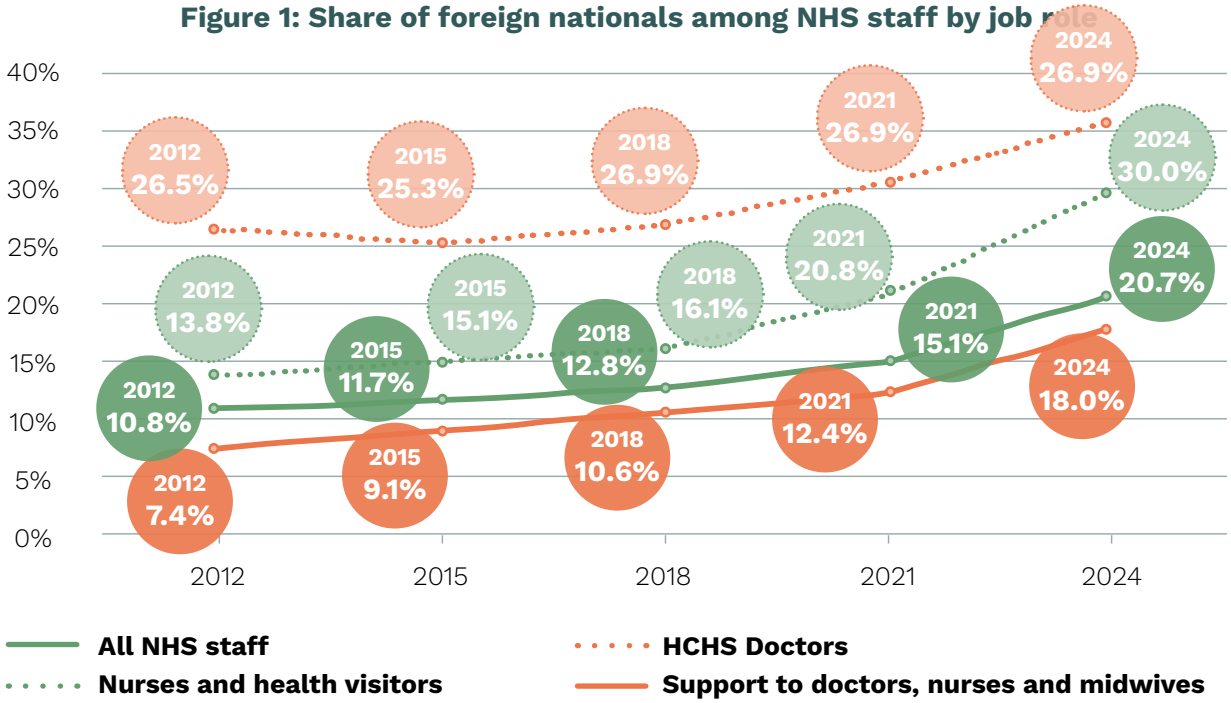
Migrant stock and flows in the UK health and care sectors

Foreign nationals are an important part of the UK health and social care workforce. According to the **NHS England Workforce Statistics**, foreign nationals represented in September 2024 almost 21% of NHS staff, a rather steep increase from under 11% in the early 2010s (see Figure 1). In particular, the proportion of foreign nationals among doctors increased from 25.3% in 2015 to 36% in 2024, while the share of foreign nationals among nurses and health visitors doubled from 15% in 2015 to 30% in 2024. The geographic distribution also varies considerably, with London, South East and Eastern regions attracting the highest shares of migrants (**Sumption and Strain-Fajth, 2023**).

The share of foreign nationals may, though, understate the role of overseas trained staff in the health and social care sectors, as some migrants become UK citizens after a period of residence in the UK (**Sumption and Strain-Fajth, 2023**). This would explain why according to **General Medical Council (GMC) data**, the share of secondary care doctors in England with an overseas qualification is relatively higher (over 45%) than the number of secondary care doctors with foreign nationality (36%; Figure 1).

The majority of the 120,055 GMC registered doctors in England with an overseas qualification are from former British colonies in South Asia (41.5%), while only 19.1 % are from the EEA, 16.8% from Africa, and 12.7% from the Middle East. Regarding nurses and health visitors, from the about 120,000 foreign nationals, about 35% are Indian, 23% Filipino and 16% have EU/EEA citizenship (**NHS England Workforce Statistics**). Comparatively, about 60% of the dentists trained abroad that are registered with the General Dental Council (GDC) have a EEA qualification, and the share of EEA-qualified dentists is further increasing. This was aided by the continued recognition of EEA dentists' qualifications after Brexit (**GDC, 2023**; also see Pathfinder 7: Public sector market power in primary dental care and adult social care and implications for long-term supply).

Figure 1: Share of foreign nationals among NHS staff by job role



Source: NHS England Workforce Statistics - September 2024

In Adult Social Care the share of the workforce with a foreign nationality was rather stable during the 2010s, at about 16%; this was also fairly evenly split between EU (7%) and non-EU (9%) nationals (**Skills for Care, 2024**). The share of foreign nationals in the ASC workforce has experienced, however, a sharp increase after 2021/22, driven by overseas recruitment to fill in vacancies left by a large number of natives leaving the sector. Over a period of just two years (i.e., 2022/23 and 2023/24), the share of non-EU ASC staff doubled, bringing the share of non-UK ASC workforce to over 25%. The three most common nationalities of non-UK ASC workforce are Nigerian (22%), Indian (17%), and Zimbabwean (8%).

Despite the (overall) more restrictive immigration policy implemented in 2021, both the health and social care sector have seen an unprecedented high inflow of overseas workforce. This was possible due to the inclusion of most health and care job roles on the Shortage Occupation List (SOL) (replaced by the Immigration Salary List (ISL) in April 2024), making it easier for UK health and care providers to hire foreign workers (**NHS Employers, 2024**). According to Home Office statistics there have been over 100,000 health and care worker sponsored visas in each 2022/23 and 2023/24, about four times higher than the previous peak registered in the early 2000s (**Home Office 2024**; **Sumption and Strain-Fajth, 2023**).

The imbalance between demand and supply of health and care workforce

The high immigration flows were demand driven. The NHS was advertising about 131,000 FTE jobs (about 9%) in September 2022, with higher vacancy rates for nurses (10.8%). Geographically, the high cost of living has been a key factor in making some areas less attractive for nurses. For example, London had in 2022 a vacancy rate of 14% overall, and over 20% for mental health nurses (**Sumption**

"Despite the (overall) more restrictive immigration policy implemented in 2021, both the health and social care sector have seen an unprecedented high inflow of overseas workforce."

and Strain-Fajth, 2023). The high vacancy rate has persisted despite a strong growth in NHS workforce over the past years, due to the large increase in demand for health professionals related to an aging population and a decrease in productivity (**Sumption and Strain-Fajth, 2023**). Given these realities, the Health Foundation projected in 2022 that even though the NHS was on track to hire 50,000 additional FTE nurses by 2024 (mainly through international recruitment), the increase would not be sufficient to meet the projected demand (**Shembavnekar et al., 2022**).

The system also seems rather ineffective in attracting enough young people in training programmes. Despite the ambition of the **NHS Long-Term Workforce Plan** to expand the education of doctors and nurses, evidence shows that numbers of students entering nursing training in the UK have dropped by 21% between 2021 and 2024 (**Nursing Times, 2024**). Research from the US showed that lack of university and clinical sites to allow for students to be accepted into programmes can be an important issue affecting the number of students trained (**Duvall and Andrews, 2010**). This could currently be highly relevant for the UK, as many universities are reported to be cutting courses, including nursing, due to financial difficulties (**BBC, 2025**). An aspect often criticised is the 2017 axing of bursaries for nursing students (**Nursing Times, 2024**; also see Pathfinder 1: The consequences of non-marginal changes in recruitment into healthcare training).

Current long-term plans for domestic training will, therefore, be rather unlikely to diminish the importance of immigration to the health and social care sectors. Even in the best case scenario, which considers doubling medical school placements and a 1:1 substitution of UK graduates for non-UK graduates, estimates suggest that the reliance on doctors qualified outside of the UK will continue increasing up to 2035 (**GMC, 2024**). The increase in UK medical student graduates will also create additional demand for clinical supervision. The estimates also show there will be differences by UK country, with both England and Wales expected to have almost one in every two doctors as non-UK graduates, compared to Scotland and Northern Ireland, where the ratio will be almost one in every four.

“Current long-term plans for domestic training will, therefore, be rather unlikely to diminsh the importance of immigration to the health and social care sectors.”

In ASC, vacancies, whilst historically above national averages, increased further after the Covid-19 pandemic, reaching 164,000 (10.7%) in 2021/22. Adding care workers and senior care workers job roles to the SOL in February 2022 supported care providers to recruit internationally and helped reduce vacancies to 131,000 (8.3%) in 2023/24. Domestic recruitment (and retention) remains, however, a challenge due to burn-out and dissatisfaction with pay and employment conditions; the number of ASC posts filled by UK nationals decreased by around 70,000 over 2022/23 and 2023/24. As stressed by the **Home Office Migration Advisory Committee (2022)**, while immigration policy can alleviate some of the workforce problems faced by the ASC sector in the short-term, the long-term solution would be in the design and funding of the system.

Skills for Care (2024) recommended the transition to an increased workforce from the UK, with lower reliance on overseas recruitment of staff. It is hoped that this can be achieved, together with improving pay, training and increasing attraction of the sector. Aligning pay and conditions in ASC to those for equivalent roles in the NHS would also support ICSs to develop strategies to create integrated health and social care labour markets and reduce competition for staff between two sectors.

Emigration of health professionals from the UK

The UK is not only a country of immigration, but also of emigration of health and care professionals. According to REAL Centre research, 12,400 registered nurses applied for a Certificate of Current Professional Status (CCPS) in 2022/23, which is a requirement to practice abroad; this was over four times more than in 2018/19 (**Bazeer et al., 2024**). Most nurses applying for a CCPS (about 70%) were overseas trained, with a first qualification outside the UK and the EU, and 80% or applications were for just three countries: Australia, New Zealand and the US. Nurses practising in the UK earn substantially less than many of their counterparts in these destination countries and pay differentials are likely one of the factors in the decisions to move overseas. Other factors could include better working conditions and poor experiences during the Covid-19 pandemic.

According to the GMC data almost 4,000 doctors gave up their licence or left the medical register in 2023 with the aim to 'practice abroad' (**GMC, 2024**). Some of this emigration is inevitable and natural, with about a third of leavers returning to their country of origin, and further about 10% moving to carry out caring responsibilities. Brexit has also played a role, with a large proportion of ophthalmology (76%) and surgery (64%) doctors who joined the specialist register between 2016 and 2018 and left within five years having had a primary medical qualification from an EEA country (**GMC, 2024**). However, a survey of doctors showed that others move due to feeling burned-out and under-valued professionally. Similarly to nurses, the most popular destinations for doctors are high-income English-speaking countries like Australia and New Zealand (**Brennan et al. 2003**). The improvement of working conditions could dissuade some from leaving and improve retention of much needed health professionals in the UK.

Nonetheless, as migrants to the UK return to their native countries, so do UK emigrants return to practice their profession in the UK. For example, 43% of doctors who were under 35 when they left UK practice between 2012 and 2017 had returned, the vast majority within three years of leaving (**GMC, 2024**).

Ethical international recruitment of workforce

While the active recruitment of overseas trained health and care workers can help ease workforce shortfalls in developed countries in the short term, it can also exacerbate shortfalls in low- and lower-middle income countries (**World Health Organisation, 2023**). The UK Department of Health and Social Care (DHSC) recognises this and has adhered to the **WHO Global Code of Practice on the International Recruitment of Health Personnel**. As a result, health and care providers in the UK should not actively recruit from countries on the WHO 'red list' (i.e., having most pressing health and care workforce-related challenges), and migrant health and social care staff in the UK should be guaranteed the same legal rights and responsibilities as domestically trained staff in all terms of employment and conditions of work, including access to further education, training, and professional development. Through bilateral work with many migrant origin countries, the DHSC is committed to support well-managed migration pathways, with the aim to deliver benefits to both the UK health and care sector, the sending countries, and the migrants themselves (**DHSC, 2024**). Despite this, more than 6,000 nurses that joined the UK register in 2022 came from 'red-listed' countries, primarily since individuals can still apply for roles directly (**Buchan et al., 2023**).

Research topics on migration of health and social care workforce

Engagement with sector stakeholders (e.g., Care Worker Charity, Homecare Association, Migration Advisory Committee) as well as discussion between team members and with other academics (e.g., University of Glasgow, The Health Foundation) led to the identification of four topics with implication for the long-term care supply of health and social care workforce and implicitly the long-term care supply of health and care services:

The attractiveness of the UK health and social care sectors and its implication for the international recruitment of health and care staff;

- The impact of immigration on the UK health and social care sectors;
- Labour market outcomes of immigrant health and social care staff;
- The drivers of emigration of healthcare professionals from the UK.

This section discusses existing research on these topics, including evidence gaps that could be covered in Phase 2 of the research programme.

International recruitment of health and care workforce

As illustrated by the large inflow of overseas trained health and care workforce during the early 2020s presented in the previous section, the UK is still a very attractive country for international migrants. Its health and social care sectors greatly benefit from these workforce inflows, without the need to invest in their training, by filling vacancies and helping to meet the increasing demand for services. Nonetheless, high reliance on overseas workers can create risks for the UK health and care systems (**Sumption and Strain-Fajth, 2023**). First, changes in developing countries' supply of international health and care workforce could reduce the ability of the NHS and other care providers to recruit from overseas in the future. As migrant source countries develop and invest more in their health and care sectors, they will likely retain more of the health and care staff. For example, the growing private investments and improved pay and working conditions in Romania's health sector – one of the EU's main emigration countries of healthcare professionals in the 2010s – has almost halved the doctors emigration rate (from 4.2% in 2016 to 2.7% in 2018) and increased the number of doctors practising in Romania by almost 60% (**Ziarul Financiar, 2024**). Second, the increasing demand for health and social care services in developed countries due to population aging may lead to more aggressive competition for international health and care workforce (**Sumption and Strain-Fajth, 2023**; **Skills for Care, 2024**).

One potential policy response to a changing international environment is to take necessary steps to maintain or even improve the UK's international attractiveness. A dominant theory explaining the international migration of labour is the push-pull model which interprets migration flows as a function of differences in income and other opportunities between origin and destination countries. The model distinguishes between push factors, which are negative conditions that drive people to move abroad (e.g., low income opportunities, poor employment conditions, high unemployment, political unrest, and severe weather/climate) and positive pull factors, which attract people to a destination

(e.g., high income, good job opportunities, as well as social, political and economic freedoms). There is substantial evidence on the drivers and barriers to international migration of medical staff to the UK. A scoping review of this literature by **Brennan et al. (2023**) identified 40 studies, including both quantitative, qualitative, and mixed-methods studies.

Brennan et al. (2023) show that while micro-level factors (e.g., financial gain, better quality of life, and family reasons) are usually linked to personal circumstances and preferences, policy-makers have influence on macro-factors. One of the most important macro-level drivers is employment opportunities, which currently are quite substantial in the UK, due to the high vacancy levels in health and social care. Policy-makers still need to prioritise improving working conditions in the NHS, as well as training and development opportunities, which are further important macro-factors not only for international attractiveness of the UK health and care sectors but also for attracting young people within the economy to pursue a career in these sectors. On the other hand, the immigration policy and assessment requirements for recognition of overseas qualifications are important barriers to migration. A cross-country study by **Adovar et.al. (2021)** shows, for example, that while the push and pull factors are influenced by historic, linguistic and geographic ties between countries (e.g., colonial ties), the migration of doctors is sensitive to visa restrictions, point-based systems, recognition of qualifications, and options of obtaining permanent resident status. A Nuffield Trust report on the UK healthcare market argued that several specialities of medicine were facing chronic shortages, like cardiothoracic surgery and anaesthetics. This was due to a substantial drop in recruitment from the EU/EEA after Brexit (and the introduction of the new immigration policy in 2021), with no increase in recruitment from the rest-of-the-world (**McCarey et al., 2022**). On the other hand, dentists with an EU/EEA qualification still move to the UK in large numbers, aided by the legislation which enables the GDC to continue to recognise their qualifications.

The impact of immigration on the UK health and social care sectors

Research shows that international recruitment policies of medical graduates help alleviate workforce shortages in many developed countries, with policies requiring or giving incentives to overseas trained doctors to work for a period of time in underserved areas being effective (see **Beduchaud et al., 2024** for a systematic review). In the US, overseas trained doctors were more likely to work in a Health Professional Shortage Area (HPSA) and less likely in rural areas, indicating that the active recruitment of overseas doctors for HPSAs benefits urban areas more (**Ramesh et al., 2023**). In Canada, despite the absence of policies requiring immigrant medical graduates to work in a rural (or underserved area) for a specific period, overseas trained medical graduates were more prevalent in rural areas than Canadian trained doctors (**Thind et al., 2007**). In Australia, immigrant medical graduates were more likely to work in small towns (**O'Sullivan et al., 2019**). Moreover, overseas trained doctors were more likely to work in rural areas compared to both Australian medical graduates and foreign graduates of an Australian (or New Zealand) accredited medical school, showing that the coercive migration policy applied by Australia appears to be effective (**McGrail et al., 2019**). Similarly, for New Zealand, international medical graduates were overrepresented among both registered physicians and GPs working in rural areas (**Graces-Ozanne et al., 2011**). Nonetheless, the effectiveness of such policies in solving healthcare staff shortages in underserved areas in the long-term is uncertain, as satisfaction with professional life and lifestyle is crucial for retention (**Malau-Aduli et al., 2020**). Evidence suggests that immigrant medical graduates have a lower retention rate in underserved areas than natives (**Mathews et al., 2008**; **McGrail et al., 2015**).

The literature review by **Beduchaud et al. (2024)** revealed important gaps in the geographical representativeness of research on this topic, with no studies identified on European countries, including the UK.

Research on the impact of international migration on social care provision is also limited to the US. **Grabowski et.al. (2023)** showed that immigration increases staffing levels in US nursing homes, particularly in full-time positions, with a positive effect on residents' outcomes. This positive impact on staffing can partly be explained by immigrants having higher retention rates (Rapp and Sicsic, 2020), which likely have knock-on effects on continuity of care. Research on the impact of international migration on social care provision in the UK would fill an important gap. Such research could also provide much needed evidence on levers to improve labour markets in coastal and rural areas (**Skills for Care, 2024**).

There is also limited evidence on the impact of immigration of healthcare professionals on the quality of healthcare supply. A study by **Nicodemo et al. (2024)** shows that GP practices with a higher share of overseas-trained GPs prescribe – everything else being equal – more medication such as antibiotics, analgesics, antacids, and statins. However, there was no evidence of any impact on patient satisfaction or unplanned hospitalisations. We identified no studies on the impact of immigration of healthcare professionals on other aspects of quality of healthcare supply, e.g., waiting times in A&E departments or levels of outpatient treatment.

We further did not identify any research evidence on the impact of immigration on productivity in the health and social care sectors specifically. Nonetheless, research evidence from the UK suggests that immigration, in general, has a positive and significant impact on productivity, with more positive results for higher skilled immigrants and no negative impact for low-skilled immigrants (**Campo et al., 2018**). There is some limited evidence that immigrant health and care staff would complement natives in terms of work patterns, by being more likely to work night shifts and weekends (**Fernadez-Reino and Brindle, 2024**). While in the short-term the main contribution of immigration to the UK health and social care sectors consists in filling substantial labour supply gaps, evidence on the impact of immigration on productivity could inform long-term staff planning.

Immigrants' labour market outcomes

"As the inflow of migrants in the health and care sector grows, it is crucial to understand the dynamics of their employment, career progression, and pay relative to their native counterparts."

As the inflow of migrants in the health and care sector grows, it is crucial to understand the dynamics of their employment, career progression, and pay relative to their native counterparts. This should help the development of policies aimed at preventing discrimination or exploitation, as well as support migrants' adaptation to working life in the UK.

Chiswick's (1978) theoretical model highlights the importance of host country-specific human capital (e.g., language, local labour market, etc.) as a determinant for labour market outcomes (e.g., pay). Immigrants start with lower levels of country-specific knowledge and skills. Therefore, at time of entry they would experience a wage gap compared to natives. The gap will, however, close over time, as immigrants invest in country-specific skills. Empirical studies, like for example **Gorshkov (2024)**, often analyse whole country labour markets, and not specific sectors. A valuable insight is that sorting into low-paying

firms at time of arrival accounts for an important part of the immigrant-native wage gap, and transition to higher paying firms constitutes a crucial factor in wage assimilation. In the context of (non-clinical) health and social care immigrant workforce, some migrants may find it easier to find lower-paying jobs in the ASC sector, and use them as stepping stones to higher paying jobs in the NHS (**Hussein et al., 2011**).

A scoping review of motivations, challenges and integration of overseas educated healthcare workers in the UK, identified 24 papers, out of which 19 focus on nurses and five on midwives and other allied health professionals (**Omiyi et al., 2024**). The methods used in the studies were mostly qualitative, comprising individual interviews, group interviews, focus groups, as well as survey and document analysis. Only one study included (descriptive) data on applications to the Nursing and Midwifery Council (NMC) register (**Plotnikova, 2013**). The review highlights that despite their contribution to the healthcare sector, overseas trained healthcare professionals face various challenges like unrecognized skills (more prevalent for nurses working in ASC), third-party recruitment issues (e.g., non-NHS organisations working outside the ethical principles and codes of practice (**Adhikari and Grigulis, 2014**), an issue that has seen improvement in recent years), and cultural adjustment difficulties (often related to inadequate language/communication skills required in practice).

For the ASC context, a scoping review by **Turnpenny and Hussein (2022)** similarly identified mostly qualitative evidence on the outcomes of migrant home care workers in the UK and their contribution to homecare provision. The reviewed literature often mentioned discrimination, racism, and unfair treatment, in particular for non-white migrant care workers (**Shutes and Walsh, 2012**; **Stevens et al., 2012**); racism being often expressed through cultural and linguistic 'grievances'. The review also highlighted the vulnerability of migrant care workers to isolation, emotional challenges, gendered risk of abuse, and unfair treatment, related to the personalised nature of home care and emotional content of the relationship between care worker and cared for person, especially in the case of live-in care (**Christensen and Manthorpe, 2016**). Moreover, a comparative study of migrant workers in elderly care in Italy, the Netherlands and England, showed that migrants were more likely to do shift work, work nights and overtime, arguing that migration policies have an important role in shaping the conditions under which migrant care workers are employed, with irregular migrants and migrants dependent on work permits being more likely to accept poor employment conditions and to be vulnerable to exploitation (**van Hooren, 2012**). The power imbalance between migrant care workers and care providers and risk of exploitation are particularly relevant in the context of the current immigration policy, with migrant care workers dependent on their sponsor-employer due to short time frames, high costs and the administrative burden involved in changing jobs (**Sehic and Vicol, 2023**).

The drivers of emigration of health and care professionals from the UK

Similar to assessing the drivers of immigration to the UK, the drivers of emigration of health and care professionals form the UK can be explained through pull and push factors, and **Brennan et al. (2023)** shows that key drivers of immigration of doctors *to* the UK were also explaining emigration *from* the UK.

In the case of emigration from a developed country with a strong healthcare sector (like the UK), push factors (e.g., poor employment conditions and lack of employment opportunities) may not be as important as for emigration from developing countries. Still, countries like Australia, Canada, New Zealand, and the US are attractive for UK healthcare professionals by offering better pay, development opportunities, and a better quality of life.

A survey of UK graduates of 2008 and 2012, three years after graduation, found that 50% were considering leaving the UK. Many respondents expressed negative views with the experience of being a junior doctor in the NHS, the difficulty of delivering good high-quality care in an under-funded system, were dissatisfied with workload and pay, and were of the view that conditions would be better elsewhere (**Lambert et al, 2017**). More recent interviews with junior doctors working in the NHS who considered leaving the UK also revealed pressures with having to choose a specialty, exposure to workplace bullying, and difficulties in raising concerns as important reasons (**Smith et al., 2018**). A pull factor for the emigration of UK-trained GPs was found to be the lower uncertainty around career and clinical outcomes in Australia, with more risk averse GP likely to emigrate (**van der Pol et al., 2019**). With respect to more specialist roles, a study by **Crossland et al. (2021)** highlights the high turnover (42% over 10 years) for congenital cardiac surgeons and cardiologists. Of those leaving, almost 50% moved to work abroad due to financial reasons, work-life balance, and working conditions in the NHS.

Smith et al. (2018) shows that UK young doctors' intentions to move abroad were rather related to a temporary break from their current working lives than to moving abroad permanently. Nonetheless, a survey of UK-trained doctors in New Zealand found that although only 30% had initially intended to emigrate permanently, 89% intended to stay at the time of the survey, revealing that despite initial intentions, most doctors move abroad permanently (**Sharma et al., 2012**). UK-trained doctors in New Zealand had higher job satisfaction and time available for leisure than their UK-based counterparts, and the main reason for staying was the preference for the lifestyle there. These findings were confirmed by a other survey of UK-trained doctors that found that their move to New Zealand was mainly motivated by quality of life considerations, and the desire to leave the NHS (**Gauld and Horsburgh, 2015**).

All these findings highlight the importance of improving pay and working conditions in the NHS to improve staff retention and maximise the workforce potential, which links strongly to Pathfinder 2: The role of pay and contracted conditions in sustaining the health and adult social care workforce for the long term.

Research gaps

Based on the research evidence discussed above, we identified several research gaps.

We found no UK research on the impact of immigration on health and social care workforce on health and social care provision, such as increasing staffing, improving skill mix and reducing vacancies in NHS trust and social care providers. Evidence on immigrant health and care staff's propensity to settle and improve supply in underserved areas could, for example, help shape policies on incentives/tie-ins for a period of time after arrival.

While there are studies assessing the impact of immigration (overall) on waiting times in A&E departments and outpatient treatment (i.e., from the demand side), research is also needed on the contribution of overseas trained doctors and nurses on improving healthcare provision (i.e., increasing number of treatments and/or decreasing waiting times). This would provide an evaluation of the success of immigration policies in supporting the health sector. The same would be true for the immigration of social care staff, with lack of UK evidence on its contribution to sustain/improve care quality and care recipients' quality of life.

There is also limited quantitative evidence on the labour market outcomes (e.g., pay, contract type, job role/career progression) of immigrant health and social care staff. Such evidence could help inform policies aimed at supporting immigrants' adjustment to working life in the UK, labour market integration, and discrimination prevention, to maximise immigrants' contribution to the UK health and care sectors.

References

Adhikari, R. and Grigulis, A. (2014). Through the back door: nurse migration to the UK from Malawi and Nepal, a policy critique. Health Policy and Planning 29(2): 237-245. **https://doi.org/10.1093/heapol/czt010**

Adovor, E., Czaika, M., Docquier, F. and Moullan, Y. (2021). Medical brain drain: How many, where and why?. Journal of Health Economics 76. **https://doi.org/10.1016/j.jhealeco.2020.102409**

Bazeer, N., Kelly, E. and Buchan, J. (2024). Nursing locally, thinking globally: UK-registered nurses and their intentions to leave. London: The Health Foundation.

BBC News (2025). Cardiff University plans to cut 400 jobs and axe courses. **https://www.bbc.co.uk/news/articles/c0k5n0k101lo**

Beduchaud, L., Celingant, E., Faure, C., Meunier, M. and Blanco-Cazeaux, I. (2024). Do international medical graduates' recruitment policies help to overcome healthcare shortage areas in developed countries? A systematic review. *Health Policy 150*. **https://doi.org/10.1016/j.healthpol.2024.105190**

Brennan, N., Langdon, N., Bryce, M., Burns, L., Humphries, N., Knapton, A. and Gale, T. (2023). Drivers and barriers of international migration of doctors to and from the United Kingdom: a scoping review. *Human Resources for Health 21*(11). **https://doi.org/10.1186/s12960-022-00789-y**

Buchan, J., Shembavnekar, N. and Bazeer, N. (2023). How reliant is the NHS in England on international nurse recruitment? London: The Health Foundation.

Campo, F., Forte, G. and Portes, J. (2018). The Impact of Migration on Productivity and Native-Born Workers' Training. IZA DP no. 11833. Bonn: Institute of Labour Economics.

Chiswick, B. R. (1978). The Effect of Americanization on the Earnings of Foreign-born Men. *Journal of Political Economy 86*(5): 897–921. **http://www.jstor.org/stable/1828415**

Christensen, K. and Manthorpe, J. (2016). Personalised risk: new risk encounters facing migrant care workers. *Health, Risk & Society 18*(3-4): 137-152. **https://doi.org/10.1080/13698575.2016.1182628**

Crossland, D.S., Ferguson, R., Magee, A., Jenkins, P., Bulock, F.A., Parry, A., Babu-Narayan, S.V., Carroll, A., Daubeney, P.E.F. and Simpson, J. (2021). Consultant staffing in UK congenital cardiac services: a 10-year survey of leavers and joiners. *Open Heart 8*: e001723. **https://doi.org/10.1136/openhrt-2021-001723**

Department of Health and Social Care (2024). Code of practice for the international recruitment of health and social care personnel in England. London: Department of Health and Social Care.

Duvall, J. and Andrews, D. (2010). Using a Structured Review of the Literature to Identify Key Factors Associated With the Current Nursing Shortage. *Journal of Professional Nursing 26*(5): 309-317. **https://doi.org/10.1016/j.profnurs.2010.02.002**

Fernández-Reino, M. and Brindle, B. (2024). Migrants in the UK labour market: an overview. Migration Observatory briefing, COMPAS, University of Oxford.

Garces-Ozanne, A., Yow, A. and Audas, R. (2011). Rural practice and retention in New Zealand: an examination of New Zealand-trained and foreign-trained doctors. The New Zealand Medical Journal 124(1330): 14-23. **http://www.nzma.org.nz/journal/124-1330/4554/**

Gauld, R. and Horsburgh, S. (2015). What motivates doctors to leave the UK NHS for a "life in the sun" in New Zealand; and, once there, why don't they stay?. *Human Resources for Health 13*:75. **https://doi.org/10.1186/s12960-015-0069-4**

General Dental Council (2023). The GDC welcomes the news that European dental qualifications will continue to be recognised in the UK for the next five years. London: General Dental Council.

General Medical Council (2024). The state of medical education and practice in the UK. Workforce report 2024. London: General Medical Council.

General Medical Council Data Explorer. (Accessed on 15 January 2025) **https://gde.gmc-uk.org/the-register/register-summary/register-data-summary**

Gorshkov, A. (2024). Job ladders and labour market assimilation of immigrants. *Labour Economics 90*. **https://doi.org/10.1016/j.labeco.2024.102594**

Grabowski, D.C., Gruber, J. and McGarry, B. (2023). Immigration, The Long-Term Care Workforce, and Elder Outcomes in the US. National Bureau of Economic Research WP30960. **https://doi.org/10.3386/w30960**

Home Office (2024). Immigration system statistics, year ending March 2024. **https://www.gov.uk/government/statistics/immigration-system-statistics-year-ending-march-2024**

Hussein, S., Manthorpe, J. and Stevens, M. (2011). Social care as first work experience in England: a secondary analysis of the profile of a national sample of migrant workers. *Health & Social Care in the Community 19*(1): 89-97. **https://doi.org/10.1111/j.1365-2524.2010.00957.x**

Ishimura, N., Inoue, K., Maruyama, S., Nakamura, S. and Kondo, N. (2024). Income Level and Impaired Kidney Function Among Working Adults in Japan. *JAMA Health Forum 5*(3): e235445. **https://doi.org/10.1001/jamahealthforum.2023.5445**

Lambert, T.W., Smith, F. and Goldacre, M.J. (2018). Why doctors consider leaving UK medicine: qualitative analysis of comments from questionnaire surveys three years after graduation. *Journal of the Royal Society of Medicine 111*(1):18-30. **https://doi.org/10.1177/0141076817738502**

Malau-Aduli, B.S., Smith, A.M., Young, L., Sen Gupta, T. and Hays, R. (2020). To stay or go? Unpacking the decision-making process and coping strategies of International Medical Graduates practising in rural, remote, and regional Queensland, Australia. *PLoS ONE 15*(6): e0234620. **https://doi.org/10.1371/journal.pone.0234620**

Mathews, M., Edwards, A.C. and Rourke, J.T. (2008). Retention of provisionally licensed international medical graduates: a historical cohort study of general and family physicians in Newfoundland and Labrador. *Open Medicine 2*(2): e37-44.

McCarey, M., Dayan, M., Jarman, H., Hervey, T., Fahy, N., Bristow, D. and Greer, S.L. (2022). Health and Brexit: six years on. London: Nuffield Trust.

McGrail, M.R., O'Sullivan, B.G., and Russell, D.J. (2019). Rural Work and Specialty Choices of International Students Graduating from Australian Medical Schools: Implications for Policy. *International Journal of Environmental Research and Public Health 16*(24): 5056. **https://doi.org/10.3390/ijerph16245056**

McGrail, M.R. and Humphreys, J.S. (2015). Geographical mobility of general practitioners in rural Australia. *Medical Journal of Australia 203*(2): 92-96. **https://doi.org/10.5694/mja14.01375**

Migration Advisory Committee (2022). Adult Social Care and Immigration: A Report from the Migration Advisory Committee. London: Home Office Migration Advisory Committee.

NHS Employers (2024). Immigration Salary List now available. **https://www.nhsemployers.org/news/immigration-salary-list-now-available**

NHS England (2024). NHS Workforce Statistics - September 2024 (Including selected provisional statistics for October 2024). **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2024**

NHS England (2023). NHS Long Term Workforce Plan. London: NHS England.

Nicodemo, C., Orso, C.E. and Tealdi, C. (2024). Overseas general practitioners (GPs) and prescription behaviour in England. *Health Policy 140*. **https://doi.org/10.1016/j.healthpol.2023.104967**

Nursing Times (2024). Student nurse numbers fall by 21% in three years. **https://www.nursingtimes.net/education-and-training/student-nurse-numbers-fall-by-21-in-three-years-19-09-2024/**

Omiyi, D., Wilkinson, E. and Snaith, B. (2024). Exploring the Motivations, Challenges, and Integration of Internationally Educated Healthcare Workers in the UK: A Scoping Review. P*olicy, Politics, & Nursing Practice 2024*. **https://doi.org/10.1177/15271544241289605**

O'Sullivan, B., Russell, D.J., McGrail, M.R. and Scott, A. (2019). Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. *Human Resources for Health 17*(8). **https://doi.org/10.1186/s12960-018-0339-z**

Plotnikova, E.G. (2013). The Recruitment of Foreign Nurses in the UK: Exploring the Shifts over the Last 15 Years. Humanities & Social Sciences 8(6): 1205-1218.

Rapp, T. and Sicsic, J. (2020). The contribution of the immigrant population to the US long-term care workforce. *Social Science & Medicine 263*. **https://doi.org/10.1016/j.socscimed.2020.113305**

Sehic, A. and Vicol, D.O. (2023). Systemic drivers of migrant worker exploitation in the UK. London & Manchester: Work Rights Centre.

Sharma, A., Lambert, T.W. and Goldacre, M.J. (2012). Why UK-trained doctors leave the UK: cross-sectional survey of doctors in New Zealand. *Journal of the Royal Society of Medicine 105*(1): 25-34. **https://doi.org/10.1258/jrsm.2011.110146**

Shembavnekar, N., Buchan, J., Bazeer, N., Kelly, E., Beech, J., Charlesworth, A., McConkey, R. and Fisher, R. (2022). NHS workforce projections 2022. London: The Health Foundation.

Shutes, I. and Walsh, K. (2012). Negotiating User Preferences, Discrimination, and Demand for Migrant Labour in Long-Term Care. *Social Politics: International Studies in Gender, State & Society 19*(1): 78-104. **https://doi.org/10.1093/sp/jxr025**

Skills for Care (2024). The state of the adult social care sector and workforce in England. Leeds: Skills for Care.

Smith, S.E., Tallentire, V.R., Pope, L.M., Laidlaw, A.H. and Morrison, J. (2018). Foundation Year 2 doctors' reasons for leaving UK medicine: an in-depth analysis of decision-making using semistructured interviews. *BMJ Open 8*(3): e019456. **https://doi.org/10.1136/bmjopen-2017-019456**

Stevens, M., Hussein, S. and Manthorpe, J. (2011). Experiences of racism and discrimination among migrant care workers in England: Findings from a mixed-methods research project. *Ethnic and Racial Studies 35*(2): 259–280. **https://doi.org/10.1080/01419870.2011.574714**

Sumption, M. and Strain-Fajth, Z. (2023). Migration and the health and care workforce. ReWage and Migration Observatory Evidence Paper, COMPAS, University of Oxford.

Thind, A., Freeman, T., Cohen, I., Thorpe,C., Burt A. and Stewart, M. (2007). Characteristics and practice patterns of international medical graduates. How different are they from those of Canadian-trained physicians?. *Canadian Family Physician 53*(8): 1330-1331. **https://www.cfp.ca/content/53/8/1330**

Turnpenny, A. and Hussein, S. (2022). Migrant Home Care Workers in the UK: a Scoping Review of Outcomes and Sustainability and Implications in the Context of Brexit. *Journal of International Migration & Integration 23*: 23–42. **https://doi.org/10.1007/s12134-021-00807-3**

van der Pol, M., Scott, A. and Irvine, A. (2019). The migration of UK trained GPs to Australia: Does risk attitude matter?. *Health Policy 123*(11): 1093-1099. **https://doi.org/10.1016/j.healthpol.2019.09.003**

van Hooren, F.J. (2012). Varieties of migrant care work: Comparing patterns of migrant labour in social care. *Journal of European Social Policy 22*(2): 133-147. **https://doi.org/10.1177/0958928711433654**

World Health Organisation (2023). Key issues for health workforce in the Global Monitoring Report 2023. Geneva: World Health Organisation.

World Health Organisation (2010). WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organisation.

Ziarul Finaciar (2024). Numărul de medici practicanţi din România a crescut cu aproape 60% în şase ani. Ce îi motivează să nu mai emigreze şi cum ajută mediul privat la retenţia lor. **https://www.zf.ro/inovatie-si-excelenta-in-medicina/numarul-de-medici-practicanti-din-romania-a-crescut-cu-aproape-60-in-22402087**